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Are we heading towards a new twist in the regular GP scheme?

PERSPECTIVES

JOHANNES BJØRNSTAD TYRIHJELL

jbt@osloeconomics.no
Johannes Bjørnstad Tyrihjell, social economist and manager at Oslo Economics.
The author has completed the ICMJE form and declares no conflicts of interest.

KINE PEDERSEN

Kine Pedersen, PhD, health economist, social economist, associate professor at the University of Oslo and senior manager at Oslo Economics.
The author has completed the ICMJE form and declares no conflicts of interest.

SUSANNE GERDA VÆRNØ

Susanne Gerda Værnø, business economist at Oslo Economics.
The author has completed the ICMJE form and declares no conflicts of interest.

GEIR GODAGER

Geir Godager, PhD, cand. oecon and associate professor at the University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

TOR IVERSEN

Tor Iversen, professor emeritus at the University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

JON HOLTE

Jon Holte, PhD, associate professor at the University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

BIRGIT ABELSEN

Birgit Abelsen, professor and head of research at the Norwegian Centre for Rural Medicine, UiT The Arctic University of Norway.
The author has completed the ICMJE form and declares no conflicts of interest.

ANDREAS PAHLE

Andreas Pahle, specialist in general practice and GP at Bolteløkka Medical Centre.
The author has completed the ICMJE form and declares the following conflict of interest: he has received fees from Oslo Economics in connection with the Norwegian Directorate of Health's follow-up evaluation of measures in general practice.

LIV AUGESTAD

Liv Augestad, PhD, specialty registrar in general practice, GP at Marienlyst Medical Centre and associate professor at the University of Oslo.
The author has completed the ICMJE form and declares the following conflict of interest: she has received fees from Oslo Economics in connection with the Norwegian Directorate of Health's follow-up evaluation of measures in general practice, and travel funding from EuroQol Group for EuroQol meetings.

IVAR SØNBØ KRISTIANSEN

Ivar Sønbø Kristiansen, professor emeritus at the University of Oslo.
The author has completed the ICMJE form and declares the following conflict of interest: he has received fees from Oslo Economics in connection with the Norwegian Directorate of Health's follow-up evaluation of measures in general practice.

ERIK MAGNUS SÆTHER

Erik Magnus Sæther, PhD, economist, partner at Oslo Economics.
The author has completed the ICMJE form and declares no conflicts of interest.

It is encouraging to see the increase in available places on GPs' patient lists in Norway. But with more and more GPs reducing patient numbers and becoming municipal employees, driving up the costs of the regular GP scheme, where are we headed?

In 2023, several of the negative trends that have been observed in the regular GP scheme were reversed. A record number of doctors took up posts as general practitioners (GPs), and for the first time since 2017, the total number of available places on GPs' patient lists increased (1, pp. 14 and 21). However, two new trends are emerging: an increase in the number of municipally employed GPs and a drop in patient numbers per GP, which has implications for public spending on the regular GP scheme. The capacity of the scheme, in terms of the total number of places on GPs' patient lists, has been in decline since 2017, and since 2021, there have been fewer places on these lists than there are residents in Norway (1, p. 14).

Shorter patient lists

Despite what the media might suggest (2–4), the reduced capacity is not due to a shortage of GPs. The number of GPs per capita has been increasing every year, and the number of GPs per capita is at a record high. In 2023, we saw a long-awaited capacity increase in the regular GP scheme. However, this increase was solely due to the record-high growth in the number of GPs, while the number of patients on each GP's list dropped more than ever before.

On average, each GP was responsible for more than 50 fewer patients in 2023 than two years ago, and 100 fewer than six years ago. New GPs in particular have shorter patient lists than before. Up until 2016, new GPs had between 1000 and 1100 patients. Those who started in 2021 had just over 900, and those who started in 2023 had an average of 760 (Figure 1) (1). We have tracked various cohorts of new GPs over time, and found that not only do new GPs start off with shorter lists, but that their lists remain shorter one, two and three years later, compared to previous years (Figure 2) (1). There is therefore no reason to believe that patient lists will increase anytime soon.

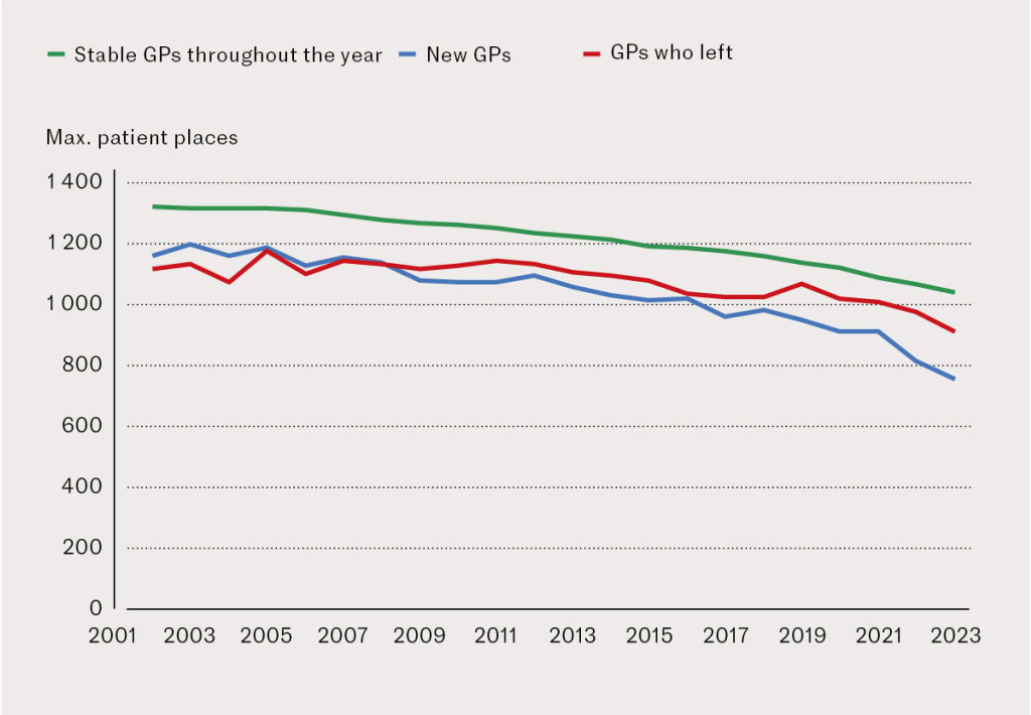

Figure 1 Average maximum number of places on patient lists for new GPs, GPs who left and stable GPs in the years 2001–23 (1).

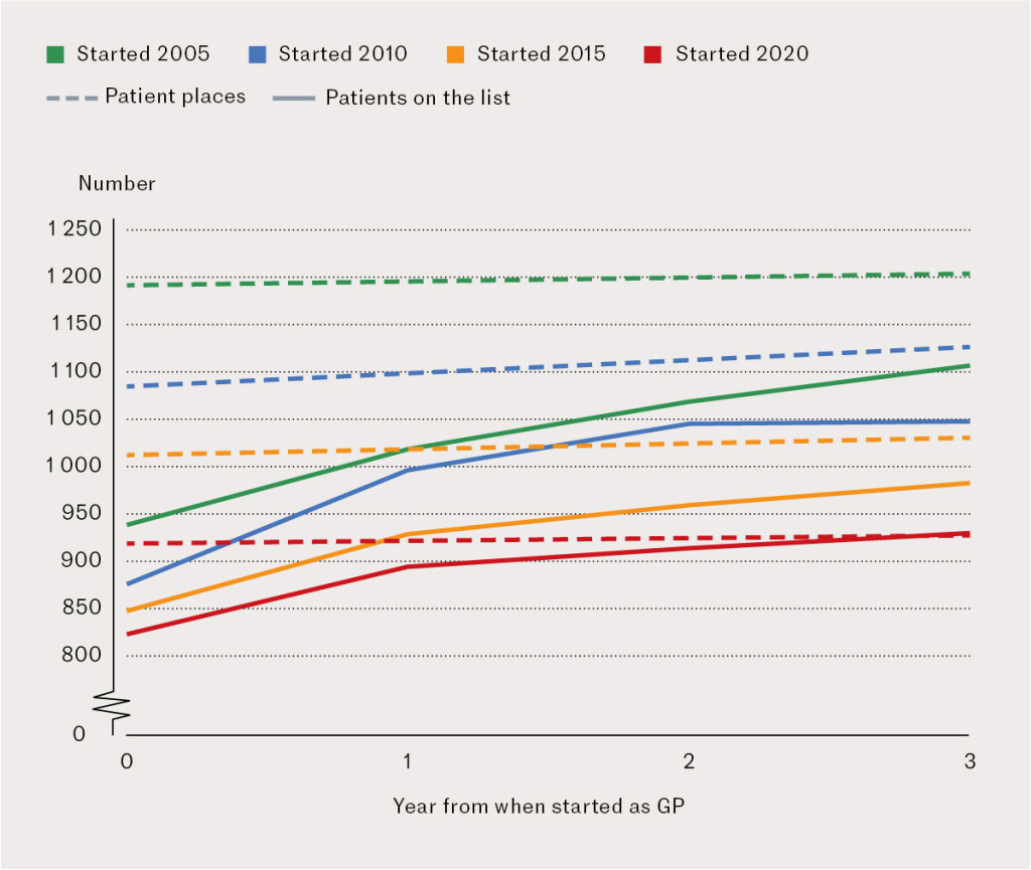

Figure 2 Average maximum number of places (dashed lines) and number of patients on the list (solid lines) during the first three years for GPs who started in 2005, 2010, 2015 and 2020 (1).

«On average, each GP was responsible for more than 50 fewer patients in 2023 than two years ago, and 100 fewer than six years ago»

There are likely various explanations for the shorter patient lists. The introduction of the requirement for specialisation in general practice in 2017 is one of them, as is the constant increase in GPs' duties. The Coordination Reform in 2012 led to the transfer of numerous tasks from hospitals to primary care services. Documentation requirements have also increased, meaning that the same tasks now require more administrative work than before. A 28 % increase in capitation payments (GPs' payment per patient) in 2023 has also made it possible to maintain shorter lists without loss of income (1, pp. 50–51).

The demand for GP services has also increased. In 2023, three GP consultations were carried out per capita, compared to 2.7 in 2018 and 2.6 in 2013 (5). This increased demand is partly due to the number of older patients with more health problems, but also to growing expectations among the population, a lower threshold for contacting health services and improved access to GPs through e-consultations (6, pp. 16 and 37). Meanwhile, GPs' opportunities to prioritise may also have diminished. E-consultations and online appointment scheduling lower the threshold for booking an appointment with a GP and reduce the opportunity to suggest 'wait and see'. GPs have five days to respond to e-consultations, which also limits their ability to set priorities between enquiries.

Doctors' preferences have also likely changed in line with broader societal trends. Society has become more oriented towards gender equality, with expectations of more equal contributions in the home. The new generation of GPs may be more focused on predictable working conditions, less financial risk and more leisure time compared to previous generations.

More are employed by the local authority

Meanwhile, a growing number of GPs are being employed by their local authority. Self-employment has been the primary model in the regular GP scheme, but recruitment challenges have led many local authorities to offer an alternative to the self-employment model for new GPs. Many young doctors are not interested in being self-employed, and the offer of employment by the local authority seems to boost recruitment. In the ALIS-Nord recruitment programme, several local authorities had to offer municipal employment in order to fill their vacant positions (7).

«Many young doctors are not interested in being self-employed, and the offer of employment by the local authority seems to boost recruitment»

Today, more than 1000 GPs are employed by their local authority (i.e. one in five GPs), twice as many as in 2017. The number is particularly high among new GPs. In the past two years, half of the new GPs have been employed by their local authority, up from 25 % in 2017.

Unlike self-employed GPs, municipally employed GPs do not earn more by increasing the number of patients on their list or by conducting more consultations per day. However, various incentive schemes help boost activity. In recent years, activity-based bonus schemes have become more common among municipally employed GPs, and these can provide similar incentives to the self-employment model. At the end of 2023, over 60 % of GPs employed by a local authority were part of a bonus scheme, compared to just under half in 2021 (1. 44) (8, p. 48).

One study examined GPs who had been both self-employed and municipal employees. When self-employed, the GPs had significantly more patients on their list, more consultations per day, a higher proportion of extended consultations and more medical interventions within each consultation (9). There is no evidence to suggest that this impacts on the quality of care provided. On the contrary, the study suggests that having a self-employed GP is associated with a reduced likelihood of hospitalisation and use of A&E services (controlled for other factors).

Growing demand

New challenges for the regular GP service are looming. The population is ageing. Patients will consequently have more health problems, while access to labour is becoming more limited (10, p. 12). The regular GP service will be a core part of future health services, and will have responsibility for more treatment areas and the coordination of services. It will also act as a gatekeeper for costly specialist health services in the public sector and various welfare benefits.

Previous projections have estimated that the demand for GP services will increase by 4600 full-time equivalents by 2040 (11, p. 28), while other sectors of society will face a growing need for both personnel and funding. The recently adopted long-term plan for the Norwegian Armed Forces entails an additional NOK 611 billion for defence over the next 12 years (12). The transition to a low-emission society and expansion of renewable industries are also expected to require significant resources (13). There will therefore be an increasing need to optimise the use of healthcare resources and to prioritise within health care to an even greater extent than before.

Interdisciplinarity and division of labour

The Norwegian Directorate of Health's action plan for the regular GP service 2020–2024 (from 2019), the Expert Committee for reviewing the regular GP service (from 2023) and Norway's National Health and Coordination Plan

2024–2027 (from 2024) all refer to interdisciplinarity at GP surgeries as part of the solution. However, our investigations show that both GPs and other personnel at GP surgeries are largely satisfied with the current organisation and do not want major organisational changes (1, pp. 64–66). In other words, there appears to be a mismatch between political objectives and staff preferences. Meanwhile, trials of primary care teams indicate that shared interest and motivation, as well as the possibility for local adaptations, are prerequisites for benefiting from teamwork (14).

GP capacity going forward

Due to the challenges posed by an ageing population and the associated burden of disease and use of health services, it may be necessary for patients with complex health problems to be treated by an interdisciplinary team at GP surgeries, with greater involvement and coordination between different parts of the health service. In such a scenario, it will be important to investigate whether municipal employment might be more suitable than self-employment. Since GP services are less expensive than specialist health services, all things being equal, expanding the GP service could, in theory, represent a cost saving. Increasing the capacity of the GP service would also be in line with what is known as the 'LEON principle' in Norway, in which medical challenges should be addressed at the lowest effective level of care (15).

> ***«Since GP services are less expensive than specialist health services, all things being equal, expanding the GP service could, in theory, represent a cost saving»***

Differences in the number of consultations per day, the amount of treatment per consultation and the number of patients on the list also indicate that it takes approximately 1.5–2 municipally employed GPs to provide the same level of service as one self-employed GP. Previous surveys have found that local authorities incur an average additional cost of NOK 590,000 per municipally employed GP (adjusted to 2024 NOK) (16). Over the past five years, around 1200 self-employed GPs have left the regular GP scheme. If we use these figures as a basis going forward, for the sake of simplicity, 1800–2400 new municipally employed GPs would be needed to maintain the service levels of these doctors. This would entail significant additional costs for society. Since young GPs have shorter patient lists than those leaving the scheme, the departing GPs will likely need to be replaced by a higher number of new GPs, even if these new ones are self-employed.

Municipally employed GPs currently have fewer consultations per patient per year than self-employed GPs (2.5 compared to 3.1) (17). With fewer consultations per GP, either the number of GPs needs to be increased or patients' access to GP services must be rationed. However, it seems unrealistic

to reduce the number of consultations on such a scale nationwide when so many patients are already dissatisfied with waiting times for appointments (18).

Low fixed charges and exemption limits, and an increased healthcare provision will continually push up patient demand for healthcare services as well as expectations from the service. Reinforcing the gatekeeper function would provide relief for the specialist health service, which is already struggling with increasing waiting times (19). However, increased capacity in the regular GP service may result in more patients requiring hospital treatment. Excessive capacity in the regular GP service could therefore reduce the optimisation of public resources. It is important that political measures reconcile the challenges faced by the service with the various concerns of healthcare personnel, while also ensuring that the health service is designed to be both economically sustainable and in line with long-term societal needs.

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