

What do we know about patient satisfaction with the Regular GP Scheme?

KRONIKK

MONICA SØRENSEN

E-mail: monica.sorensen@helsedir.no

Monica Sørensen (born 1982), PhD candidate at the Faculty of Health Sciences at OsloMet – Oslo Metropolitan University.

The author has completed the ICMJE form and declares no conflicts of interest.

Developing patient-centred health care is a political goal. However, knowledge of patients' preferences and needs is insufficient, particularly with regard to the GP service, and it is unclear how such information may be obtained.

The government white paper on primary health and care services describes the patients as the health service's most important change agents (1). The goal is for patients and their relatives to participate on a par with professionals and politicians in the efforts to achieve the changes necessary to build patient-centred health and care services.

General practice may be viewed as medicine's interface with society; however research and professional development in primary care have not been prioritised to the same extent as in secondary care. Knowledge of patient satisfaction is scant, and the association between user experience and quality of the GP service, and patient record data, is not used to any significant degree for quality improvement (2). No user surveys are systematically conducted, and there are no specific plans for gathering such information through the newly established municipal patient and user registry (KPR) (3).

Nor are healthcare personnel's experiences systematically gathered and used in quality development. This has now become clear, as the concern related to the regular GP scheme is on such a scale that many predict its imminent collapse if immediate measures are not taken (4, 5). This is a situation that probably could have been avoided if policy makers had more closely attended to what GPs actually do, asked more questions and evaluated the Regular GP Scheme on a continuous basis.

The basis for creating the patient's health service is therefore insufficient – knowledge of the users' and healthcare personnel's experiences is needed (6). Through The Commonwealth Fund's international health policy surveys, in which we have participated since 2009, satisfaction with primary care practices, the healthcare service for high-needs older adults and the healthcare service for the general adult population are scrutinised annually in a three-year cycle. In the evaluation in 2009, Norwegian users scored GPs' routines for quality

measurement and quality assessment, coordination of services, availability and digital services lower compared to participants from other countries (7). In 2016, the survey showed that Norwegian patients had poorer experiences with their GP in the areas of communication, user involvement and consultation time compared to patients in ten other participating countries (8).

In the survey published in 2016, it was found that in the period from 2002 to 2015, there was a statistically significant decrease in participants who completely agreed with the question on whether the doctor takes 'me and my problems seriously' and more disagreed somewhat or completely (9). The survey also shows that in 2012, fewer had full confidence in the treatment provided than in 2002.

However, the results do not state what changes the patients would like to see or how this might come about, and they may be interpreted in different ways. For example, Norwegian patients could be more demanding than patients in other countries. The results may also be related to the fact that primary health care in Norway, and particularly the Regular GP Scheme, has not adapted to social changes and the new needs that these entail. In any case, we cannot rest easy with these results given that Norwegian primary care is aiming towards being among the best in the world.

However, the results do not state what changes the patients would like to see or how this might come about, and they can be interpreted in different ways. Could it be that Norwegian patients are more demanding than patients in other countries? It may also be the case that the primary healthcare service in Norway, and particularly the Regular GP Scheme, has not adapted to social changes and the new needs that these entail. In any case, we cannot rest easy with the results if we want the Norwegian primary healthcare service to be among the best in the world.

In light of the absence of patient-reported needs, the question of how user surveys should be conducted and how the results should contribute to development of the services is an important one. The Norwegian Knowledge Centre for the Health Services has developed a standardised method for measuring patients' experiences with the GP service at both local and broad level (called PasOpp), which constitutes a rational basis for collecting this type of data (10).

Nevertheless, use of pre-defined questionnaires does not provide answers to questions such as 'What is important for you?', a campaign launched in 2014 by the Norwegian Minister of Health and Care Services and the Norwegian Association of Local and Regional Authorities (KS) as part of the work of creating patient-centred care and to increase patient participation in their treatment. Evaluation of the responses to this question will place entirely different demands on resources with regard to collection and analysis of data. So why not establish a portal at municipal level, where patients and their relatives can record their views on the municipality's health and social care services?

Prioritisation in the primary healthcare service

This municipal patient-directed portal can provide pivotal information about the needs for cultural change, service innovation and new financing schemes, and thus keep the goal of patient-centred care in sight. The need for cooperation across levels and professions, as well as with the patients, has never been greater.

As a consequence of this, the website *Samvalg.no* has been established. The website states that 'Shared decision-making happens when patient and therapist together agree on the treatment to be chosen'. In cases where changes to life and health have arisen, it is recommended that an explanatory conversation should take place in which the patient's reflections and awareness of their own needs are supported. However, what does not appear clear is the fact that user involvement is something other than patient education – that it implies a dialogue of equals.

It is also unclear what constitutes good or poor practice with regard to patient involvement and what is the correct emphasis on individual preferences as opposed to the principle of 'treat like cases alike'. The shared decision-making instruments are largely developed for use in the specialist health service. Do we possess too little knowledge of the decisions taken in primary health care, or are the issues too complex for such tools to be developed here as well?

Good medical practice unites humanism with natural science. The degree of patient involvement, the need for patient guidance and the choice of objectives are considerations that imply questions of prioritisation. This may present challenges with regard to both personal values and time, while also increasing the risk of variation in the services offered. If the requirement for patient involvement is to be taken seriously, it is a challenging task for doctors to assess and discuss the importance of evidence-based practice jointly with the patient, to listen, provide guidance and meet individual preferences. The distinction between personal and medical problems may be less clear – and may lead to a greater sense of helplessness and more personal wear and tear on the doctor (11).

Until now, the criteria for prioritisation in the health service have been discussed in five Official Norwegian Reports, all of which have been directed towards the specialist health service. Other considerations should form the basis of decisions taken in the primary healthcare service, and the first committee that will undertake an overall review of the challenges for prioritisation in the municipal health and care services is expected to submit its proposal by the end of 2018 (12).

Let us hope that the newly appointed prioritisation committee dares to discuss how medical practice will appear once the goal of creating patient-centred care is achieved, what specific measures must be initiated to achieve this goal, the cost-benefit effects and how the services should be assessed. Most likely one of the main challenges of prioritisation in primary health care is that the consequences of decisions will be dealt with outside the general practice – by patients themselves – as compared to secondary care, where the hospital's responsibility ceases simultaneously with the full stop in the discharge summary.

Everything starts with a question

The possibility of using the response to the question 'What is important for you?' for any rational treatment purposes is affected by the therapist's empathic abilities, the trust that has been established, and the patient's experience of talking about his/her feelings and needs (13). It requires an adjustment of the doctor's role and good communication skills in both parties. The doctor, who has traditionally been trained to be autonomous, self-driven and independent, must place more emphasis on humility, listening and cooperation. The patient must become accustomed to being asked more questions and making more decisions.

It is also relevant to raise the question of whether expectations for patients' responsibility for their own treatment and follow-up of treatment goals should increase when their opportunity for involvement is enhanced. Follow-up of chronic diseases provides a good example, where maintenance, prevention and treatment take place between – and not during – doctor appointments. It is an unexploited potential that patients are not better enabled to monitor their own illness, whereby they could be made more responsible for preventing or postponing disease exacerbation (14). Improvement in this regard relies on knowledge about what information patients need and the communicative strategies that most fully enhance patients' ability to self-master.

It is a challenge to create the patient's health service without sufficient knowledge of doctors' and patients' responses to the question 'What is important for you?'. Who will take responsibility for asking it?

REFERENCES:

1. Meld. St. 26 (2014-2015). Fremtidens primærhelsetjeneste – nærhet og helhet. <https://www.regjeringen.no/no/dokumenter/meld.-st.-26-2014-2015/id2409890/> (13.3.2018).
2. Jamtvedt G, Young JM, Kristoffersen DT et al. Audit and feedback: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2006; 2: CD000259. [PubMed]
3. Forskrift om kommunalt pasient- og brukerregister (KPR). <https://lovdata.no/dokument/LTI/forskrift/2017-08-25-1292> (13.3.2017).
4. Moe M. Frykter fastlege-kollaps innen fem år. *Dagens Medisin* 9.9.2016.
5. Sæther AS, Nærø AF. Kampen om fastlegene. *VG* 2017. <https://www.vg.no/spesial/2017/fastleger/> (13.3.2018).
6. OECD. Reviews of Health Care Quality: Norway 2014. Raising Standards. Paris: OECD, 2014.
7. Holmboe O, Iversen HH, Sjetne IS et al. Commonwealth Fund's International Health Policy survey. Results from a comparative population survey in 11 countries. Report No.: 1890-1298. Oslo: Folkehelseinstituttet, 2011.
8. Skudal KE, Sjetne IS, Bjertnæs ØA et al. Commonwealth Fund's population survey in 11 countries: Norwegian results in 2016 and changes over time. Report No.: 978-82-8082-784-5. Oslo: Folkehelseinstituttet, 2016.
9. Godager G, Iversen T. Brukernes erfaringer med fastlegeordningen 2001 – 2015. Trender i bruk, tilgjengelighet og fornøydhet. Oslo: Health Economics Research Network at the University of Oslo, 2016.
10. Holmboe O, Danielsen K, Iversen HKH. Utvikling av metode for måling av pasienters erfaringer med fastleger. Oslo: Nasjonalt kunnskapssenter for helsetjenesten, 2015.
11. Nessa J, Schei E, Stensland P. Korleis møter allmennlegane pasientanes livsproblem? *Tidsskr Nor Legeforen* 2009; 129: 1323 - 5. [PubMed][CrossRef]
12. Utvalg skal se på prioritering i den kommunale helse- og omsorgstjenesten. Pressemelding 5.4.2017. <https://www.regjeringen.no/no/aktuelt/utvalg-skal-se-pa-prioritering-i-den-kommunale-helse-og-omsorgstjenesten/id2548572/> (13.3.2018).
13. Schei E. Dannelse til lege – pasientkontakt og profesjonalitet i første fase av medisinstudiet. *Uniped* 2016; 39: 357 - 67. [CrossRef].. [CrossRef]
14. Meld. St. 10 (2012-2013). God kvalitet – trygge tjenester— Kvalitet og pasientsikkerhet i helse- og omsorgstjenesten. <https://www.regjeringen.no/no/dokumenter/meld-st-10-20122013/id709025/> (13.3.2018).

Published: 31 May 2018. *Tidsskr Nor Legeforen*. DOI: 10.4045/tidsskr.17.0861

Received 6.10.2017, first revision submitted 26.12.2017, accepted 13.3.2018.

© The Journal of the Norwegian Medical Association 2020. Downloaded from tidsskriftet.no