The future for out-of-hours services

The population’s need for acute medical help is largely based on easily available medical services, and the out-of-hours service is an established concept in people’s minds. The local councils are responsible for organizing out-of-hours services. The National Centre for Emergency Primary Health Care was set up, in conjunction with the University of Bergen, in 2005. The aim was to strengthen the competence of Norwegian emergency medicine, mainly through research (1).

This issue of the Norwegian Medical Journal has five articles on various aspects of out-of-hours organization (2–4). Four of them are from The National Centre for Emergency Primary Health Care (2–5). Tobias Nieber and colleagues have shown that there are large differences in the organization of the out-of-hours services (2). In 2005, about two thirds of all Norwegian local councils cooperated with other councils in the organization of out-of-hours services; one third of the rest planned to do so. Erik Zakariassen and colleagues describe large variations in the type of premises and routines (3). Only half of the out-of-hours services had a system for training doctors and other medical staff, and only half of the doctors on call always used radio contact. There are also large differences in patient requests, as shown by Elisabeth Holm Hansen & Steinar Hunskår (4) in their study of three out-of-hours services. Hogne Sandvik & Steinar Hunskår (5) show that GPs receive just a little over half of all reimbursement for out-of-hours work, and that older and female doctors have far lower incomes from out-of-hours work than their younger male counterparts. Regular GPs in small, outlying districts with a good GP population ratio have high incomes from being on call, while long and full patient lists are associated with low duty incomes. Official figures probably contain several mistakes about regular GPs and out-of-hours duty. Bjørn Otterlei & Niels Bentzen (6) report that regular GPs participate to a lesser degree than previously assumed.

The results of these studies must be assessed in the light of three conditions: the increase in duties without a corresponding growth in general practice capacity in recent years, a raising average age for Norwegian GPs and the fact that the authorities’ appear to not be interested in improving the organization of the out-of-hours emergency service.

From 1980 to 2001, the number of doctors working in somatic hospitals rose considerably (from 8.8 to 16.0 per 10,000 inhabitants), while the number of doctors working in primary healthcare remained stable (7). After implementation of the regular GP scheme in 2001, the number of specialists increased by 13% up to 2005 and the number of GPs only by 1.6% (7). Based on data from Statistics Norway’s income and expenditure studies from 1998 to 2003, there is reason to believe that full-time GPs have increased their working week by 6–7 hours to 49 hours (7). On-call duties come on top of this. GPs are also older. The average age has increased from 43.5 years in 1995 to 47.1 years in 2006 (A. Taraldset, Norwegian Medical Association, personal communication).

GPs daily experience an increasing workload, coupled with high expectations of being able to cooperate with several authorities. More patients than before are older and have chronic disease. They more often have complicated health problems, psychological prob-
Literature