UNIVERSITY OF BERGEN

Er allmennmedisinens tid forbi?
eller
Is the GP absolute necessary or rather a postmodern anomaly?

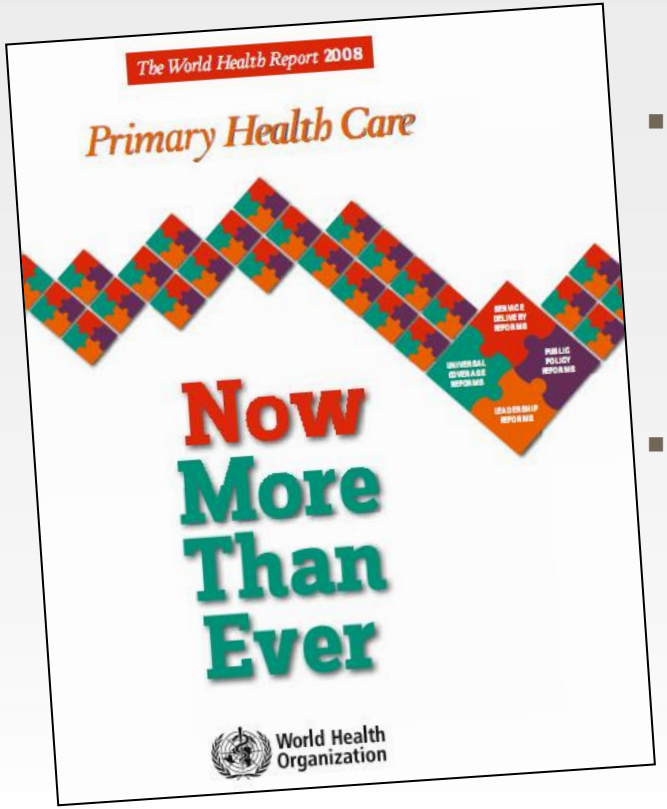
Steinar Hunskår
Professor in General Practice
University of Bergen, Norway

An expert is a person more than 50 miles from home, with no responsibility for his message or advice, and who is showing slides

What I will talk about

- Primary care vs general practice and family medicine
- The Norwegian experience 1990-2023: From chaos to success and now in stormy weathers
- Continuity of care (CoC) and its effects
- General practice under stress internationally
- Some future perspectives

Good advise from Geneva



- «Everyone» knows:
  - The value of primary care and the aim of lowest effective care level
- Fewer know the the hard facts:
  - The scientific evidence
  - The personal doctor
  - Continuity
  - The doctor’s coordinator role and effects of gate keeping

The basics: General practice is a clinical specialty and a discipline in its own right, not only a level of care

General practice	**UK, Australia, New Zealand, The Netherlands, Denmark, Norway, Iceland, Sweden, others**
Family medicine	**USA, Canada, some Asian countries, others**
A personal doctor	

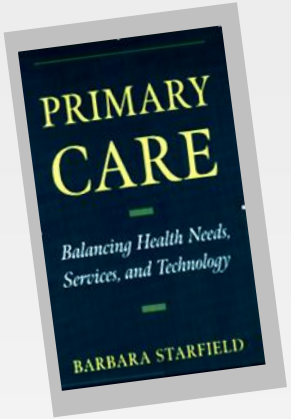
The basics (II). Some founding fathers

«Two characteristics distinguish the GP from any other medically qualified person, and they must be balanced:

(1) the patient has direct and unqualified *access* to the GP doctor

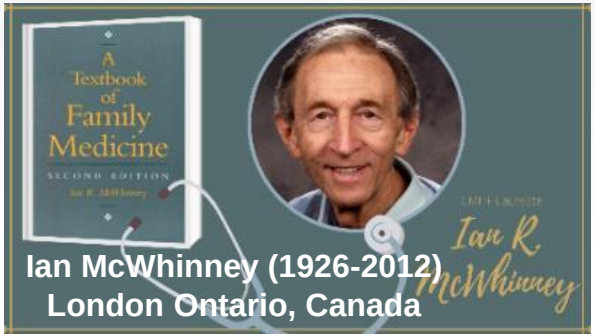
(2) the GP provides *continuity of care»*

Barbara Starfield (1932-2011)
John Hopkins, USA



Primary care research

Richard Scott (1914-1983)
Edinburgh, Scotland



Ian McWhinney (1926-2012)
London Ontario, Canada

Continuity and the patient centered clinical method

Core Values and Principles of Nordic General Practice (2020)

CORE VALUES AND PRINCIPLES OF
NORDIC GENERAL PRACTICE/FAMILY MEDICINE

1. **We promote continuity of doctor-patient relationships as a central organising principle.**

   The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care.

2. **We provide timely diagnosis and avoid unnecessary tests and overtreatment. Disease prevention and health promotion are integrated into our daily activities.**

   We care for our patients throughout their lives, tending to them through disease and suffering while encouraging progress toward health. We help patients understand their own health – to confront and manage their limitations, improve and maintain their well-being.

   Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment elsewhere. When equally effective interventions are available, we choose those that cost less.

3. **We prioritise those whose needs for healthcare are greatest.**

   We aim to minimise inequalities in how health services are provided. We organise our practices to devote the most time and effort to those whose needs for treatment and support are greatest.

4. **We practice person-centred medicine, emphasising dialogue, context, and the best evidence available.**

   We engage professionally with our patients' current life situations, biographical stories, beliefs, worries, and hopes. This helps us to recognise the links between social factors and sickness, and to deepen our understanding of how life and life events leave their imprint on the human body. We promote patients' capacity to make use of their individual and communal resources.

   To safeguard our long-term resilience as caregivers, we attend to our own well-being.

5. **We remain committed to education, research, and quality development.**

   We engage actively in the training of our future colleagues We implement and promote research that is suited to the knowledge needs of General Practice/ Family Medicine. We take a constructively critical view of new knowledge and approaches within our areas of specialisation.

6. **We recognise that social strain, deprivation, and traumatic experiences increase people's susceptibility to disease, and we speak out on relevant issues.**

   Respect for human dignity is a prerequisite for healing and recovery.

   We acknowledge that many circumstances contribute to health inequalities: childhood experiences, housing, education, social support, family income/ unemployment, community structures, access to health services, etc.

   We recognise our duty to speak out publicly on specific factors that cause or worsen disease, increase inequality in health outcomes, or make resources less accessible to certain people.

7. **We collaborate across professions and disciplines while also taking care not to blur the lines of responsibility.**

   We engage actively in developing and adapting effective ways to cooperate.

Read more about The Nordic Federation of General Practice on **www.nfgp.org**

.... continuity

.... timely diagnosis and avoid overtreatment

.... prioritise those with greatest needs

.... person-centred medicine with best evidence

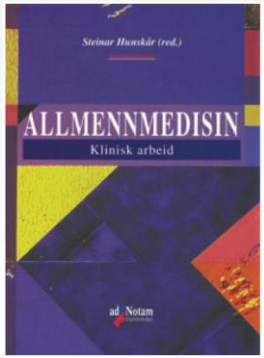
.... education, research, and quality

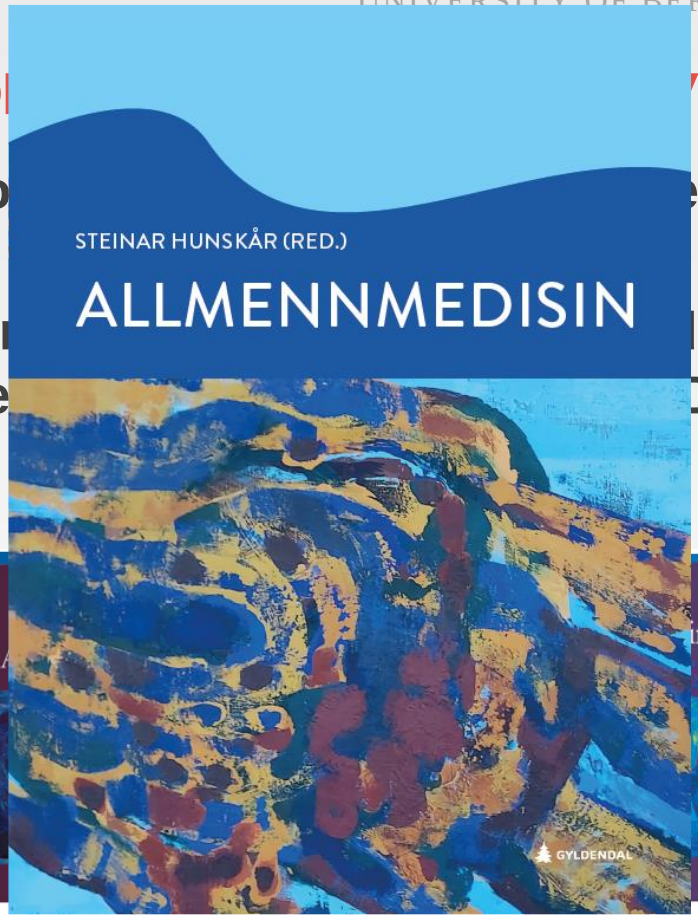
.... social strain, deprivation, and traumatic experiences increase susceptibility to disease

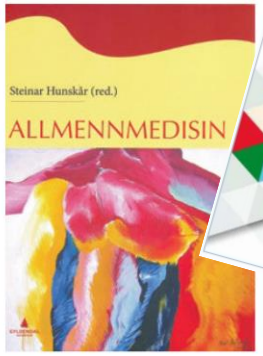
.... collaboration across professions and disciplines

A co…vian textbook

- A co…eneral practice and the role …– for *all* doctors
- An i…l many academic and othe…Denmark and Estonia







The typical GP office and role

- All medical problems at all ages
- Coordination of medical care and gate keeping of resources
- Different engagement in emergencies and out-of-hours care
- Small practices of 3-10 GPs. Increasin
  - Ideal practice size 5-10? Secures
  - Few other personnel
- Salaried doctors or strictly regulated
  - No or small user fees
  - Very variable laboratory service
- Very high productivity, 1-5 tasks in sa
  - *Hypertension and osteoporosis prescription, referral to dermatol all in 20 minutes*

«Fastlegeordningen»

The Norwegian list system (2001 - 2023)

General practice in Norway before 2001

- No listing system
- Less personal responsibility, no obligation for the doctor
- 1997: 28 % of GP positions in Northern Norway were vacant
- Many short time locums
- Doctor shopping
- Little coordination of services
- Chronic diseases undertreated
- Hospitals and specialists did not know which doctor should receive the report or manage follow up

The regulation of 2001 - the patient list system

The citizen

- has a right to a regular GP
- co-payment 15-30 € per cons.
- direct access by phone or email
- maximal waiting time 5 days

The local municipality

- responsible for the GP service including out-of-hours service
- contracts with GP's
- state pays per citizen, not per GP

The GP

- agrees to take care of a set number of patients in office hours
- list size 500-2500, norm 300/day (1250)
- must participate in out-of-hours service
- runs the practice or is employed
- fee for service (reimbursement codes)

The central government

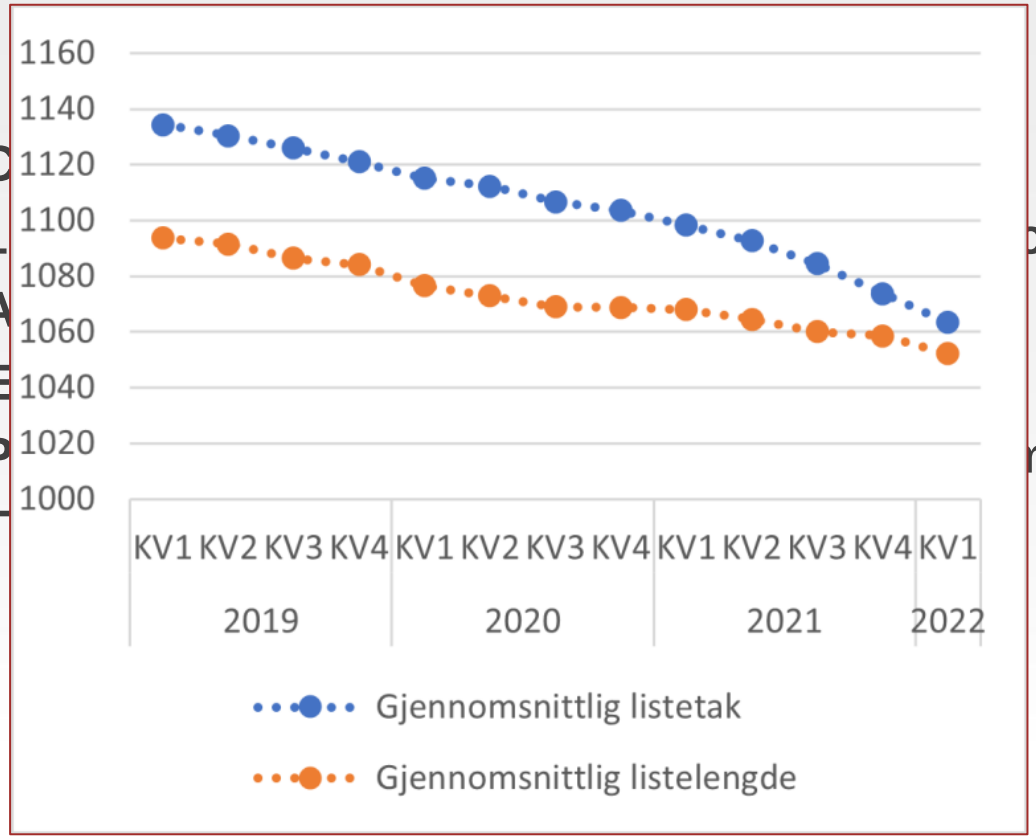
- determines the prices and fees – good cost control
- *should* take responsibility for quality, development, infrastructure, research etc (with low fulfillment)

What happened? An immediate success!

- **Within 1-2 years:**
  - Almost all inhabitants participated (~99%)
  - Good availability for all. Very high CoC (>0.75)
  - Much better coordination, information and follow-up
  - Public satisfaction among the best of any public service (not for telephone access)
  - Most GPs report more satisfaction
  - Recruitment was very good, almost no vacancies

2023 data of GPs in Norway

- C
- 1 …office
- A
- E
- P …ment
- T



Scientific evaluation 2006: The system is a success and has achieved its goals!

- For most patients ...
- For most GPs ...
- For most municipalities ...
- For most politicians ...

- Are there still some problems?

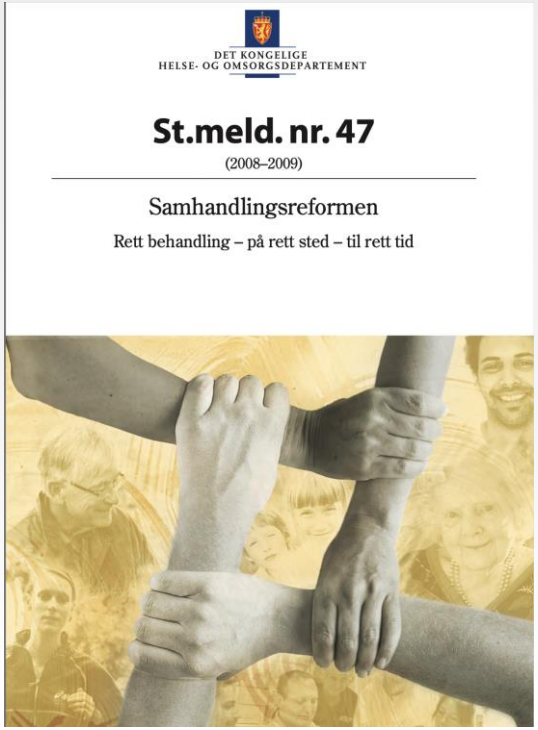
A crisis silently evolves (2015 – 2018)

What went wrong?

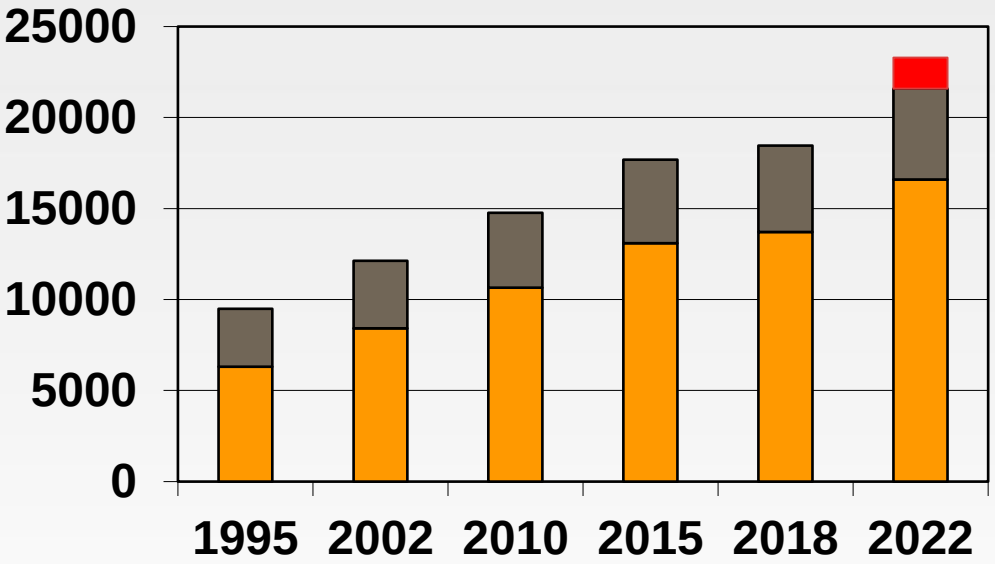
The Coordination Reform 2012

- More patients should be treated in primary care, both chronic diseases and emergencies
- Established pre-hospital low threshold wards in primary health care
- Primary emergency 24-7 beds in the municipalities for patients not in need of hospitalisation
- Estimated need for 2000 more GPs

  – almost none in reality, a fundamental betrayal from the politicians



Doctors in Norway 1995-2022



2002-2022:	10 285 more in hospitals
	1 286 more GPs
Share of GPs	from 31% to 23%
“missing” GPs	> 1 700

Norwegian GP crisis 2015 – 2023 (I)

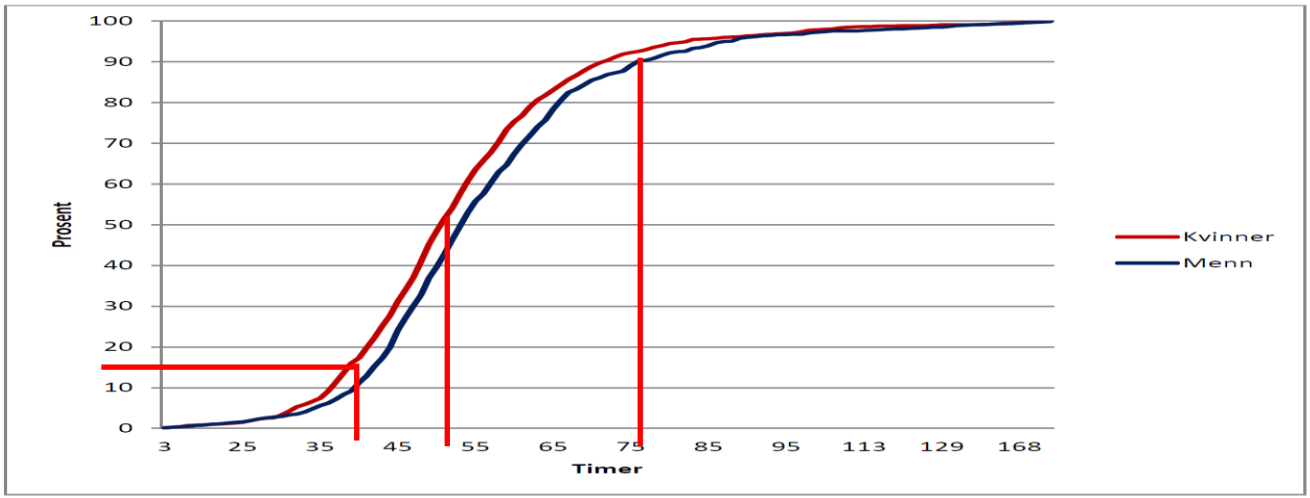
- Increasing number of tasks per patient
  - Medical c
  - Point of c
  - Digitaliza ith the regulatio
  - Digitaliza
- Lack of do
  - Many qu eek).
    Still love oad
  - Low rec
  - Many lo costs

ka list without a GP 2002-2022

Workload per week (N= 1954) (2018)

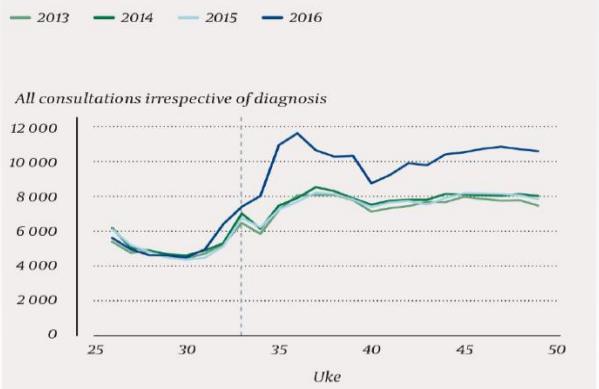
Working hours per week:

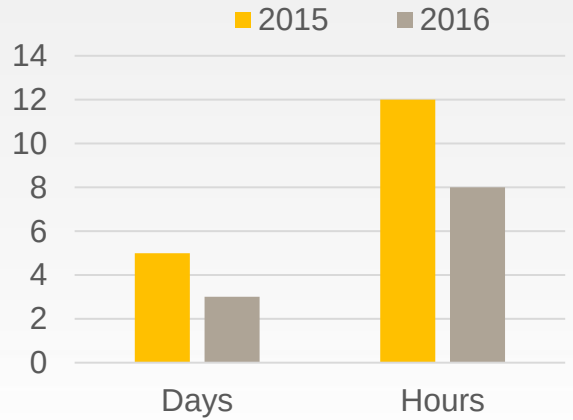
- **Mean 55.6 Median 52.2**
- **Women 3 hours less**
- **25% worked more than 62 hours**
- **10% worked more than 75 hours**



Drowning in paper work, certificates and reports

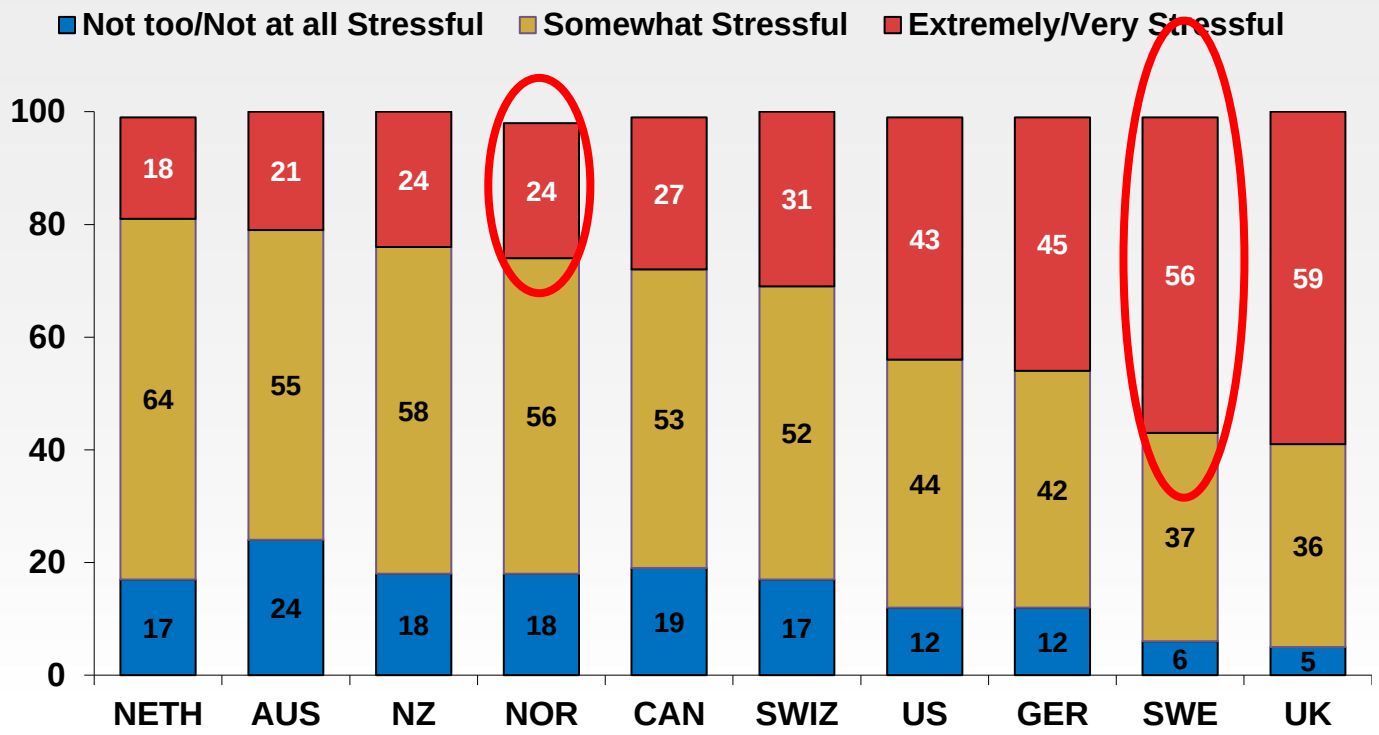
New rules for absence with stricter requirements for documentation were introduced in upper secondary schools in the autumn of 2016



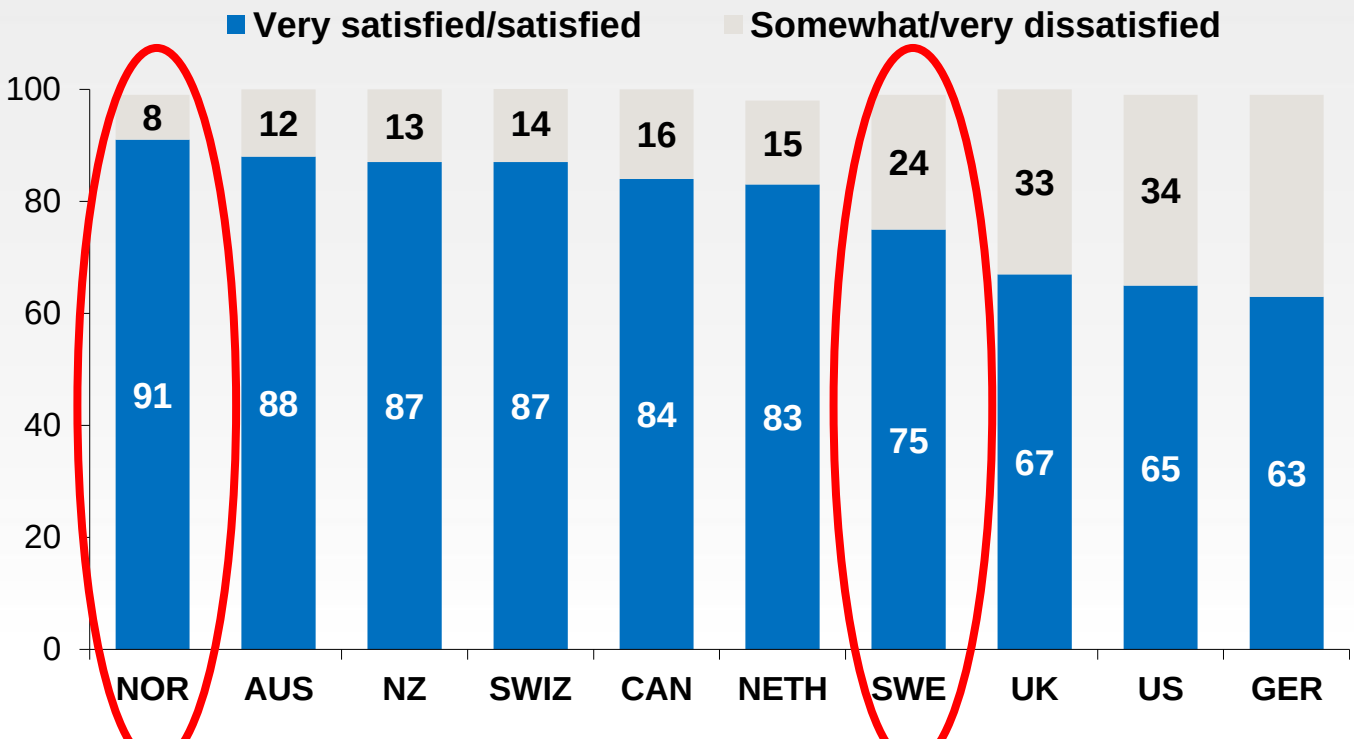


- **Consultations for 16 – 18-year-olds was 30 % higher in 2016 than in 2015**
- **The dispensing of drugs increased by 8 %, antibiotics by 26%**
- **>60.000 more contacts in 2016 than in 2015!**

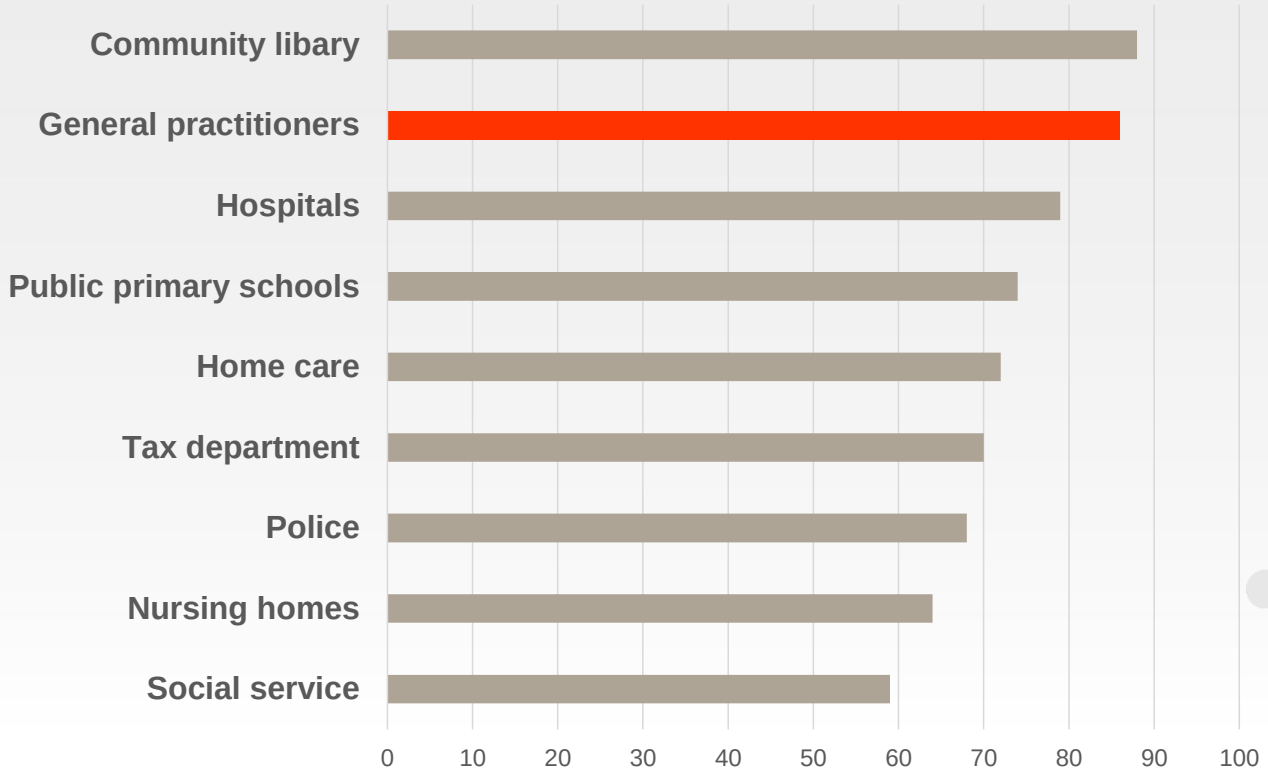
How stressful is your job as a GP?



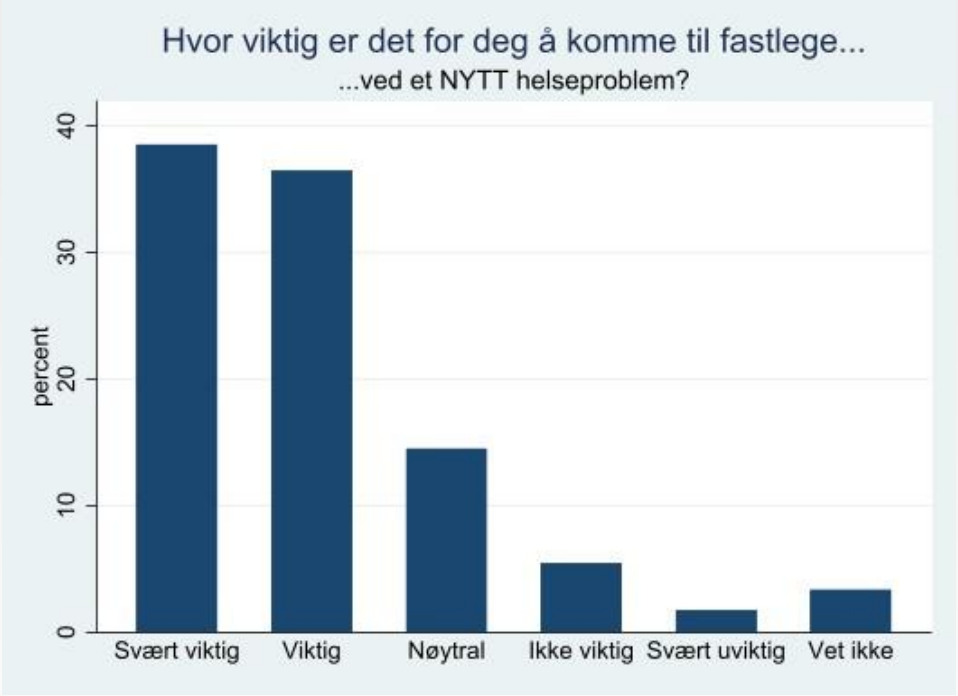
GPs' satisfaction with practicing medicine (2015)



Satisfaction score with public services among Norwegian inhabitants (2017)



How important is it to see your known GP when you have a NEW problem?

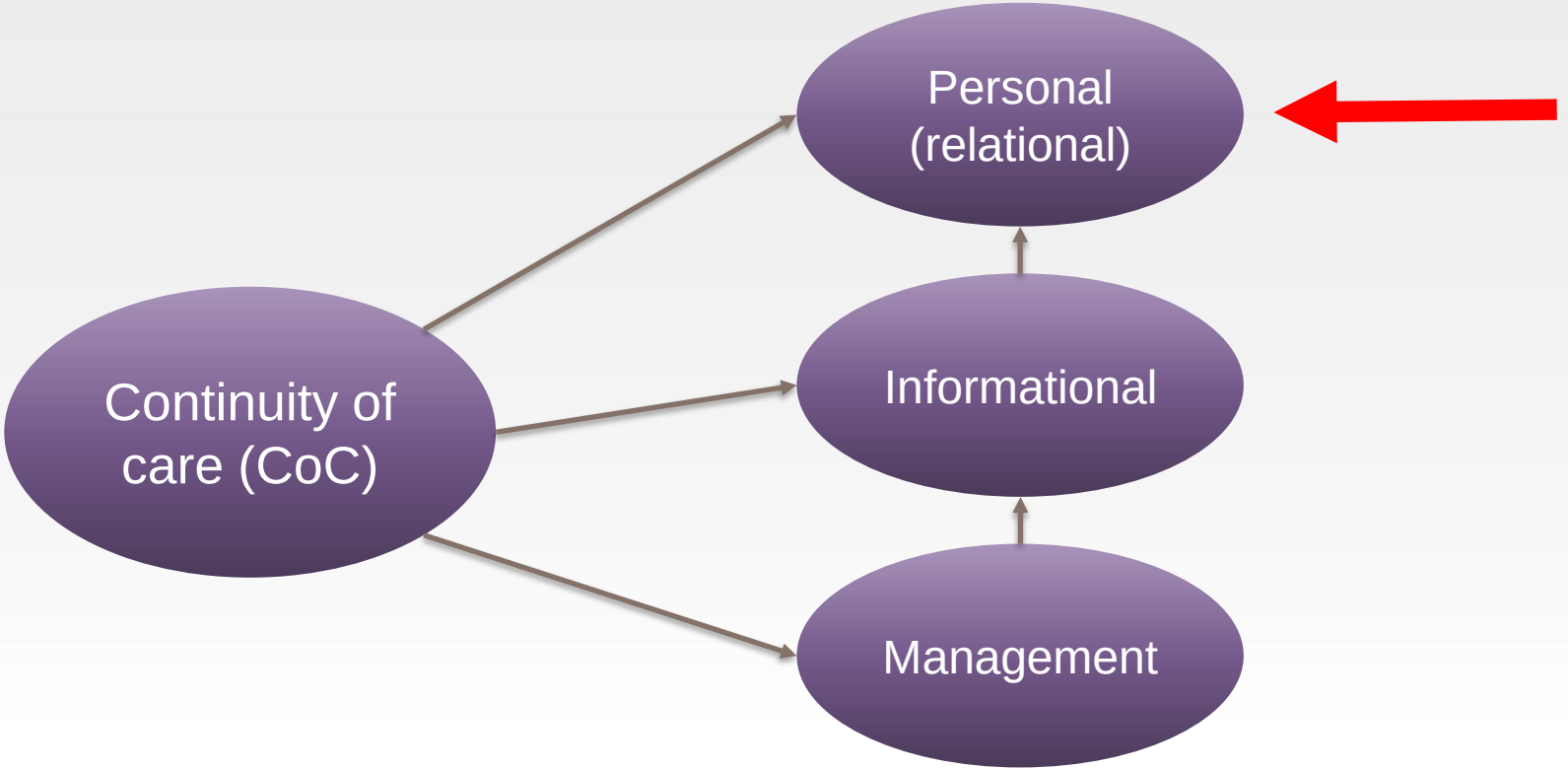


How important is it to see your known GP for your known problems?

Continuity of care!

What do we mean by continuity of care (CoC), and how do we measure it?

Different types of continuity of care (CoC)



Measures of CoC

Usual Provider of Care Index (UPC)

$$UPC = \frac{n}{N}$$

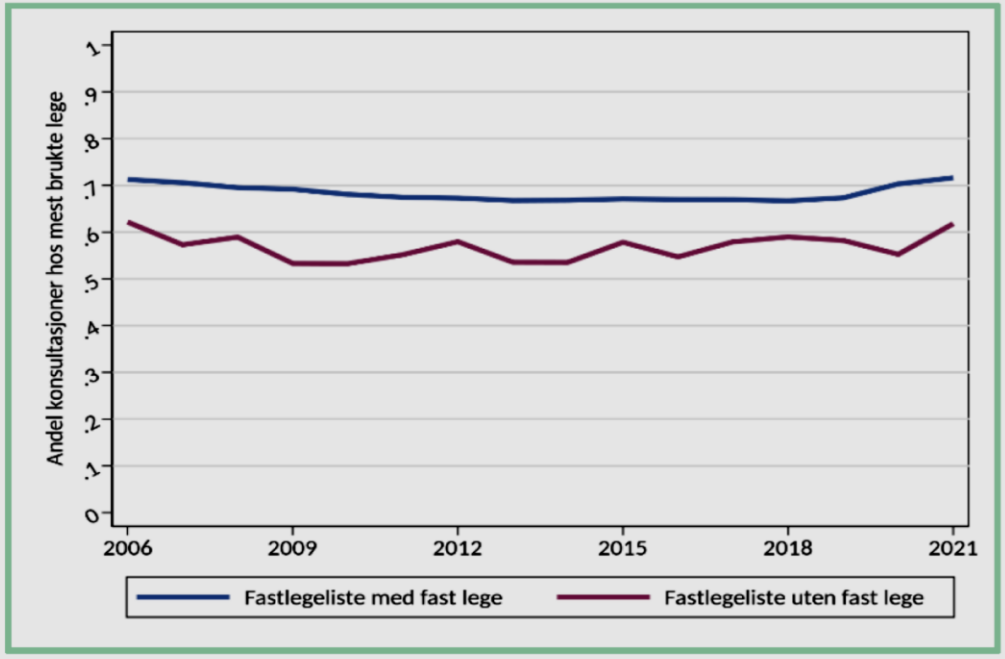
N = total number of consultations with all providers (GPs or others)
n = total number of consultations with a specific GP
0 ≤ UPC ≤ 1

High UPC	≥ 0.75
Moderate	0.50 – 0.74
Moderate/low	< 0.50
Low/very low	< 0.25

Some examples

- UK
- Finland
- Norway

Figur 2-9: Utvikling i andel konsultasjoner hos mest brukte lege, totalt



Merknad: Som andel av totale konsultasjoner. Kilde: FLO og KUHR, 2006–2021.

UPC for patients with combined chronic conditions, 2013-2016 (COPD, heart failure, diabetes, asthma)

Diagnoses	CCC* Same RGP		
	Patients (N)	Mean	SD
Total	121,118	0.78	0.22
Sex			
Female	47.5	0.78	0.22
Male	52.5	0.79	0.22
Age groups (years)			
<65	39.3	0.75	0.23
≥65	60.7	0.80	0.21
Centrality index			
1 (most central)	18.0	0.81	0.21
2	24.6	0.81	0.20
3	27.5	0.80	0.21
4	19.1	0.77	0.22
5	8.2	0.70	0.26
6 (least central)	2.6	0.58	0.31
Educational level			
Low	33.5	0.78	0.22
Medium	44.7	0.80	0.21
High	17.1	0.80	0.21
Missing	4.8	0.62	0.25

What are the proven benefits from relational continuity of care (CoC)?

From satisfaction only to hard endpoints

(The short version)

The benefits of relational continuity in primary care

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

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

Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway

by
Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg, and Steinar Hunskaar


Research

Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg and Steinar Hunskaar

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

a registry-based observational study in Norway

Abstract

Background

Aim

Design and setting

Method

Results

Conclusion

Keywords

INTRODUCTION

METHOD

The Norwegian RGP Scheme

Br J Gen Pract 2022; 72 (715): e84-e90.
DOI: https://doi.org/10.3399/BJGP.2021.0340

British Journal of General Practice
bringing research to clinical practice

Having the same GP for years saves patients' lives

Kat Lay, Health Editor

Tuesday October 05 2021, 12.01am BST, The Times

A Norwegian study found that patients with a long GP history were 8 per cent less likely to die within a year

THE TIMES

Having the same GP for years saves patients' lives

Kat Lay Health Editor

Seeing the same GP for more than 15 years cuts a patient's risk of needing admission to hospital by 28 per cent, according to a study, with almost as big an effect on the risk of premature death.

Researchers found that the longer the relationship between a patient and one GP, the less likely they were to need out-of-hours care, emergency hospital treatment, or to die within 12 months.

The study, based on Norwegian health records, is published today in the *British Journal of General Practice*. Hogne Sandvik, the lead researcher, said: "Over time GPs become specialists on their individual patients, rather than on their diseases. The GP may therefore identify important symptoms earlier than doctors without this knowledge."

In Norway, all residents are assigned a named GP. The study used data on 4,708 GPs, looking after an average of 1,113 patients each. Data on the length of relationship was compared with patients' use of out-of-hours services, hospital admissions and deaths in 2018.

Compared with a one-year patient-GP relationship, those who had had the same doctor for between two and three years were about 13 per cent less likely to need out-of-hours care, 12 per cent less likely to be admitted to hospital, and 8 per cent less likely to die that year. After 15 years the figures were 30 per cent, 28 per cent and 25 per cent.

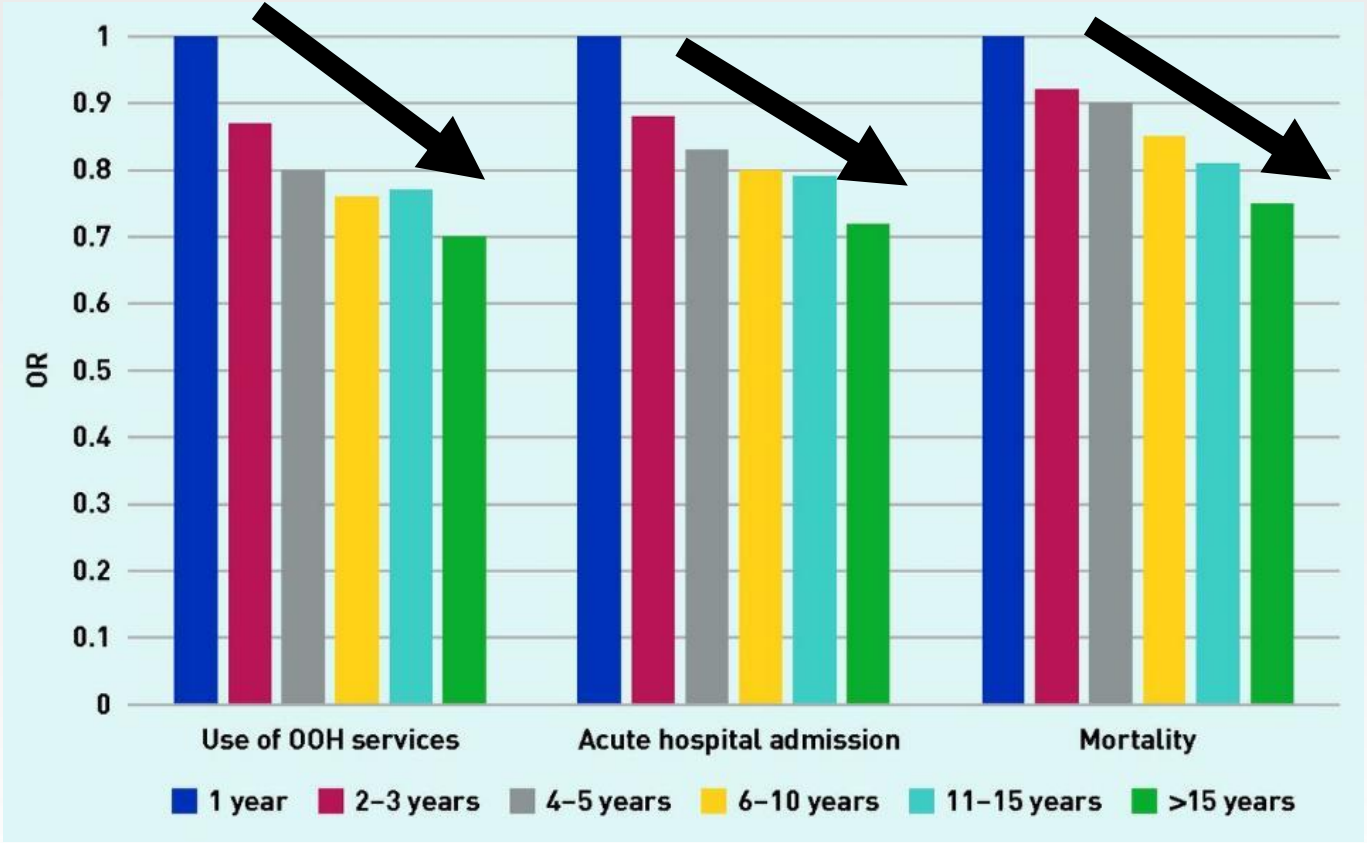
Sandvik, a senior researcher at the National Centre for Emergency Primary Health Care, part of the NORCE research centre in Bergen, added: "It can be lifesaving to be treated by a doctor who knows you. If you lose a general practitioner you've had for more than 15 years, your risk of needing acute admission to hospital or dying increases considerably the following year."

The paper warned that the kind of long-term continuity of care shown to be beneficial was "not possible without physicians who remain in their practices over time", suggesting the benefits of a stable GP workforce.

Professor Martin Marshall, chairman of the Royal College of GPs, said continuity of care was "highly valued" but that providing it was "becoming increasingly difficult as GPs and our teams struggle to deal with intense workload and workforce pressures". He added that the government needed to make good on its promise of providing 6,000 more GPs as well as tackling the "undoable" workload in practices.

What did we do?

- Registry-based observational study covering 4 552 978 Norwegians
- Duration of GP–patient relationship 2001-2018 was used as explanatory variable for the three main explanatory variables:
  - use of OOH services
  - hospital admission (at least one acute admission)
  - death (all in 2018)
- Adjustments/covariates:
  - Sex, age, educational level, country of birth, multimorbidity, centrality, and frequency of GP visits.
  - GP variables: sex, age, general practice specialist or not, list size, and vacant list capacity



15 years with the same GP:

- **Mortality – 25 %**
- **Hospitalization – 28 %**
- **Out-of-hours care – 30 %**

Hogne Sandvik et al. Br J Gen Pract
doi:10.3399/BJGP.2021.0340

British Journal of General Practice
bringing research to clinical practice

SOCIEDAD MADRID SANIDAD MÉDICOS

Qué supone que un millón de madrileños no tengan médico asignado

Las asociaciones médicas estiman que el 15% de la población de la Comunidad de Madrid no tiene médico o pediatra de referencia en Atención Primaria. Esto trae consecuencias para pacientes, profesionales y para el sistema en su conjunto.

Por Marina Velasco

22/01/2023 08:52am CEST

GOIB CONSELLERIA SALUT I CONSUM
ÀREA SALUT MENORCA

MANTENER EL MISMO MÉDICO/A DE FAMILIA APORTA BENEFICIOS A LA SALUD

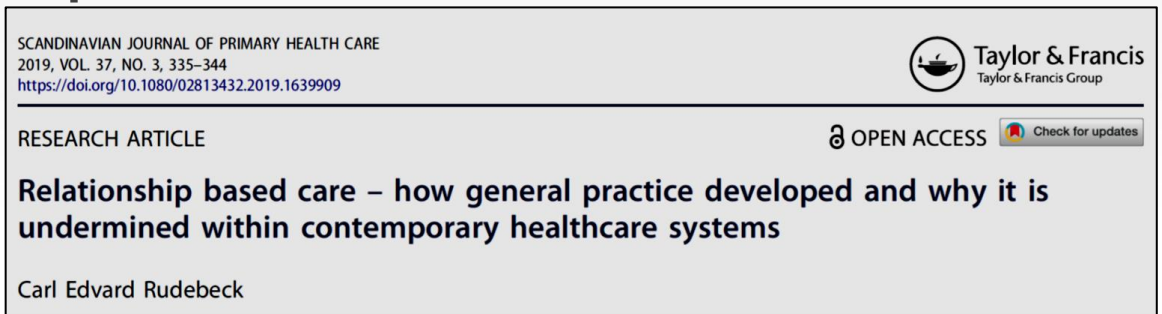
El tiempo con el mismo médico/a reduce	2-3 años	15 años
Uso de servicios de urgencias	↓ 13%	↓ 30%
Hospitalizaciones	↓ 12%	↓ 28%
Mortalidad	↓ 8%	↓ 25%

Hogne Sandvik, Øystein Hetlevik, Jesper Blinkenberg, Steinar Hunskaar
Continuity in general practice as predictor of mortality, acute hospitalisation, and use of out-of-hours care: a registry-based observational study in Norway.British Journal of General Practice 4 October 2021;

International perspectives

Traditional general practice under stress

- Access vs continuity
- Doctor of disease and organization vs doctor of the whole patient
  - In disease based structures, the doctors come and go
  - In general practice, the diseases come and go, but the doctor prevails
- The personal doctor vs consultant for the team
- The heavy focus on systems and contracts hinders clinical and academic development of the field itself



SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE
2019, VOL. 37, NO. 3, 335–344
https://doi.org/10.1080/02813432.2019.1639909

Taylor & Francis
Taylor & Francis Group

RESEARCH ARTICLE

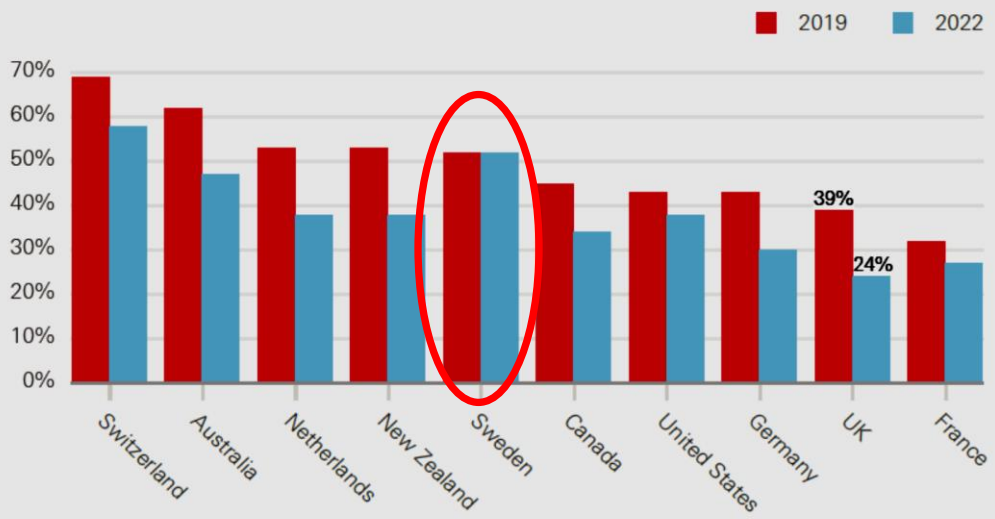
OPEN ACCESS Check for updates

Relationship based care – how general practice developed and why it is undermined within contemporary healthcare systems

Carl Edvard Rudebeck

GPs internationally: Stressed, dissatisfied and overworked

Figure 1: Overall how satisfied are you with practising medicine?
The percentage of GPs answering 'extremely satisfied' or 'very satisfied', 2019 and 2022



Source: Health Foundation analysis of the Commonwealth Fund's International Health Policy Survey of Primary Care Physicians, 2019 and 2022.

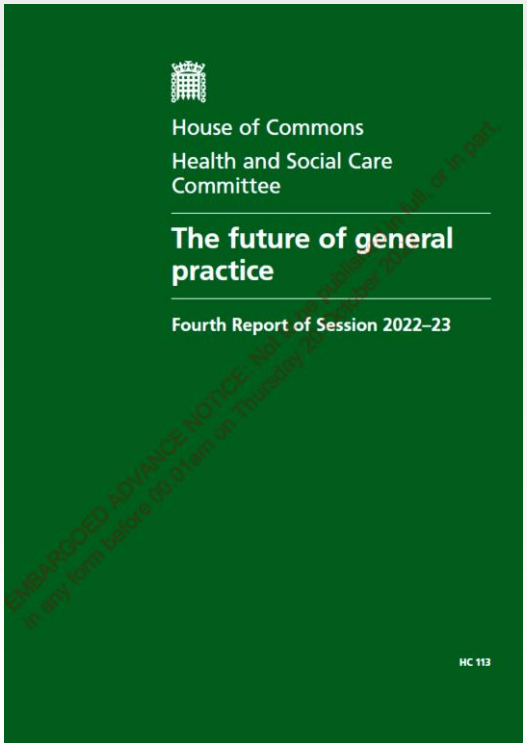
When the basics go wrong: The UK story!

When access trumps continuity, general practice dissolves into bits and pieces with serious consequences:

- False impression of productivity
- Suboptimal compensatory actions
- Not obtaining its potential hard endpoints
- Exhaustion of GPs
- Escape from the profession
- Lower educational quality
- Decreased patient satisfaction
- Opens for quick-fix and commersialism

UK Parliament proposals 2022 on CoC

- The decline in CoC must be reversed
- Even patients without a preference for CoC, benefit from receiving it!
- CoC should be reported by all GP practices by 2024 (UPC)
- Champion the list model rather than dismissing it as unachievable
- An ambition that by 2027 80% of practices have returned to personal lists, and for all GPs from 2030



Sweden 2020: The «Nära vård» (close care) reform

- From focus on organization to focus on person and relation
- Primary care as the hub
- Main aims:
  - Increased access
  - Increased patient centredness and participation
  - Increased continuity of care
- Patient list system, 1100 persons per GP specialist and 550 per resident/trainee

Denmark 2022: «Sundhedsreformen» (The Health Care Reform)

- 43 % increase in GPs 2022-2035
- Continue with list system and GP's as private enterprises/contracts
- Primary care health centres, «Sundhedshuse», co-localization of several professions, including GPs
- 10-15 community based acute care hospitals, «Närhospitaler», with integrated care

Access priority often trumps continuity and good medical practice

Chapter 1. The challenges of a changing world — 1

Trends that undermine the health systems' response

Hospital-centrism: health systems built around hospitals and specialists

Fragmentation: health systems built around priority programmes

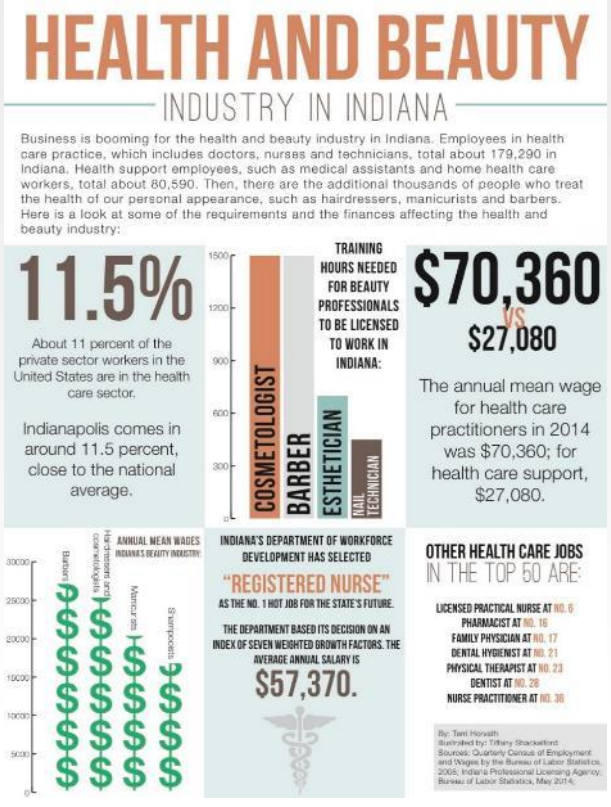
Health systems left to drift towards unregulated commercialization

World Health Organization

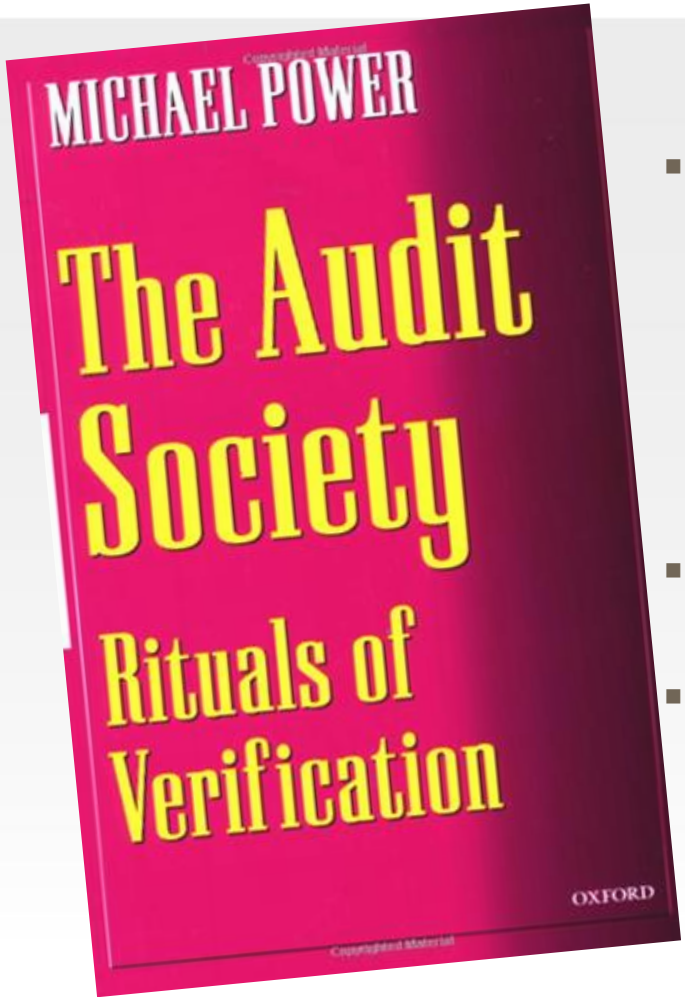
So, what more is going on, out in the real world?

- The market orientation and consumerism
- The audit society
- Overdiagnosis and no-risk approach through screening
- Access to (often useless) care trumps continuity and comprehensiveness
- Will people believe that it is good enough to be good in general?

Health as a product and an industry



- Commersialization of hospitals
- New public management
- Billing and cross-payments
- Fee for (all) services
- Incentives
- Consumerism, health, body and beauty



- The audit society:
  - The explosion of rules
  - Reporting and punishment
- A philosophy built on doubt, conflict, mistrust, and risk
- The methods are many, time consuming, and always costly
- More administrators and accountants, less clinicians

A squeeze between doing well and creating harm:

Opportunistic screening, a popular service

Is opportunistic disease prevention in the consultation ethically justifiable?

Linn Getz, Johann A Sigurdsson, Irene Hetlevik

Medical resources are increasingly shifting from making patients better to preventing them from becoming ill. Genetic testing is likely to extend the list of conditions that can be screened for. Is it time to stop and consider whom we screen and how we approach it?

BMJ 2003; 327: 498-500

BMC Family Practice

BioMed Central

Research article

Open Access

Current European guidelines for management of arterial hypertension: Are they adequate for use in primary care? Modelling study based on the Norwegian HUNT 2 population

Halfdan Petursson*[1], Linn Getz[2], Johann A Sigurdsson[1] and Irene Hetlevik[2]

Address: [1]Department of Family Medicine, University of Iceland, Solvangur Health Centre, IS-220 Hafnarfjördur, Iceland and [2]Research Unit of General Practice, Department of Public Health and General Practice, Norwegian University of Science and Technology (NTNU), Trondheim, Norway

Email: Halfdan Petursson* - halfdanpe@gmail.com; Linn Getz - linngetz@med.is; Johann A Sigurdsson - johsig@hi.is; Irene Hetlevik - irene.hetlevik@ntnu.no

* Corresponding author

Published: 30 October 2009

BMC Family Practice 2009, 10:70 doi:10.1186/1471-2296-10-70

Received: 17 March 2009

Accepted: 30 October 2009

Who should have the Total Body Screening CT-scan?

Age:

- **A woman over 40 or postmenopausal.**
- **A man over 40.**
- **These are general age guidelines. Others may benefit from the scan dependent upon current health, lifestyle and family history of health issues.**

A recent offer from Norway (NOK/SEK 38 000, USD 3 300)

Aleris Vi tilbyr Her finner du oss

Sykehus & medisinske tjenester › Executive Health › Timeplan for dagen

Timeplan for dagen

Slik kan en dag hos Aleris Executive Health se ut:

07:50	Velkommen
08:00	Innledende samtale og undersøkelse hos allmennlege
09:00	Blodprøver, urinprøve og måling av fettprosent
09:15	CT av lunger (ultra lavdose) for røykere
09:30	MR prostata for menn ved behov/ MR bryster for kvinner
10:00	Ultralyd abdomen (indre organer)
10:15	Koloskopi (tarmundersøkelse)
11:00	Pause med matservering
11:30	Øyelege
12:00	Spirometri (lungefunksjonsmåling), audiometri (hørselstest) og vaksiner ved behov
12:30	Hudlege (sjekk av føflekker m.m.)
13:00	Hjertespesialist
14:30	Urolog for menn, gynekolog for kvinner
15:00	Oppsummering og prøvesvar hos allmennlege
16:00	Ferdig

A DAY AT ALERIS EXECUTIVE HEALTH!

Welcome
General practitioner
Blood, urine and body composition
CT of lungs (smokers only)
MR prostate/breasts
Ultrasound abdomen
Coloscopy

Lunch break!

Eye doctor
Spirometry, audiometry, vaccinations
Dermatologist
Cardiologist

Urologist/gynaecologist
General practitioner: Summary, test results, follow up
Finish

Access seems to trump everything!

RediClinic is high-quality, affordable healthcare that fits how we live today. Routine treatment and preventive care are available without an appointment. RediClinic's staff provide convenient and affordable treatment for more than 25 common conditions, such as strep throat and ear infections. They also provide health screening tests, vaccinations, immunizations, and physicals.

Snakk med legen hjemmefra

Ta legetimen på mobilen - raskt, enkelt og sikkert. Våre leger kan skrive ut resept, legeerklæring, henvise til spesialist og rekvirere blodprøve og radiologi.

kr 350,- per konsultasjon

Få svar raskt

7 min 14 sek

Gjennomsnittelig ventetid fra bestilling til timen starter

Åpent 8-22 (10-22)

Last ned fra App Store

TILGJENGELIG PÅ Google Play

Where is the future? My recommendations

- Still rather small practices with 5-15 GPs
  - Balance access and continuity of care
  - More nurses and health secretaries per GP
- "Primary care health teams" *within* the practice, with nurses, administrators, physiotherapists, psychiatric nurses. Costly, but increases quality. USA: *The medical home* or *The Teamlet*
- Increased digitalization, home monitoring, video consultations
- Disease specific silo organizations should be avoided
  - Outsourcing of GPs tasks must be balanced against loss of continuity

That said …

- In general,
  - the Nordic models for undergraduate and postgraduate education produce physicians that provides high quality, patient-centered, and affordable primary health care, for the benefits of patients and society

- To all GPs that feel the current battleground:
  - Fight for the general practice basic principles, values, personal doctoring, and broad clinical content through education
- Politics change – the field of GP will overcome.
- Quality never goes out of style!!

My final messages

Calm down!

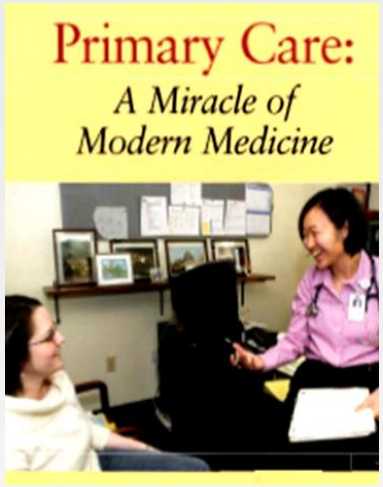
General practice may be under pressure, but will survive!

Stick to basic concepts, but modernize!

Read and analyze the research literature!

Spread the message!

Be proud of our specialty!



I wish you
GOOD LUCK
in further developing general practice in Sweden!

Thank you
for your attention

Thank you for your attention