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EDITORIAL

Future primary care in Norway: valid goals without clear strategies

In 2015, the Norwegian Ministry of Health and Care Services published a White Paper on the future of primary care in the country [1]. A strategy for research for primary care is strikingly missing [2]. Nevertheless, the goals for Norwegian primary care are reasonably concrete: better coordinated services, more patient orientation, and more decentralized services close to where patients live to reduce costs.

The White Paper offers some clear signals: First, it suggests that primary care should be oriented towards multidisciplinary teams, so-called primary health teams. Second, we must assure higher competence among primary health care providers. Third, Norwegian primary care needs much stronger leadership than it has today. Although the measures to achieve the latter two points may be discussed, the need is indisputable. The first point implies a whole new way of organizing Norwegian general practice. Normally, that would be subject to a debate with the strength of a hurricane.

However, a huge debate has not followed. Why is this? One reason may be that Norwegian GPs do not feel that they have time for a public debate on the subject. If so, that is a pity. Another reason may be that the White Paper is so unclear on how to go about changing the current system that nobody knows where to start. That is a pity, too.

The vague direction for reorganization may originate from the fact that the Ministry has not paid enough attention to research and evaluation from other countries. Before Norwegian GPs start raising their voices to keep the current system, we too should take a close look at research from health care systems more prosperous than our own.

High quality of the health care system is a multifaceted phenomenon (3). When one aspect of quality is strong, other aspects may be weakened. For example, a high degree of continuity between patient and provider may be at stake when a system strongly favours accessibility (4). Additionally, Norway is a country with high diversity in terms of geography and size of local communities, and we need to discuss whether one size fits all. The perfect system simply does not exist, but that does not mean that we should not strive to achieve our goals by organizing wisely.

In Norway, GPs are mainly organized in small teams consisting of a few doctors and some health secretaries with 1–2 years of health education. Nurses have been rare in Norwegian general practice for the last 15–20 years due to high costs. Over the last decades, a desired transition from many single practices with only one doctor to bigger practices has taken place. Multidisciplinary practices with nurses, physiotherapists, pharmacists, and other complementary professions are still rare. This is in contrast to many other countries, such as the Netherlands, Great Britain and Canada. The robustness and quality of multidisciplinary teams have been highlighted by research [3–5], and Norway should pay close attention to the experiences from these countries – and probably start an orientation towards multidisciplinary teams.

How multidisciplinary teams should be recruited, co-located, and paid is not well described in the White Paper. Currently, fee for service combined with a capitation system dominates the income structure for GPs in Norway. Sensible financial incentives to support a transition to primary health teams are difficult to provide. Multidisciplinary approaches to better address the patients' varying and complex needs are a valid goal. However, if we end up offering the services of many independent professions without real team organization and co-location, further fragmentation of Norwegian primary care will be the result [5]. To avoid such a development, GPs must participate in the discussion. We should do so based on research to make evidence-based choices.

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Guri Rørtveit[a,b]
[a]National Editor, Scandinavian Journal of Primary Health Care, Research Leader, Research Unit for General Practice, Uni Research Health, Bergen, Norway; [b]Professor, Research Group for General Practice, Department of Global Public Health and Primary Care, University of Bergen, Norway
Guri.Rortveit@uib.no