Primary care in Norway

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SUMMARY. The organization of primary care in Norway is described and the shortage of general practitioners, particularly in remote areas, discussed. Improvement in working conditions is one approach to solving this problem. However, enhanced status for the general practitioner, achieved by improvements in his vocational training, is acknowledged as an important prerequisite for better recruitment to general practice.

Introduction

The population of Norway is approximately four million. There are about 6,000 doctors, 1,500 of whom are in primary care. About 500 primary care doctors are ‘district doctors’, mostly in rural communities. The remaining 1,000 primary care doctors are independent general practitioners, mostly in urban areas, and often working single handed.

In spite of the 350-year history of the ‘district doctor’, Norway is experiencing a crisis in primary care. Developments in hospital-based medical care over the last 10 years, with increases in the size and number of hospitals, the number of specialties and consequently medical staff, have contributed to a depletion of general practice. The situation has been exacerbated by the shortening of working hours of hospital doctors (in common with other Norwegian employees and contrasting with the long hours of work of many general practitioners). A further aggravating factor has been the declining financial status of the general practitioner because of increasing practice costs.

The district doctor

The district doctor is appointed by the State, mostly to rural communities of 2,000 to 3,000 patients; as well as doing general practice on a payment for item-of-service basis like his independent colleagues, the Distriktslege also has responsibilities for preventive medicine and public health. He is, so to speak, a combined general practitioner and local medical officer of health. He is paid a basic salary for his public health work—in child health clinics, the school health service and chronic sick and disabled institutions—and is provided with a health centre and often a place to live. He plays an important role in local health and welfare administration and is Chairman of the local Board of Health. Attached to his practice is a public health nurse (with training and role similar to our health visitor) and sometimes a social worker. In larger communities two or three district doctors may work together and there may also be an assistant district doctor—a young doctor doing the six months community component of his 18-month pre-registration period.

The Health Service

Since 1956 all Norwegians have received comprehensive medical care through National Health Insurance. All hospital treatment is free and hospital doctors are salaried but may supplement their incomes from private specialist practice. Primary medical care, on the other hand, is not entirely free at the time of use. Patients pay a consultation fee (equivalent to about £2) to the doctor, who also claims a supplementary fee from the Insurance fund as well as other fees for various procedures and investigations and for travelling expenses. The patient too is able to claim the cost of travel to receive medical care and also pays the full cost of medication prescribed by the general practitioner, except for a small number of drugs necessary for the treatment of certain dangerous or chronic diseases, for example digoxin and insulin.

The Norwegian general practitioner does not have a list of patients; any individual may consult any doctor, including a specialist in private practice. However, attendance at hospital is almost invariably through referral by a general practitioner.

The organization of medical care in Norway is decentralized. There is a Director-general of Health Services, responsible to the Government and with overall responsibility for administration. But for more than 100 years the local community has been the basis of
organization of medical services. There are 19 provinces (Fylke), which are further subdivided into a total of 444 "communes" and it is to one of these communities that the district doctor is appointed. Responsibility for provision of hospital services rests with the provinces.

Problems

There are two areas where the shortage of primary care doctors is serious—the remote areas of the north and Oslo.

In the north many district doctor appointments have remained unfilled for some time, placing additional burdens on doctors in neighbouring communities. The harshness of the environment and the isolation have discouraged doctors, and more particularly their wives, from venturing there.

There are three medical schools at Oslo, Bergen, and Tromsø, and a clinical school at Trondheim which since 1975 has taken a third of its pre-clinical students from Bergen. One of the main reasons for the establishment of the new medical school in the north, at Tromsø, was the belief that it would help to remedy the under-doctoring of the north of Norway. Other steps taken to encourage doctors to work there include entitlement to periods of sabbatical leave and promotional advantages in relation to new appointments. The appointment of two doctors where previously only one existed is also a crucial development.

Recently the provision of good facilities for medical practice has been seen as an important incentive to recruitment of doctors to under-doctored areas. An excellent example of this is the first class Health Centre at Alta—a coastal community in Finnmark, a few hours’ drive from the North Cape. This superbly designed and constructed building was completed in 1977 at a cost of three million pounds and caters for a population of about 15,000 people. The team of seven doctors who work there have excellent accommodation and many facilities including pathology laboratory, x-ray unit, physiotherapy department, day hospital with occupational therapy department, and inpatient beds. There are also dentists working in the Health Centre as well as a large number of nurses, public health nurses, social workers, and ancillary staff.

In Oslo too, the provision of good working conditions is one of the strategies now being adopted to promote better primary medical care. Like large cities elsewhere, Norway's capital fails to satisfy the general practice needs of its inhabitants. In 1972 the Health Authority began to tackle this problem by establishing health centres in the city, each to cater for about 12,000 patients and to house up to five general practitioners. The doctors are salaried and work a five-day week; out-of-hours work is covered by an emergency service (as is that of most independent general practitioners). There is a supporting staff of nurses, public health nurses, and social workers and emphasis is on team work. The accommodation and equipment are good and the posts are attractive to young doctors, especially women, the relatively modest income being acceptable in return for a limited commitment and the provision of good facilities.

General practice training

It is recognized that the most important requirement for improved recruitment to primary care in Norway is enhanced status for the general practitioner and that the way to achieve this is by improvement in his training.

After graduation all doctors must do 18 months’ pre-registration work—a year in hospital and six months in the community as assistant to a district doctor. This requirement that all doctors should have a minimum period of experience of medicine outside hospital is surely sensible. For the intending general practitioner there is then three years of voluntary vocational training, consisting of one year of hospital jobs followed by two years in general practice, with a requirement to attend certain courses. The doctor who completes this programme is recognized by the Norwegian Medical Association as having a ‘higher qualification’ and is entitled to a higher scale of Health Service fees. To maintain this status, however, the doctor must return to hospital work every five years, for a three-month period and attend a minimum number of courses. About a third of doctors entering general practice are currently pursuing such programmes. However, their educational value is limited by the absence of supervision and teaching. The two years’ general practice component consists of experience only—unsupervised and with no teaching—a situation which contrasts strongly with developments in Britain. Nor has any attempt been made to evaluate such programmes.

The requirement to return to hospital every five years is an interesting development in continuing education, but there are major practical problems in implementing this, particularly in respect of the provision of a practice deputy. However, participation in research and teaching may be acceptable as substitute educational activities.

Discussion

As elsewhere, there is an appreciation by government, the profession, and the public of the importance and value of front line medical care; the polyclinic approach adopted in neighbouring Sweden is not seen as the answer. There is an awareness that some redistribution of resources needs to take place and some evidence that this has already started. But the achievement of a better balance between primary and secondary care will ultimately depend on the acknowledgement by the educational system of the proper professional status of the general practitioner. The thesis that basic medical education produces a general practitioner is no longer acceptable. As a specialist in 'personal, primary and
Training for general practice

The noble Lord, Lord Flowers, asked for evidence from general practice. During the last few years there has been a swing towards a broad approach to medical care, both in hospitals and in the community, and an appreciation that this is becoming increasingly critical in a society where many opportunities for prevention lie outside hospitals and are related to the behaviour of our patients in their environments. I, and many others, hope that the Flowers’ Working Party, when looking at our diminishing educational resources and at what will be needed in future in London, will consider carefully and favourably those medical schools which are fostering this modern approach.

About half our medical students still go into general practice. When there, they treat about 90 per cent of the medical problems of the population without sending them to hospital. What they need most in the later stage of their medical education is preparation for their own subject. Most of those who want to go into general practice have decided to do that by the end of their general professional training. They do not want highly academic teaching or to spend too much time with basic scientists or to be taught about highly complicated pathological processes or various specialized surgical, electronic, or other super-specialist techniques: nor do they want to be involved in other highly academic exercises or in research, however much all this may be advantageous to the young specialist. Clinical competence is acquired by participation in medical care in the branch of medicine which a doctor chooses.

In their vocational training they want to be given expert advice from experienced general practitioners on all the community and behavioural aspects of their future work and on how they can care properly for the multiplicity of organic and psychological illnesses that they will meet later in their practices. These will set them thousands of problems, starting with the care of young children at home and ending with the proper care of the elderly, the dying, and the bereaved.

Reference
London: HMSO.