Is the «regular general practitioner» scheme too rigid? Should the lists be reduced and the capitation fee removed?

The stability of regular GPs

On the whole, Norwegians are satisfied with their regular GPs (RGPs) and the continuity that these represent. It is commonly assumed that continuity is a criterion of quality and that having stable primary doctors is beneficial. In fact, an evaluation of the RGP reform showed that continuity was the main criterion that patients applied when choosing an RGP (1).

Administrative data for the RGP scheme show that the average list size amounted to 1 175 when the scheme was introduced in 2001 (2). By 2012, it had fallen to barely below 1 170. In other words, during the first ten years no real reinforcement of the RGP scheme took place. The increase in the number of practice licenses only kept up with population growth. There has since been a modest reinforcement, causing the average list size to drop to 1 132 as of year-end 2014.

In the same period, the RGPs have been given more responsibilities and tasks. The new regulations on out-of-hours duty, with their heightened requirements for competence and increased need for secondary on-call duty, provide just one example of how new and otherwise rational reforms impose heavier burdens on the RGPs. Other examples include the Coordination Reform and the new regulations on RGPs. Such reforms call for increased capacity, otherwise stability will be compromised.

The duration of GP contracts is the topic of a study undertaken at the National Centre for Rural Medicine and published in this issue of the Journal of the Norwegian Medical Association (3). Abelsen and collaborators find that there are major variations in stability among the RGPs. These variations are related to the size of the municipalities, list size and the RGP's gender and age. In the largest municipalities, the GP contracts lasted three times longer than in the smallest ones. Young RGPs terminated their RGP practice faster than their older colleagues. Most likely, many of them discovered that general practice was not the right career path for them, and chose other career options. Among the rest, who continued to another job as RGP, the majority moved to a larger municipality.

The proportion of women among Norwegian doctors has grown considerably. This is also reflected in the proportion of women RGPs, now at 40 % (2). It has been claimed that women face particular challenges in terms of working as self-employed RGPs, and that they more often choose to opt out of the rat race (4). It is therefore somewhat surprising when Abelsen and collaborators find that women RGPs are more stable than their male colleagues.

A high degree of stability is a strength of the RGP scheme, but may also represent a problem. The stability among older RGPs may be a hindrance to new recruitment and expansion of the number of practice licenses. Establishing a new practice with a new and empty list is arduous. The patients value their RGPs and the stability they represent so highly that they tolerate suboptimal accessibility. This is why they rarely switch to new doctors with ample free capacity.

In the context of the Coordination Reform, the then minister of health signalled a need for 2 200 new RGPs, claiming that the maximum list size should be reduced from 2 500 to approximately 1 000. Those known as the «RGP barons» should have patients taken away from them (5). However, this is based on misconceptions and ignorance. The large lists are not necessarily excessive. List size must be assessed in relation to the RGP's capacity, for example their number of days in curative practice. RGPs with large lists tend to be more accessible than their colleagues with small lists (6). Their patients use on-call services less frequently (7). In fact, Abelsen and collaborators show that RGPs with large lists stand out in terms of their high degree of stability. We may assume that these are doctors who enjoy their work and operate their practice efficiently. Financial matters are also likely to play a role. A large list will tend to generate a high income, but may also require considerable investments in equipment and personnel. Leaving all this behind is less easy than quitting a job with a fixed salary.

There is a political desire for RGPs to be more accessible and assume further tasks. However, if the RGP scheme is to be reinforced with more practice licenses, the *average* list size must be reduced. This is simple arithmetic. The need for a reduction of the list may be more urgent for a part-time RGP with 800 listed patients than for a full-time RGP with 2 000. Existing RGPs need to actively reduce their lists. As a result, some patients will experience an involuntary interruption of continuity and will have to find another RGP. At the same time, the funding scheme needs to be amended. The present capitation fee per person on the list is a strong incentive to accumulate excessively large lists. We need a funding scheme that balances the costs to doctors of reducing their list, instead providing more services to each individual patient (8).

We ought to consider abolishing the capitation fee, at least in its present form. The old scheme that provided a practice allowance also had its weaknesses, however. The municipalities were reluctant to establish new authorised positions, because of the increased costs that these would incur. A possible model for funding of the RGP scheme could be based on patient charges and reimbursement from the national insurance system. In addition, this would make it easier to steer practices in the desired direction with the aid of financial incentives. Moreover, there ought to be opportunities to try out a job as RGP without having to assume major financial responsibilities. Obviously, this can be done in a locum position, but there are also many young doctors who prefer a fixed-salary job at this stage of their career. The most important measure to support young RGPs would nevertheless be to provide specially adapted training positions under skilled supervision.

Hogne Sandvik
hogne.sandvik@isf.uib.no

Hogne Sandvik (born 1954), MD, PhD, specialist in general practice, RGP at Morvik Health Centre and researcher at the National Centre for Emergency Primary Health Care, Uni Research Health.
The author has completed the ICMJE form and declares no conflicts of interest.

References
1. Sandvik H. Evaluering av fastlegereformen 2001–2005. Sammenfatning og analyse av evalueringens delprosjekter. Oslo: Norges forskningsråd, 2006.
2. Fastlegestatistikk. Utviklingstrekk og endringer i fastlegeordningen. https://helsedirektoratet.no/statistikk-og-analyse/fastlegestatistikk (9.11. 2015).
3. Abelsen B, Gaski M, Brandstorp H. Varighet av fastlegeavtaler. Tidsskr Nor Legeforen 2015; 135: 2045–9.
4. Wennevold K. Arbeidsvilkår i allmennmedisin – modent for revisjon? http://legeforeningen.no/lokal/troms/Skalpellen/Arbeidsvilkar-i-allmennmedisin--modent-for-revisjon/ (9.11. 2015).
5. Nielsen A, Stølan J. Fastlegekongene skal miste pasienter. VG 16.2. 2009.
6. Godager G, Iversen T. Brukernes erfaringer med fastlegeordningen 2001–2012. Trender i bruk, tilgjengelighet og fornøydhet. HERO Skriftserie 2014: 2. Oslo: Helseøkonomisk forskningsnettverk, Universitetet i Oslo.
7. Sandvik H, Hunskår S, Diaz E. Fastlegepasienters bruk av legevakt. Tidsskr Nor Legeforen 2012; 132: 2272–6.
8. Utviklingsplan for fastlegeordningen 2015–2020. http://legeforeningen.no/yf/Allmennlegeforeningen/Nyheter/2014/Utvilingsplan-for-fastlegeordningen/ (9.11. 2015).