Norsk forening for allmennmedisin

DEN NORSKE LEGEFORENING

# *Continuty of care and the Norwegian «fastlegeordningen» - the regular GP Scheme*

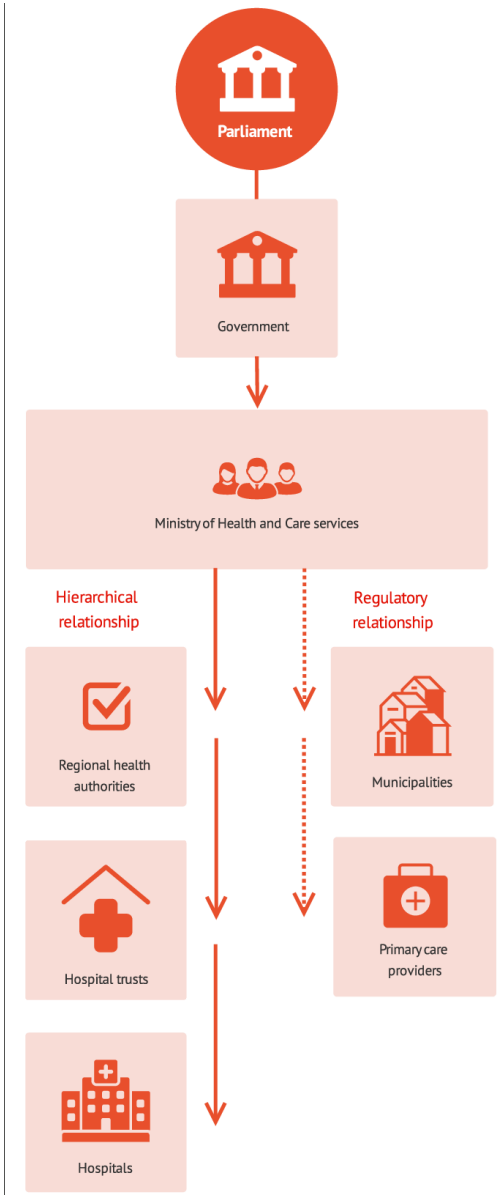
*Marte Kvittum Tangen*

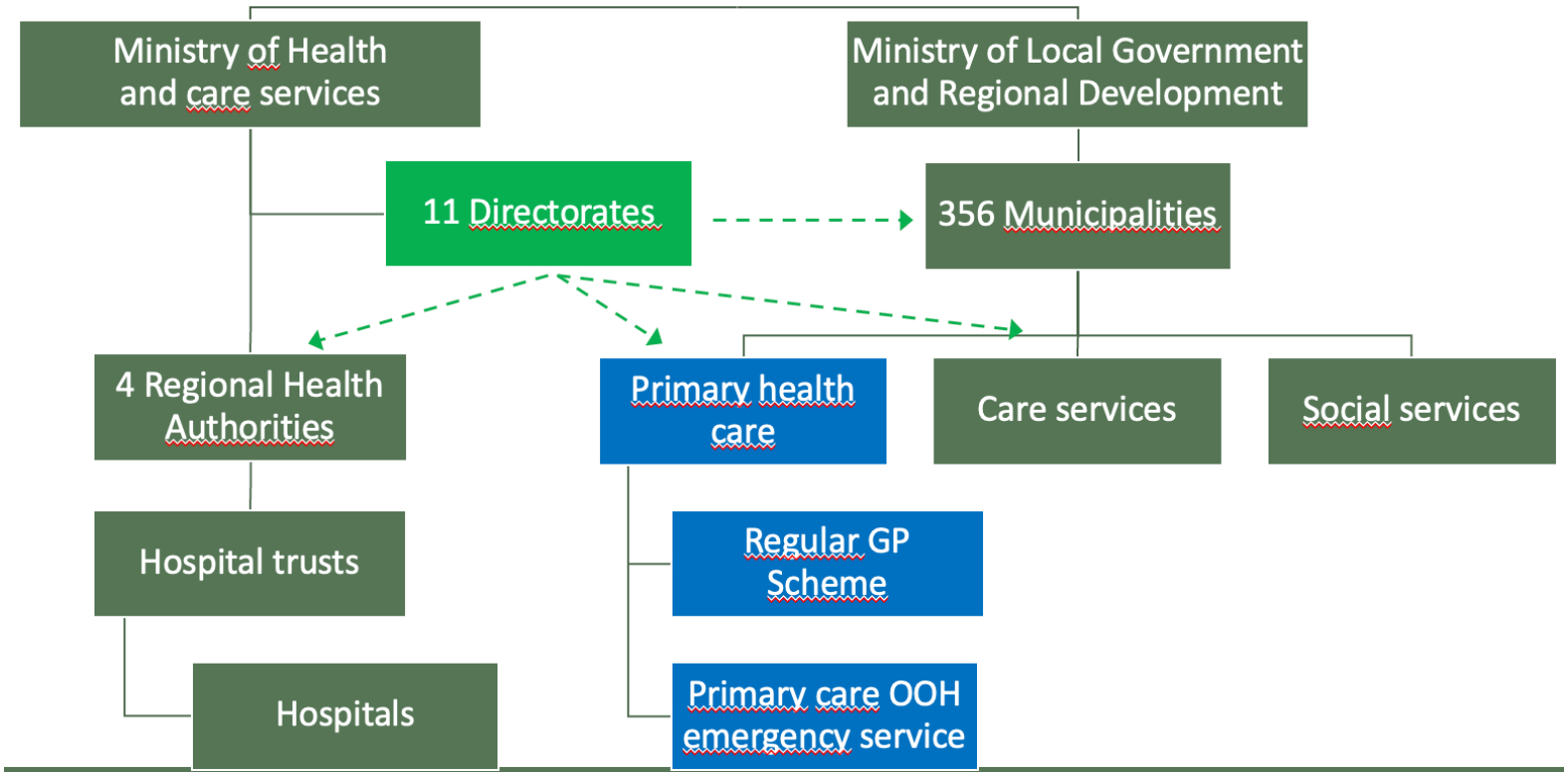
Chair of the Norwegian College of General Practice

# *Norway*

- 5.4 million inhabitants
- Life expectancy in 2020 was 84.9 years for women and 81.5 years for men
- Strong economy
- Challenging geography
- Many small peripheral communities
- 365 municipalities (Utsira 192 inhabitans and Oslo 699 827 inhabitants).
- 11 counties

# The Norwegian Health system




Ministry of Health and care services
Ministry of Local Government and Regional Development
11 Directorates
356 Municipalities
4 Regional Health Authorities
Primary health care
Care services
Social services
Hospital trusts
Regular GP Scheme
Hospitals
Primary care OOH emergency service

# Primary care

municipalities health care consist of

- general practitioneers services
- emergency room services/ out-of-hours emergency primary health care
- district (or city) medical officers
- physiotherapists/ergotherapist
- nursing homes and care homes
- midwife services and nursing services (including home nurses, public health nurses, school health nurses and psychiatric nurses)

# *Norwegian General Practice*

## 1948-

- Inspiration: *NHS - Universal, free at the point of care, patient lists*
- Private practice is the norm. overseen by District medical officers
- General Practice develops its unique basis and is recognized as a medical specialty with university departments

## 1984: the Municipal Health Services Act

- The municipality must provide GP services including out-of-hours
- GP's are either employed or contracts written with private GP's

## 1990's

- GP's are unhappy with government control
- Municipal GP's slower to start using new equipment/techniques
- Fewer consultations per GP
- Turnover increases (GP's leave their positions faster)
- Recruitment slows down

**Marte Kvittum Tangen**

# General practice in Norway
# 25 years ago

- no listing system
- no predictability for the patients
- less personal responsibility, no obligation for the doctor
- little coordination of services
- little advanced medicine
- long waiting times
- little autonomy – varying professional development

# *The regular GP scheme of 2001 - a patient list system*

**The citizen**

- has a right to a regular GP
- pays a small amount (15-40 € per consultation, maximum 300 €/year)

**The local government (municipality)**

- responsible for the GP service including out-of-hours service
- contracts with GP's
- reimbursed per citizen (not per GP)

**The general practitioner**

- agrees to take care of a set number of patients in office hours
- must participate in out-of-hours service
- runs the practice or is employed

**The central government**

- determines the prices and fees – good cost control
- *should* take responsibility for quality, development, infrastructure, research etc

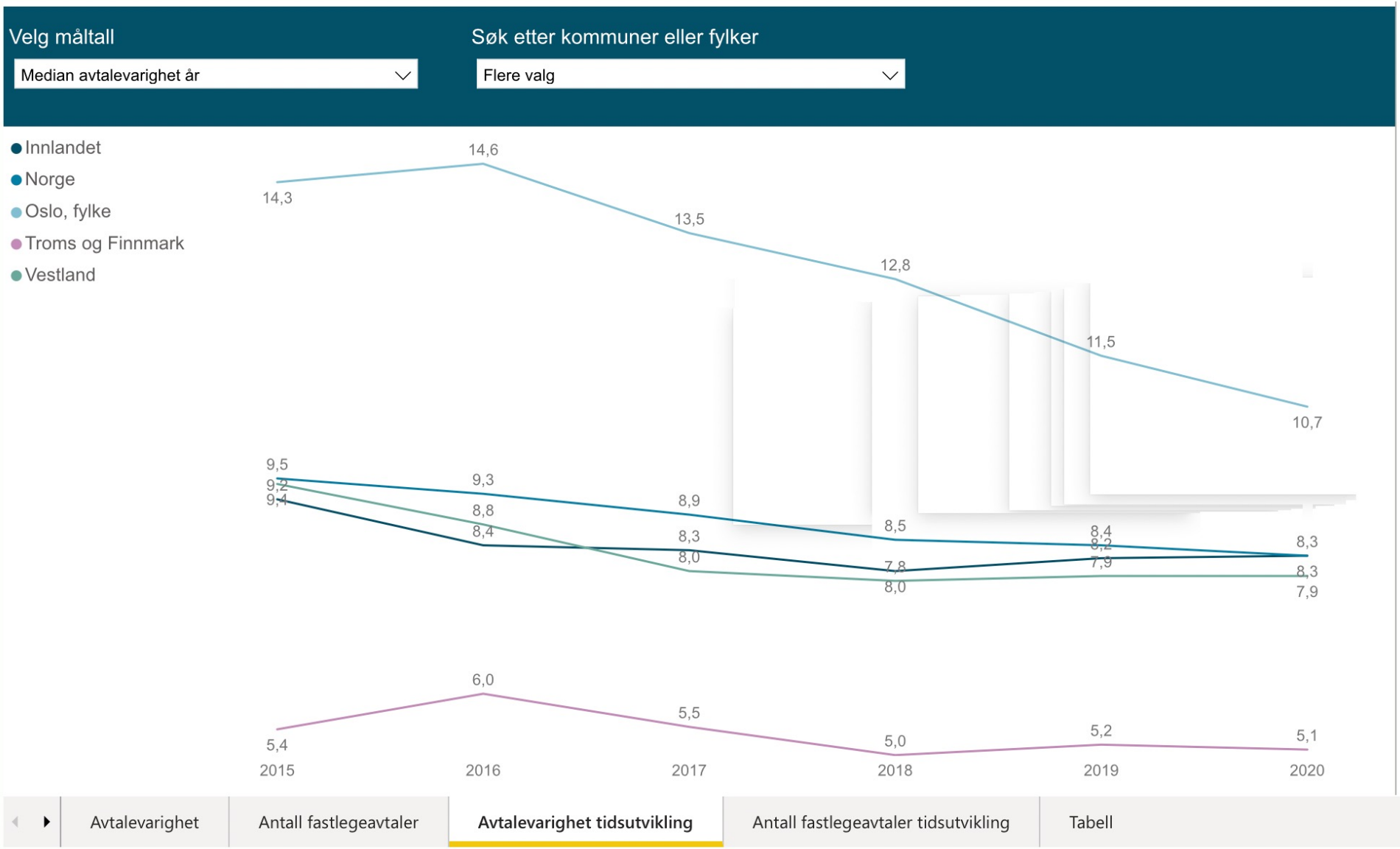
Norsk forening for allmennmedisin
DEN NORSKE LEGEFORENING

# The GP Regulations from June 2001

- § 1. Purpose: *"The purpose of the GP scheme is to ensure that everyone receives the necessary general practitioner services of good quality at the right time, and that people living in Norway have a permanent general practitioner to deal with."*
- In 2021; **16,5 million consultations**. Each resident had an average of 3.0 consultations with their GP (men 2.2 and women 3.2)
- It is not allowed with contracts with companies (bolag)

# Personal list system

- All inhabitants have the right to a General Practitioner
- The GP has a maximum allowance for the number of patients on the patient list.
- If you are entitled to a GP, you may select the one you want if there is room on the GP's list.
- The GP must prioritise the patients on the list over patients not on the list.
- The GP is a gatekeeper


Velg måltall
Median avtalevarighet år
Søk etter kommuner eller fylker
Flere valg
Innlandet
Norge
Oslo, fylke
Troms og Finnmark
Vestland
14,3
14,6
13,5
12,8
11,5
10,7
9,5
9,2
9,1
9,3
8,8
8,4
8,9
8,3
8,0
8,5
7,8
8,0
8,4
8,2
7,9
8,3
8,3
7,9
5,4
6,0
5,5
5,0
5,2
5,1
2015
2016
2017
2018
2019
2020
Avtalevarighet
Antall fastlegeavtaler
Avtalevarighet tidsutvikling
Antall fastlegeavtaler tidsutvikling
Tabell

# a distributed, national arrangement

- we are approximately 5,000 regular GPs (RGP)
- we work in 1,600 RGP offices
- we have on average 1000 patients on the list
- each GP employs approximately 0.8 health secretaries
- primary assignment - diagnostics and treatment
- acts as coordinators of health services
- the responsibility is – and feels – personal
- the organization provides continuity

# Commitments of the RGP

Examination and treatment in office and house calls

Refer to specialist services *when needed* (gatekeeper)

Participate in out-of-hours services

Other clinical work: Nursing homes, jails, schools etc.

Certificates, sick leave notices, welfare documentation etc.

Coordinator of medical information and follow-up, *secures continuity*

# Examples of what we do as RGPs

- minor surgery
- follow-up chronic diseases
- taking care of acute events and infections
- EKG
- laboratory
- spirometry
- pregnancy control
- IUD insertions, cervical smears
- psychotherapy
- wound care
- sick leave, work clearance allowance, disability benefits
- ++++++

# *Municipal cooperation*

- meetings with home care/psychiatric nurses
- joint consultations
- electronic messages
- meetings with the municipal doctor

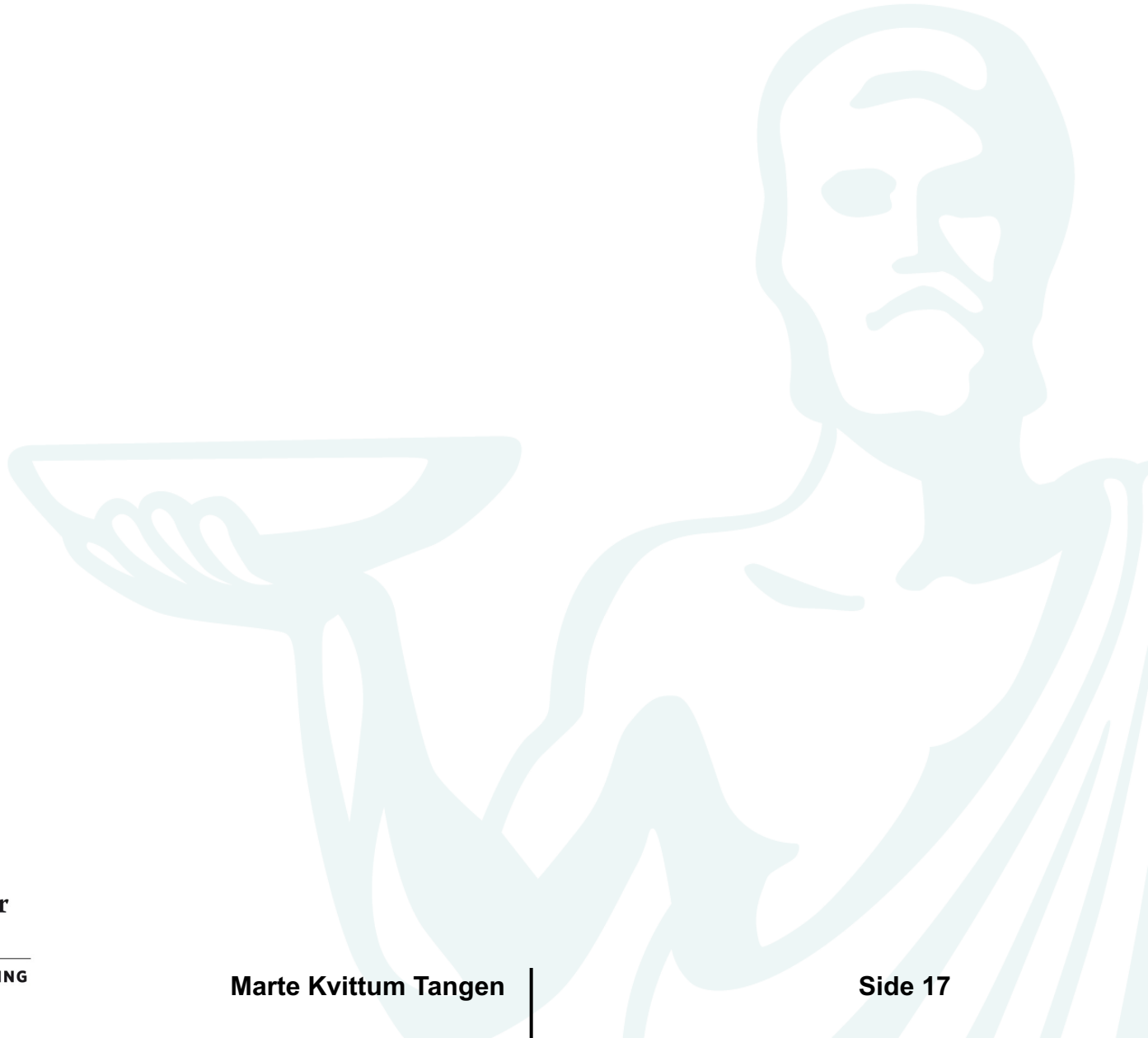
---

- meetings with local employees from the Norwegian Labour and Welfare Organisation (NAV)
- meetings with employers

# Cooperation with the specialist health service

- ***Gatekeeper role*** - referral obligation!
- The gatekeeper role helps the hospitals in triaging and prioritizing
- RGPs also works parttime in hospitals - with interaction
- RGPs coordinate health services
- Hospitals need good RGPs

# RGPs and emergency primary health care



# Reimbursement models

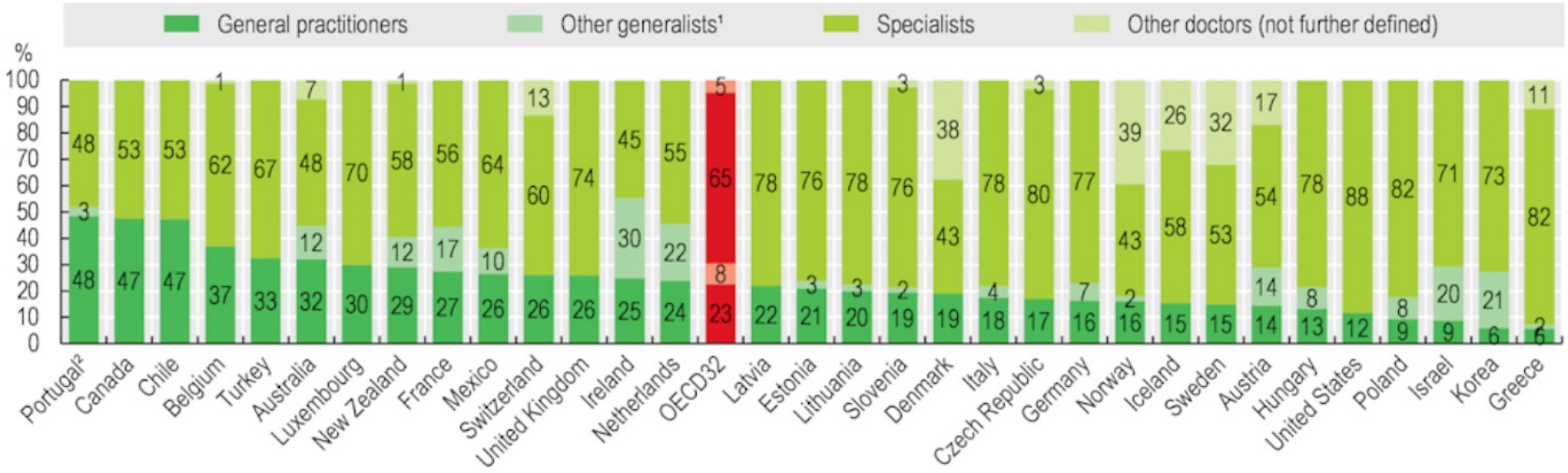
Experience shows that a combination model works best

- regular/basis component (provides economic security for the GP)
- activity-based component (secures efficiency and high doctor-patient consultation rate)
- 2022: growing interest among younger doctors in a fixed salary, but 90% also want an activity component

Private practice or employment?

- Private seems to be most popular among GP's and provides stability over time
- Employment is attractive for certain groups and has always been the solution in small municipalities

Figure 8.7. **Share of different categories of doctors, 2019 (or nearest year)**

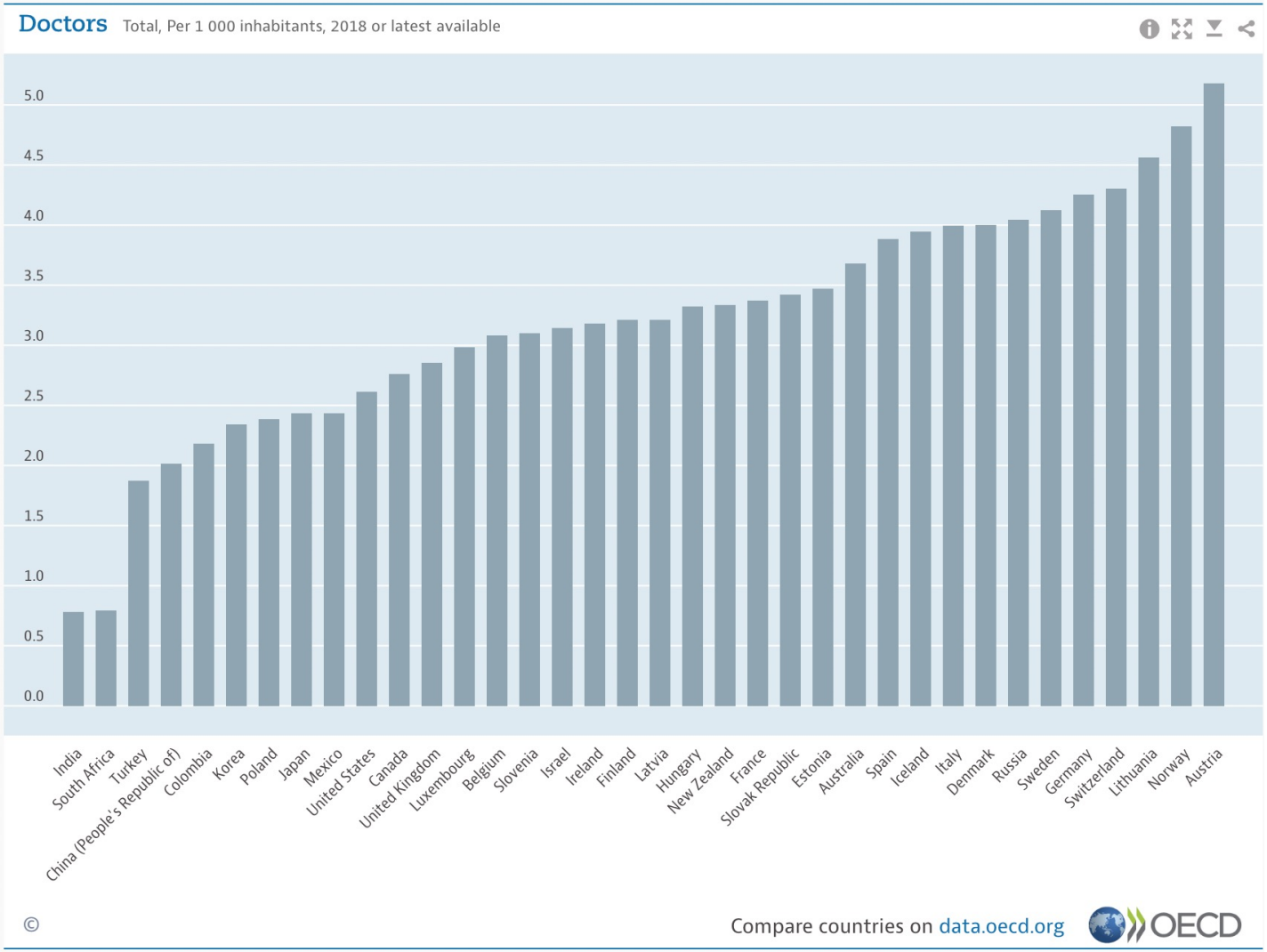



1. Includes non-specialist doctors working in hospitals and recent medical graduates who have not yet started postgraduate specialty training. 2. In Portugal, only about 30% of doctors employed by the public sector work as GPs in primary care – the other 70% work in hospitals.

Source: OECD Health Statistics 2021.

*StatLink* https://stat.link/c6qlsd

## DATA ON HEALTH WORKFORCE



# Does the regular GP scheme work?

- Good availability for all – instrument to fight social inequality
- Coordination of information and follow-up from many services
- Point of contact for patients and for services inside/outside health sector
- Public satisfaction among the best for public services in Norway for quality and availabilty (though not telephone access)
- Most GPs report more satisfaction with their working conditions and find it easier to provide good medical services when they can relate to their patients over (long) time. Recruitment was good the first 10 years.
- 20 years later, we can see that continuity over time DOES improve health

# Other experiences

- The reform is being evaluated by independent academic institutions.
- The population is much more satisfied with access to care and quality of care
- Most GPs report to be more satisfied with their working conditions
- GPs find it easier to provide good medical services when serving patients they can relate to over (long) time

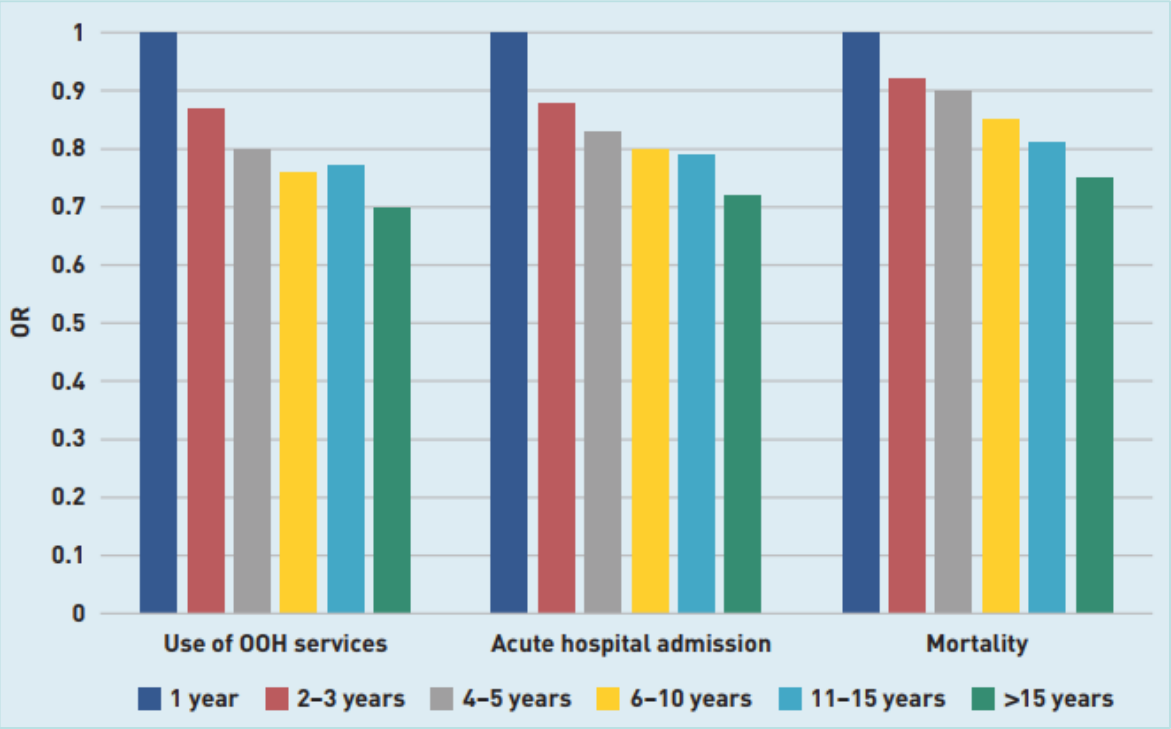
# The benefits of relational continuity in primary care

- Lower utilization and hospitalization
- Improved health
- Better care quality
- Increased patient satisfaction
- Cost savings
- Improvement in preventive care
- Reduced mortality
- Improved self-management and treatment adherence

[Evidence Summary 2017 - Benefits of Relational Continuity in Primary Care (ID 149216).pdf (gpscbc.ca)]


Norsk forening for allmennmedisin
DEN NORSKE LEGEFORENING

# Continuity in general practice as predictor of mortality, acute hospitalization, and use of out-of-hours care

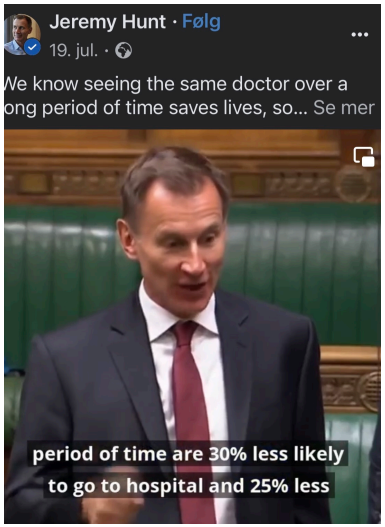



After 15 years with the same GP

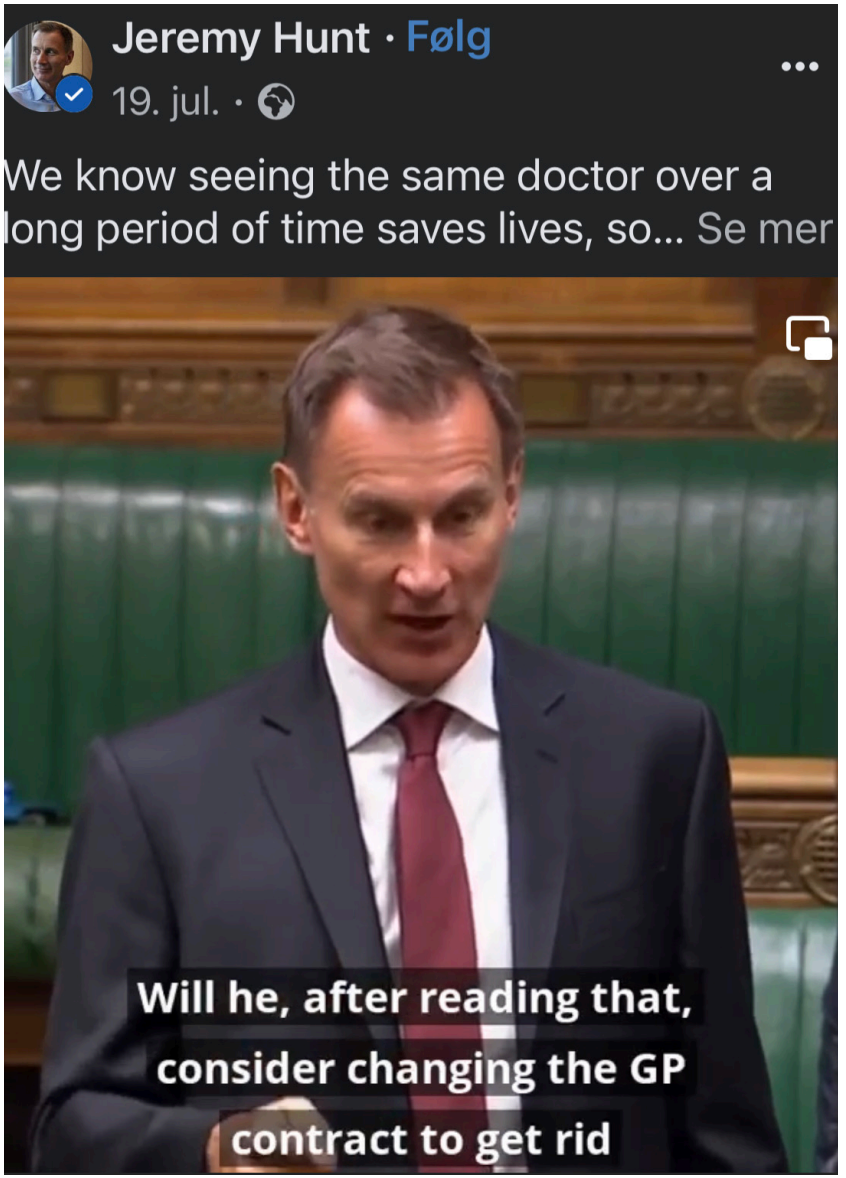
- Mortality – 25 %
- Acute hospitalization – 28 %
- Out-of-hours care – 30 %

Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg and Steinar Hunskaar
Br J Gen Pract 2021;DOI: https://doi.org/10.3399/BJGP.2021.0340

Norsk forening for allmennmedisin
DEN NORSKE LEGEFORENING


Jeremy Hunt · Følg
19. jul. ·
We know seeing the same doctor over a
ong period of time saves lives, so... Se mer
period of time are 30% less likely
to go to hospital and 25% less


DR KATE SIDAWAY-LEE
DR REBECCA ROSEN
PROFESSOR ITZHAK HOLMES
And what we found is the same as other studies

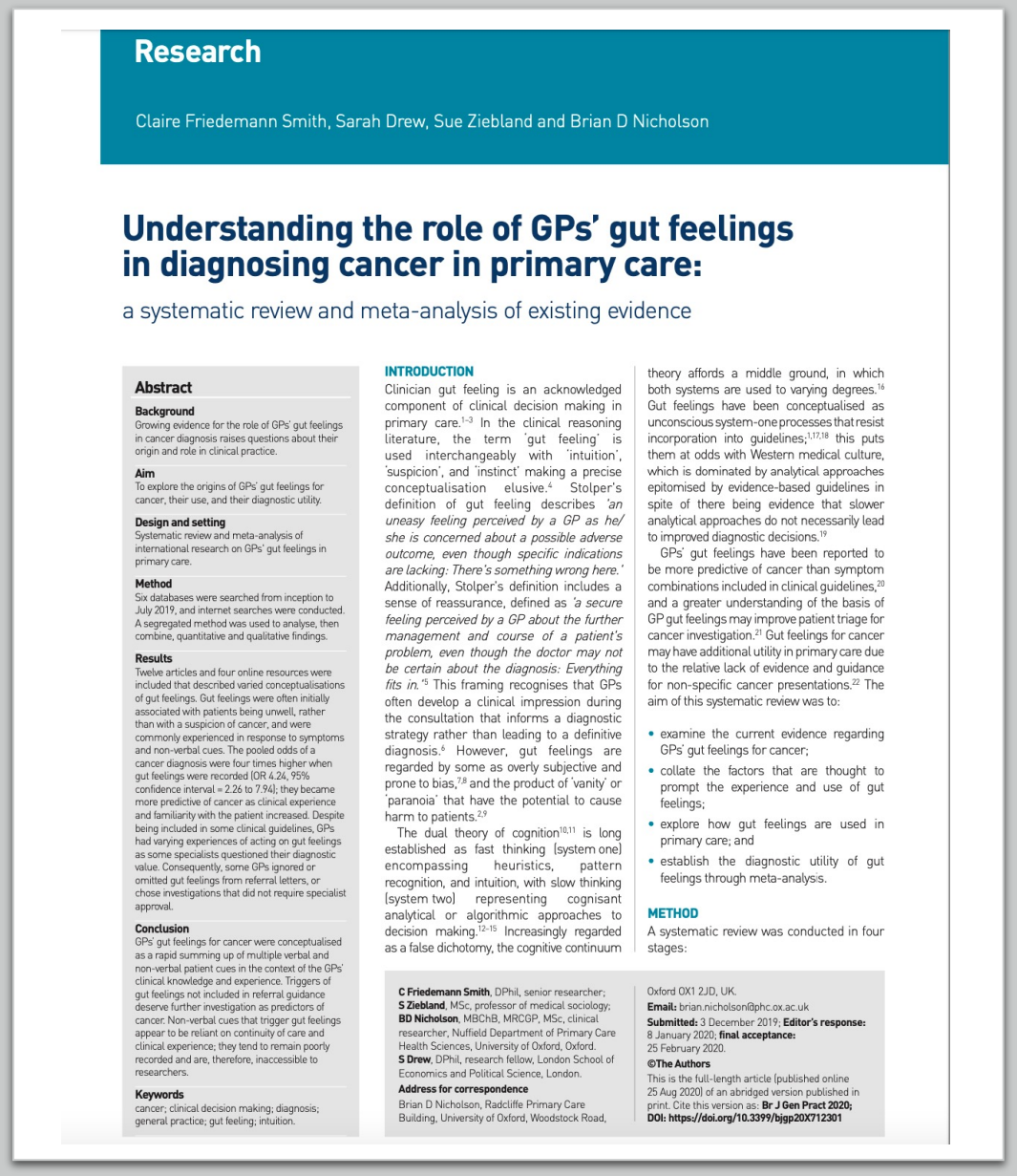

Jeremy Hunt · Følg
19. jul. ·
We know seeing the same doctor over a
long period of time saves lives, so... Se mer
Will he, after reading that,
consider changing the GP
contract to get rid

# The gut feeling

Clinician gut feeling is an acknowledged component of clinical decision making in primary care.

Definition of gut feeling: *'an uneasy feeling perceived by a GP as he/ she is concerned about a possible adverse outcome, even though specific indications are lacking: There's something wrong here.'*

This framing recognises that GPs often develop a clinical impression during the consultation that informs a diagnostic strategy rather than leading to a definitive diagnosis.



Research

Claire Friedemann Smith, Sarah Drew, Sue Ziebland and Brian D Nicholson

## Understanding the role of GPs' gut feelings in diagnosing cancer in primary care:

a systematic review and meta-analysis of existing evidence

**Abstract**

**Background**
Growing evidence for the role of GPs' gut feelings in cancer diagnosis raises questions about their origin and role in clinical practice.

**Aim**
To explore the origins of GPs' gut feelings for cancer, their use, and their diagnostic utility.

**Design and setting**
Systematic review and meta-analysis of international research on GPs' gut feelings in primary care.

**Method**
Six databases were searched from inception to July 2019, and internet searches were conducted. A segregated method was used to analyse, then combine, quantitative and qualitative findings.

**Results**
Twelve articles and four online resources were included that described varied conceptualisations of gut feelings. Gut feelings were often initially associated with patients being unwell, rather than with a suspicion of cancer, and were commonly experienced in response to symptoms and non-verbal cues. The pooled odds of a cancer diagnosis were four times higher when gut feelings were recorded (OR 4.24, 95% confidence interval = 2.26 to 7.94); they became more predictive of cancer as clinical experience and familiarity with the patient increased. Despite being included in some clinical guidelines, GPs had varying experiences of acting on gut feelings as some specialists questioned their diagnostic value. Consequently, some GPs ignored or omitted gut feelings from referral letters, or chose investigations that did not require specialist approval.

**Conclusion**
GPs' gut feelings for cancer were conceptualised as a rapid summing up of multiple verbal and non-verbal patient cues in the context of the GPs' clinical knowledge and experience. Triggers of gut feelings not included in referral guidance deserve further investigation as predictors of cancer. Non-verbal cues that trigger gut feelings appear to be reliant on continuity of care and clinical experience; they tend to remain poorly recorded and are, therefore, inaccessible to researchers.

**Keywords**
cancer; clinical decision making; diagnosis; general practice; gut feeling; intuition.

**INTRODUCTION**

Clinician gut feeling is an acknowledged component of clinical decision making in primary care.[1–3] In the clinical reasoning literature, the term 'gut feeling' is used interchangeably with 'intuition', 'suspicion', and 'instinct' making a precise conceptualisation elusive.[4] Stolper's definition of gut feeling describes *'an uneasy feeling perceived by a GP as he/ she is concerned about a possible adverse outcome, even though specific indications are lacking: There's something wrong here.'* Additionally, Stolper's definition includes a sense of reassurance, defined as *'a secure feeling perceived by a GP about the further management and course of a patient's problem, even though the doctor may not be certain about the diagnosis: Everything fits in.'*[5] This framing recognises that GPs often develop a clinical impression during the consultation that informs a diagnostic strategy rather than leading to a definitive diagnosis.[6] However, gut feelings are regarded by some as overly subjective and prone to bias,[7,8] and the product of 'vanity' or 'paranoia' that have the potential to cause harm to patients.[2,9]

The dual theory of cognition[10,11] is long established as fast thinking (system one) encompassing heuristics, pattern recognition, and intuition, with slow thinking (system two) representing cognisant analytical or algorithmic approaches to decision making.[12–15] Increasingly regarded as a false dichotomy, the cognitive continuum theory affords a middle ground, in which both systems are used to varying degrees.[16] Gut feelings have been conceptualised as unconscious system-one processes that resist incorporation into guidelines;[1,17,18] this puts them at odds with Western medical culture, which is dominated by analytical approaches epitomised by evidence-based guidelines in spite of there being evidence that slower analytical approaches do not necessarily lead to improved diagnostic decisions.[19]

GPs' gut feelings have been reported to be more predictive of cancer than symptom combinations included in clinical guidelines,[20] and a greater understanding of the basis of GP gut feelings may improve patient triage for cancer investigation.[21] Gut feelings for cancer may have additional utility in primary care due to the relative lack of evidence and guidance for non-specific cancer presentations.[22] The aim of this systematic review was to:

- examine the current evidence regarding GPs' gut feelings for cancer;
- collate the factors that are thought to prompt the experience and use of gut feelings;
- explore how gut feelings are used in primary care; and
- establish the diagnostic utility of gut feelings through meta-analysis.

**METHOD**

A systematic review was conducted in four stages:

**C Friedemann Smith**, DPhil, senior researcher; **S Ziebland**, MSc, professor of medical sociology; **BD Nicholson**, MBChB, MRCGP, MSc, clinical researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford. **S Drew**, DPhil, research fellow, London School of Economics and Political Science, London.
**Address for correspondence**
Brian D Nicholson, Radcliffe Primary Care Building, University of Oxford, Woodstock Road, Oxford OX1 2JD, UK.
**Email:** brian.nicholson@phc.ox.ac.uk
**Submitted:** 3 December 2019; **Editor's response:** 8 January 2020; **final acceptance:** 25 February 2020.


Norsk forening for allmennmedisin

DEN NORSKE LEGEFORENING

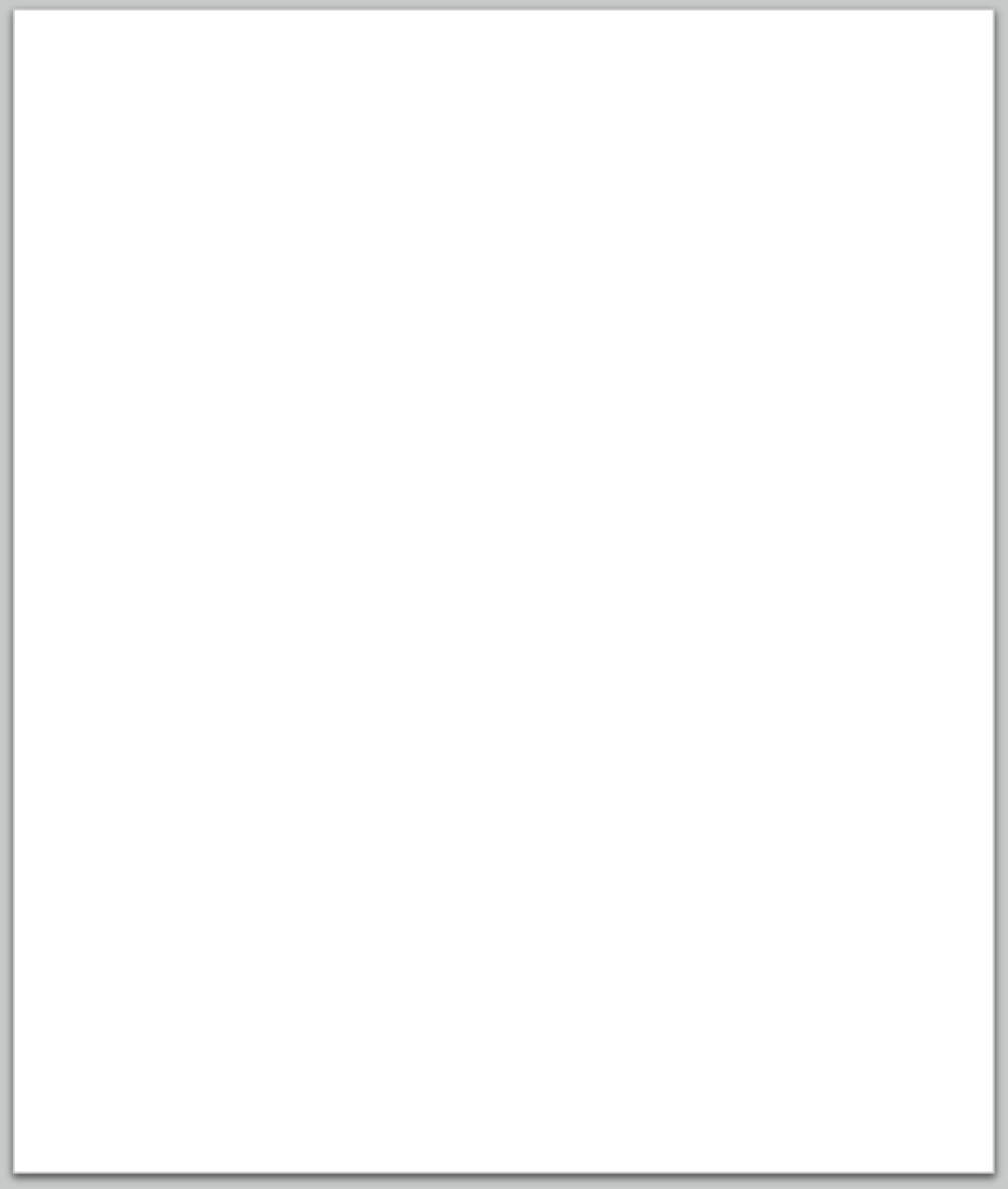
GPs' gut feelings for cancer were conceptualised as a rapid summing up of multiple verbal and non-verbal patient cues in the context of the GPs' clinical knowledge and experience.

Triggers of gut feelings not included in referral guidance deserve further investigation as predictors of cancer.

Non-verbal cues that trigger gut feelings appear to be reliant on continuity of care and clinical experience; they tend to remain poorly recorded and are, therefore, inaccessible to researchers.

# …but general practice in Norway are still in trouble

In Norway as well as most other countries

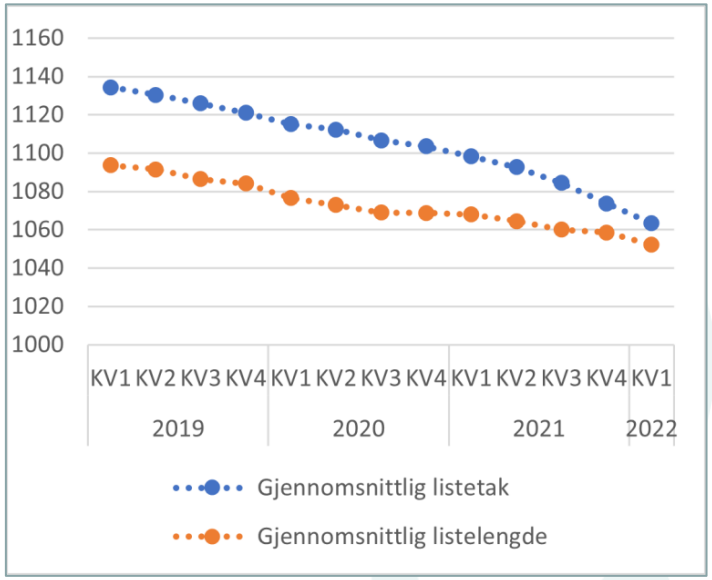


# The Coordination Reform

- in 2012
- established pre-hospital low threshold wards in primary health care and made it mandatory to establish primary emergency 24-7 beds in the municipalities for patients not in need of specialized hospitalisation
- estimated need 2000 more RGPs – almost none in reality

# Norwegian GP crisis 2022

- increasing number of tasks per patient
  - medical development and public expectations
  - point of contact for both patients, health services and others
- lack of doctors
  - many quit because of increasing workload (average 56 hrs/week)
  - low recruitment
- lack of development
  - many new demands, but little support to increase quality
- Lack of funding
  - new tasks are often not paid
  - no freedom to set prices, 100 % state controlled




patients per RGP 2019-2022


pasients without RGP 2002-2022

Norsk forening for allmennmedisin
DEN NORSKE LEGEFORENING

# How to solve the RGP crisis?

- Secure working and educational conditions for young doctors
- Remove/simplify non-medical tasks
- Increased funding so the RGP's can reduce their patient lists
- Establish teams where the doctor can delegate tasks to other personell
- A sharp increase in the number of RGP-s

# In conclusion

- The RGP Scheme provides good quality services to satisfied patients at a controllable cost
- The service is popular, workload is rapidly increasing
- With our framework today, another 2.000 RGP's are necessary in addition to the 5.200 GP's serving 5,4 million people
- System maintenance is urgent:
  Funding, Workload reduction, Recruitment, Quality and development support
- The regular GP Scheme in french (radio Canada)

# Multiprofessionality in Norway

- In our RGP offices we work together 2-15 RGPs with health secretaries and for some nurses
- We have a pilot of “primary health teams” with nurses, administrators, physiotherapists, psychiatric nurses – the evaluation shows that implementing this will double the cost
- We refer to other professionals and cooperates with them via mostly digital dialog

# How do you handle aging multimorbidity patients?

- For those are living at home we have home nursing care that cooperate with the RGP
- Some are at nursing homes (varies from municipality to municipality)
- Example: a patient with diabetes, KOLS, osteoporosis, anxiety and high blood pressure will be seen regularly - if needed appointment checks every two months or individually.

# Improving primary care for what purpose?

- The evidence shows that primary care helps prevent illness and death

- The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies.

- *(Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. The Milbank quarterly. 2005;83(3):457-502)*