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Reform disorder

EDITORIAL

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Do we need a healthcare reform? Not if it is driven by a desire to be seen rather than the aim of genuine service development.

Photo: Sturlason

'Renew, reinforce, refine' (1).

The Norwegian Minister of Health and Care Services, Jan Christian Vestre's favourite phrase about general practice lies at the heart of the Healthcare Reform Committee's remit. The committee began its work in August last year and is due to submit proposals for an integrated health and care service on 2 November. Many of the proposals will shape health policy and the health service for years to come. The Minister has already signalled what he describes as the largest healthcare reform in 25 years (2).

A range of areas are to be reviewed and reconsidered (3). What is the value of maintaining a distinction between primary and secondary care? How should responsibilities be divided between local authorities and the specialist health service? And what should be done about private healthcare providers?

As regards primary care, the Minister's instructions to the head of the Healthcare Reform Committee, Gunnar Bovim, might have been along the lines of: 'Give me headlines, Gunnar. We need something new. Particularly for general practice and the rest of the frontline services. It needs to be forward-looking and effective!'

Against this backdrop, it is worth questioning the value of the general practitioner (GP) system, currently marking its 25th anniversary (4), which connects 98 % of Norway's population (5) to one of 5758 (6) GPs with

registered patient lists. The task of reviewing healthcare services and making proposals and recommendations seems daunting. As is often the case with the current Health Minister, it must be done quickly and packaged as a named reform. Everything, it seems, is moving too slowly for Jan Christian Vestre (7). The Norwegian Directorate of Health appears to be under considerable pressure, with a large number of responsibilities assigned by the Ministry of Health and Care Services in recent years, often subject to tight deadlines. This is concerning if important processes and changes risk being rushed. Major change requires a specialist directorate to be given the framework to carry out thorough work.

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New tasks risk crowding out important maintenance work at the Directorate, such as the revision and updating of guidelines. While there is scope to strengthen and improve this work, clinical guidelines are not a particularly 'saleable' political product.

Several projects have been launched in parallel, some of which have been grouped under a list of particularly promising initiatives: Project X (8). This includes proposals such as transferring antenatal care to midwives (without the involvement of a doctor), closer collaboration between admissions units at district psychiatric centres (DPS) and local authorities, and multidisciplinary teams for older patients with complex needs, involving a geriatrics specialist, GP, pharmacist and district nurse. The nature of these initiatives varies considerably, as does their potential.

How does the Healthcare Reform Committee see the GP system fitting into the organisational structure, and what changes are proposed? Is it to remain in primary care, or should it be managed by hospitals or regional health authorities? All of these options are apparently on the table.

As a GP committed to collaboration across healthcare professions, I find it difficult to see how reorganising service levels would lead to any real improvement. Collaboration across different service levels can be challenging, but little is likely to be gained by changing logos on uniforms or the names of employers. What matters most is how we work together, and the recognition that patients are not problems to be passed between services, but a shared responsibility.

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According to the action plan for general practice, the future service will be team-based (9). However, Norway's 1331 GP practices (10) are already effective teams where doctors and medical secretaries work alongside other occupational groups, although not necessarily in the same physical premises. The guiding principle is that staffing is determined by need, not the other way around.

Psychologists and physiotherapists are seeking integration into Norwegian general practice, and reimbursement for consultations with nurses was introduced on 1 January (11–13). An unintended consequence of requiring nurses or other occupational groups to be part of the practice team may be that service delivery becomes increasingly driven by reimbursement opportunities.

With an ageing population and increasing digital access, priority setting is arguably the most important task for healthcare personnel in the years ahead. This means saying no to some things in order to say yes to others. In Norwegian GP practices and out-of-hours services, triage is carried out daily between urgent and non-urgent care. It is a finely tuned and well-calibrated system, but one that requires continuous efforts to maintain quality.

Norway ranks highly in international comparisons of the world's best health and care systems. In my experience, other countries look to Norway when organising their primary care services. For example, one of the largest regional health authorities in Finland has now introduced a model similar to the Norwegian system (14).

There is considerable scope for improvement that does not involve major structural reform. One possibility is a clearer specification of what GPs and practices are expected to deliver. Another is systematic quality improvement efforts with the GP practice as the unit of quality. If there are too many and too far-reaching measures, the result is unlikely to be 'renew, reinforce and refine', instead it will drive up costs, complicated matters and lead to frustration.

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