

Should we be surprised by the new hearing-round memo on the regular GP scheme sent out by the Ministry of Health and Care Services? Perhaps not.

The devil is in the details

Bjarne Håkon Hanssen took office as Minister of Health and Care Services on 20 June 2008. Before two weeks were up, he had visited all the country's health regions and seen a number of patient groups and health institutions, he had been to Copenhagen to obtain information on the Danish «capital-city process» and the Danish regional reform, and he had already had time to diagnose the Norwegian health-care system. On 3 June 2008, Hanssen told Norwegian broadcasting that he wished to enact a reform that «would ensure that cooperation between the hospitals and the municipalities becomes a lot more active and advanced than it is now». One month later, at a press conference at Øya health centre in Trondheim, he explained how the work on the interaction reform should be organised: «We must unravel a big tangle, and we need to look at several things: funding, legislation, organisation, communication and electronic solutions. All these must be established. We will have completed this by April 2009. By that time, I will have prepared a specific proposal for a new administration system and a legal framework that will ensure that municipalities and hospitals interact with the best interests of the patient in mind». Nothing less.

Hanssen's time schedule was a couple of months delayed, but he presented his solution to the problems of the Norwegian health-care system (The Interaction Reform) in a report to the Storting on 16 June 2009 – just before the assembly went on holiday that year (1). After the holidays the election campaign started, and after the elections Bjarne Håkon Hanssen decided to retire from politics, in spite of the fact that his party remained in government. The reasons he gave for his transition to the lucrative consultancy business instead of completing what he himself described as «Norway's most important reform» included a lack of motivation for continuing in a top-level political office and that he considered himself not to be an «implementer». In other words, he believed that he was better at identifying problems than at rectifying them. Bjarne Håkon Hanssen's decision did not cause the Ministry of Health and Care Services to reconsider its work on the reform. They continued, and the interaction reform has now been implemented from the beginning of this year. It is surprising to see how little debate there has been among doctors – for example in this journal – and the public, given the scope of this reform. We can think of many reasons why this is so.

One reason is obvious: There was no great disagreement regarding Bjarne Håkon Hanssen's original key point – that the cooperation and coordination of health services for patients with complex and chronic illnesses, as well as the need to cater to an ageing population, constitute the main challenges to present-day health services. Another reason is Hanssen's undisputable charisma, which could be difficult to resist. A third reason could be that the documents that have been published after the report to the Storting have been close to impenetrable, partly because of their volume, but perhaps mostly because they contain so many self-evident truths and imprecise formulations that it is hard to ascertain exactly what they are saying.

On 22 December, however, the Ministry of Health and Care Services circulated a document that caused something of a stir – so far mostly among the GPs. The document was a draft hearing memo for the revision of the regular GP scheme regulations. This may sound dull, but its impact may be felt far beyond the confines of the primary health services. For reasons of space we cannot go into the details here, but the gist of it is that the authorities wish to govern

the activities of the primary health services and doctors quite differently from today. And they want to use legal instruments to do it – by way of regulation – to enable sanctions to be used if the doctors fail to fall into step.

Having read the hearing-round memo for the new regulations for the regular GP scheme it becomes clear that everything in it has already been described in the previous documents. It has just been buried under a mountain of verbiage. As we know, however, the devil is in the details.

Should the new proposal from the authorities surprise us? Perhaps not, since a lot of it is old hat. Before the introduction of the regular GP scheme on 1 June 2001, years had passed of negotiation and conflict over the content and direction of the primary health services. The authorities wished to govern, while the Norwegian Medical Association argued that voluntariness and professional autonomy would provide the best health services for individual patients and for the country as a whole. There was also major internal disagreement on whether acceding to the regular GP scheme would be a correct decision. In the late 1990s the negotiators of the NMA succeeded in obtaining acceptance for many of their demands, and this may be part of the reason why the regular GP scheme has functioned so well until now. Doubtlessly, however, the scheme included a number of opportunities for public governance.

The day before the regular GP scheme entered into force in 2001, the professional commission of APLF, represented by Mette Brekke and collaborators, published an article in this journal where they wrote (2): «This article is an attempt to reflect on the positive opportunities – but also the dangers – that are inherent in an unambiguous population responsibility. In our opinion, the reform will entail changes in professional practices. Most likely, it will involve an increased homogeneity, and it includes opportunities for overruling as well as overloading the doctors». They further described what could happen if the authorities started to govern the content of the primary health services: «In Cuba, for example, the content of each doctor's population responsibility is regulated in detail by the central government. Each person on the list should meet for a certain number of consultations and receive a certain number of home calls every year, even if he or she is completely healthy, for example in order to receive specific health information from the doctor. Identification of specific risk factors (such as smoking, or having a cat in the house) immediately triggers an instruction for more activities by the doctor. No wonder each doctor may have only 500 patients on his or her list. Those of us who visited Cuba some time back felt strongly that we would not have enjoyed working in general practice under such conditions».

Let us hope that we can avoid Cuban conditions.

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References

1. St.meld. nr. 47 (2008–2009). Samhandlingsreformen. Rett behandling – på rett sted – til rett tid.
2. Brekke M, Gudim HB, Hansen TE et al. Populasjonsansvaret i fastlegeordningen – blir vi annerledes leger etter 1.6.? Tidsskr Nor Lægeforen 2001; 121: 1725–7.