Provision for the Elderly in Norway and Sweden
A report on the Health Committee’s visit to Norway and Sweden
March 2004
Membership of the Health & Public Services Committee

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**Proportionality:**

2 Conservatives, 2 Labour, 1 Liberal Democrat, 1 Green

**Terms of Reference**

1. To examine and report from time to time on -
   - the strategies, policies and actions of the Mayor and the Functional Bodies
   - matters of importance to Greater London as they relate to the promotion of health in London and the provision of services to the public (other than those falling within the remit of other committees of the Assembly) and the performance of utilities in London.

2. To liaise, as appropriate, with the London Health Commission when considering its scrutiny programme.

3. To consider health matters on request from another standing committee and report its opinion to that standing committee.

4. To take into account in its deliberations the cross cutting themes of: the achievement of sustainable development in the United Kingdom; and the promotion of opportunity.

5. To respond on behalf of the Assembly to consultations and similar processes when within its terms of reference.

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The UK community care reforms, introduced in the Spring of 2004, adopted the Swedish model of charging local authorities if they fail to ensure prompt discharge of elderly patients out of hospitals and back into their own homes or into care in residential or nursing homes. These are significant reforms with potential life changing consequences for some of our most vulnerable citizens. It is vital therefore that there is proper overview of how these changes are working.

My initial thoughts are necessarily impressionistic given the short nature of our inquiry, but I hope they will contribute to the emerging debate on this issue. In particular, in order to ensure high levels of care and protection for elderly patients:

- individual care plans should be fully integrated with primary care and the range of other care services (chiropody, domestic help) offered to elderly people need to ensure a full-joined up approach to their care;

- local authorities should look again at the extent of the provision of sheltered housing in their locality to ensure there is adequate supply available;

- the NHS needs to secure swift placement for discharged patients needing nursing care.

- primary care trusts should ensure adequate resourcing for community health services;

- new ways are needed to consult with and understand more clearly the wishes of elderly patients; and

- efforts should be expended to ensure that a strong relationship is maintained and developed at senior management and at working level between the NHS and local authorities, to ensure that financial incentives do not recreate a blame culture.

Some London boroughs have already begun to discuss with health-care providers how these reforms are affecting elderly patients, and we welcome their efforts. I hope that the new Health and Public Services Committee may find a place in its future work-programme to draw together information from across the boroughs to offer a view as to how this reform is impacting on London.

This short report also offers a brief review of the changes being introduced in Norway to improve both access to GP care and patient satisfaction with primary care services.
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1. INTRODUCTION

1.1 The London Assembly Health Committee’s short visit to Sweden\(^1\) and Norway in March 2004 focused on policy reforms designed to improve health care for elderly people. By developing a better understanding of these reforms in action and by discussing issues of concern with front line staff, we aimed to highlight key lessons learned for those involved in the delivery of health care services for elderly people in London.

2. CARING FOR ELDERLY PEOPLE

Reform in the UK…

2.1 The Community Care (Delayed Discharges) Act 2003 placed new duties upon the NHS and councils in England relating to communication between health and social care systems around the discharge of patients.

2.2 The Act also introduced a system of reimbursement from councils to hospital trusts for delayed hospital discharges. If a patient fails to be discharged because the council has not put in place services that allow for safe discharge then the council will pay the NHS a daily rate for the amount of time the patient remains in hospital (£120 in London). The legislation places a requirement on the NHS to notify councils of a proposed discharge date and the patient’s needs for community care services. This impacts particularly on elderly patients.

2.3 The system commenced in ‘shadow’ form in October 2003 and went ‘live’ from 5\(^{th}\) January 2004.

…based on policies adopted in Sweden

2.4 In 1992, Sweden\(^2\) introduced the Adele Elderly Care reforms to raise the quality of care for elderly people. Prior to the legislation, elderly people were mainly cared for in long-stay hospital wards or nursing homes owned and run by the 21 county councils.

2.5 The intention of the reform was to modernise care for elderly people by:

- providing good health care effectively integrated with social services;
- moving away from institution-based care with the abolition of long-term wards. Nursing homes and long term hospitals wards were closed or rebuilt to form supported housing for elderly people;
- the reform also enabled elderly people to have a say in their care with health care at home dependent on each individual’s condition.

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\(^1\) The Health Committee spoke to representatives from: Committee For Evaluation Of The Elderly Care Reform, National Board of Health and Welfare and the Swedish Confederation of County Councils and the Swedish Association of Local Authorities (SALASCCC) who have evaluated the reforms.

\(^2\) A background to Sweden and its political systems is set out in Appendix 1
2.6 The reform also includes a cross-charging element whereby the 21 county councils charge the 290 municipalities for people who are not found alternative accommodation within 5 days of being declared medically fit. Although cross-charging was not primarily introduced to deal with bed-blocking and late discharges, improvements in these areas have proved a welcome development.

2.7 The reforms in Sweden separated out health care responsibilities from social care responsibilities with municipalities taking over social care for elderly people. Funding for elderly care was transferred to the municipalities by means of a tax switch. Standards are set by individual municipalities, which spend approximately one third of their budget on care for the elderly. Municipal funds are mainly raised by local taxes.

2.8 Once out of hospital, elderly patients contribute to the cost of their care. Charges are divided into services, food and rent. The charges are capped and subsidies for parts of the charges are available, although these are means tested. All patients contribute to the cost of hospital stays, although not of medical procedures, at a nominal rate up to a fixed amount per year.

There are a number of positive effects from the introduction of the charging regime....

2.9 The cross-charging rules are designed to encourage those organisations involved in care for elderly people to find a long-term care solution as quickly as possible. Municipalities are charged if patients are not discharged within five days of being declared medically fit. Current levels are £144 per day for a bed in a specialist elderly ward and £202 per day for a bed in an acute ward. This does not fully reflect the cost of care, which is estimated at £227 for a specialist elderly ward and between £320-£710 per day in an acute ward.

2.10 After the introduction of these charges, the average length of stay for an in-patient fell from 7.5 days in 1990 to around 5 days in 2000, and total delayed discharges in acute care fell from 15% to 7% over the same time period. We were told by the Committee for the Evaluation of Elderly Care Reform that the fall in the number of elderly people staying in specialist elderly wards and bed blocking led to a 40% reduction in bed numbers, a 60% reduction in elderly bed numbers and even closure of some hospitals.

2.11 We were told about two further positive knock-on effects; namely that specialist housing for elderly people, publicly funded through the municipalities, increased considerably following the reforms and that local authority care providers employed more qualified nurses to provide primary care.

2.12 When there are no care spaces available, patients are placed in short term units funded by the municipalities. These short-term units are also used for respite care. Municipalities advocate an “aging in place (or in the home)” philosophy as it is preferred by elderly people and is cost efficient. The ideal is to keep people in their own home for as long as possible and then for them to move to sheltered housing if necessary (e.g. because of dementia). The good quality of

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3 The caps are €150 Euros for care services, €150 for food and €400 for rent.
4 Only 12% of people pay the full amount of rent.
housing in Sweden allows for effective care at home, particularly because disability aids are easy to fit. There are no significant waiting periods for adapting people’s home to allow them to return.

2.13 In the early years, the reform was criticised on the grounds that patients were being discharged from hospital before they were medically fit. Following lobbying from both local government associations, new regulations stipulated that doctors had to initiate and sign off elderly care plans before patients could be discharged. The care plan is signed by all agencies responsible for a patient’s care. It is designed to ensure that all agencies are in agreement and aware of their responsibilities for the different elements of the care package.

...but quality of service varies across locality

2.14 Discharge procedures differ between municipalities due to the amount and type of care facilities available. Though they are not bound to, in practice, patients take what is offered. The National Board told us that people tolerate the difference in service provision between municipalities and counties as local authorities have historical independence and the service is provided locally. However SALASCCC commented that pensioner organisations have identified large difference across the country in terms of fees and the fact that some counties can’t provide some medical services. The National Board also identified huge variances in fees between the municipalities, and resulting reforms in 2002 set a national ceiling on sheltered care fees.

A number of key concerns remain, including:

a lack of home care services; and

2.15 Budget cut-backs have reduced the level of home support services available to elderly people. The National Board reported that service levels have dropped over the last 10 years for both the proportion of people receiving care and the type of care offered. Some less dependent residents may not now receive support for both cleaning and delivery of meals. Although nursing and personal care have improved, those who get offered such care tend to be those who are seriously ill and who have multiple needs.

a lack of GP engagement

2.16 Following the reforms, nurses were employed by the municipalities but primary health care doctors remain employed by the counties because they are reluctant to be employed by the municipalities. This split in provision has caused difficulties in the provision of care for elderly people, with doctors not sufficiently engaged in making home visits or visiting nursing homes. Elderly care is therefore largely nurse led, with nurses having some prescription rights, while doctors act as consultants.

2.17 Each municipality has to appoint a Chief Community Nurse (CCN) who has responsibility for ensuring that safe care and correct treatment is given. The nurses will advise the municipalities on the impact of their decisions and on care plans. They do not have control over budgets, but have a remit to ensure quality of care.
The lack of capacity at primary care level …

2.18 The Committee for the Evaluation of Elderly Care Reform reported that primary healthcare doctors did not provide enough on call assistance to special housing facilities for elderly people, nor did they the elderly or provide home visits. This led to elderly people being unnecessarily treated in hospitals, which is worse for them and more expensive for county councils. The Committee therefore proposed that municipalities and county councils make yearly agreements on the extent and format of GP involvement. Under these agreements the county council must reimburse municipalities if the latter has to find alternative primary health care providers due to county councils employed GPs being unavailable.

2.19 The Board also commented that the shortage of doctors, both in primary care and in specialist elderly care, impacts on the care of elderly people, especially when there is need for rehabilitation work (in contrast to the abundance of hospital doctors). There is a marked shortage in rural areas, particularly in the north, leading to a reliance on locums/agencies in these areas. This variability in service coverage across the country seems to be increasing.

…led to an increase in emergency treatments

2.20 The Swedish Association of Local Authorities and Swedish Confederation of County Councils – SALASCCC - commented that the decrease in hospital beds following the reform (Sweden now has no long term elderly wards) may have placed too much burden on the municipalities too quickly. There has been a rise in the number of elderly patients unnecessarily treated in emergency facilities.

Responsibility for rehabilitation is confused

2.21 It has been left to county councils and municipalities to resolve who would be responsible for rehabilitation care and home nursing. About half of the municipalities have taken responsibility for this. The Committee for the Evaluation of Elderly Care Reform found that this sharing of responsibility causes tensions. The Committee recommended that municipalities take on responsibility for all aspects of home care apart from doctors’ services and that there needs to be greater doctor involvement in care for elderly people.

2.22 The reduction in bed numbers seems to have worsened rehabilitation services and from July 2003 municipalities and counties have been permitted to set up joint boards in order to make arrangements for the provision of rehabilitation centres, including their financing.

And the most vulnerable are losing out

2.23 The Committee for the Evaluation of Elderly Care Reform found that elderly people with multiple needs are treated by a number of care providers without any proper overview of the patient’s status. The unclear division of labour and responsibility between different care and administrative levels, and the lack of co-operation between them, can result in expensive care of limited or little benefit to the patient. The Committee proposed that municipalities and county councils be legally bound to co-operate in care provision for patients with multiple needs, including specialist and primary healthcare, social care and rehabilitation. Patients and their families should have the right to demand that
a joint municipal/county council care plan is set up when the need for multiple care provision arises.

NORWAY

Charging for delayed discharges has reduced hospital stays…

2.24 Norway has also introduced reforms to improve elderly care. The key values of the reforms were safety, dignity, respect and the right to choose.

2.25 The main objectives of the reform were:
- to promote independent living in one’s own home;
- to offer sufficient health services for the elderly population – both in hospitals and urban districts
- to facilitate discharge from hospital

2.26 A reform to reduce bed blocking, including the introduction of charges, was implemented in 1996. Arrangements were first introduced in Oslo and were then adopted nationally. When the charges were introduced the municipalities had fourteen days to find alternative accommodation before the charge was applied. This was reduced to seven days in 1997 as delayed discharges from hospitals were still resulting in overcrowding, in beds placed in corridors and long waiting lists for treatment.

2.27 From 1992 to 2002 the number of hospital beds for elderly people was reduced from 1841 to 1572. If the municipalities have not set up alternative care arrangements hospitals can discharge directly into short stay units. The municipalities fund these units, which have a maximum period of occupancy of three weeks. Grants were switched from hospitals to the urban district to reflect the cost of the change in responsibilities.

2.28 Further regulations were introduced in 1999 in order to clarify the roles and responsibilities between different tiers of government and hospitals and to set out a patient charter.

…but concerns about quality of care remain.

2.29 Hospital doctors initially determine discharge dates and any services needed after discharge. However, these decisions sometimes conflict with the view of the municipality and the doctor does not always have good awareness of local services. Doctors tended to over-prescribe care with little regard to the municipality who would be providing it. In a similar manner to Sweden it was decided that care plans need to be agreed by both the doctor and the municipality responsible for the person’s care after discharge. This also allows the patient to be clearer about what services they should receive.

2.30 Under the new system, the doctor reports to the district administrator in the municipality in advance of the discharge, in order to allow for coordination between the hospital and the municipality. To assist communication, there are named co-ordinators in each department of the hospital and each municipality. Under the terms of a service charter for patients, the municipality is obliged to
visit the patient within seven days and to plan post-discharge care. Nurses normally make the evaluation of the patient. The local medical officer is sent all discharge plans and will contact the hospital doctor where necessary. The plan should be a formal written agreement, but it is normally informal.

2.31 The medical services are working to prevent too early discharge and re-admission into emergency care. Pilot programmes are in place for hospital observation staff to visit nursing homes to enable the elderly to stay in the nursing home with a higher level of care. However it is felt that more hospital admissions would be prevented if there were improved working between home nursing services and GPs.

2.32 Responsibility for rehabilitation services remains split across different levels of government.

Our key findings from Norway and Sweden are that:

- Charging for delayed discharge, combined with other reforms, has resulted in shorter stays in hospitals for elderly patients
- This change has encouraged greater investment in development of sheltered housing; elderly patients prefer this to long term care in specialist elderly wards
- Provision of medical care at home has increased
- A decreased number of hospital beds has allowed financial savings for hospitals
- Both countries recognise the importance of individual care plans for ensuring the correct discharge and care for elderly people.
- Providing consistent high-quality rehabilitation services is a challenge particularly when responsibilities are divided between government tiers
- Greater engagement of GPs is needed to deliver quality primary care
- Shortages of GP and elderly specialists continue to hamper care levels for the elderly
3 PRIMARY HEALTH CARE

3.1 London faces a number of inter-linked challenges to provide high quality and timely access to primary health care for all its citizens:

- a shortage of GPs
- a large number of dilapidated practices
- a growing and often highly mobile and transient population
- increasingly complex case loads
- a great diversity of language and cultures

The Health Committee has investigated these issues in two major reports: Access to Primary Care (April 2003) and Recruitment and Retention of GPs in London (May 2003).

3.2 The challenge of improving access to, and the quality of, primary care in London will not be easily or quickly addressed. Recruitment of healthcare workers, improving physical access to GP surgeries or health care centres, the impending retirement of large numbers of London-based GPs and hospital doctors, and inequality in access to healthcare are all crucial issues for the London NHS and the Department of Health.

3.3 The Norwegian\(^5\) long-term strategy is designed to:

- devolve control of GP resources down to local levels,
- increase the number of GPs and
- computerise patient records

It allows scope for initiatives designed to improve doctor-patient relationships, to improve performance management of GPs, and to protect against the marginalisation of vulnerable groups in the health care system.

The Regular General Practitioner (RGP) Scheme

3.4 The patient list system introduced in Norway on 1\(^{st}\) June 2001 gives the right to every resident, including asylum seekers in hostels, to register with a permanent GP. Prior to the introduction of the scheme, Norwegian GPs did not have a list of patients, so patients made appointments on an ad hoc basis and in some cases would have had to ring round a number of surgeries in order to find and book an appointment.

3.5 The aims of the reform were primarily:

- to give easier access to GPs;
- to give continuity in the doctor-patient relationship

and for the health care system as a whole:

- to computerise GP records

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\(^5\) Appendix 2 sets out more detail on the medical arrangements in Oslo including details of our visit to a GP surgery
• to rationalise the country’s medical resources by improving the collaboration between primary and specialist health services; and
• to strengthen primary care with the GP acting as “gatekeeper” to reduce unnecessary use of higher levels of the health care system.

3.6 The first investigation into a regular GP scheme started in 1975 and pilot projects were carried out in four municipalities (borough/city councils) between 1993-6. Parliament agreed to the scheme in 1997.

3.7 The 430 municipalities\textsuperscript{6} took over control for primary health care from the counties in 1984, with the Central Government and the counties sharing the responsibility for the hospital system. Since 2001, the municipalities have a statutory duty to offer all residents the possibility of being registered with a regular GP or medical practice. In order to do so, the local authorities have to take out RGP contracts with general practitioners who undertake to give services to people on their lists.

3.8 Patients have the following rights under the scheme:

• To be registered with a regular GP
• To choose their own regular GP
• To be given priority by their own GP
• To change GP a maximum of twice per year
• To obtain a second opinion by a GP other than the patient’s own

3.9 The RPG scheme has had a number of intended outcomes:
• the formalised relationship means that GPs have the responsibility for planning and co-ordinating individualised preventative work, examination and treatment
• GPs are also responsible for a patient’s medical records, updating medical history and recording the use of medicines, and ensuring continuity of the patient’s medical history
• It should be easier for GPs to plan their practices in co-operation with colleagues and the local authorities.
• systematising the working relations between primary and secondary healthcare and making it easier for the authorities to manage and evaluate GP services.

A new locally set GP Contract

3.10 The GP contract is the key mechanism to manage the supply of doctors. Most Norwegian GPs are not salaried but have a contract to provide services, negotiated with the municipality. The contract sets the number of patients on a doctor’s list. A full time doctor must have more than 1,500 patients, but no more than 2,500, unless a special exception has been made. However, as many doctors choose to work only part-time within the public health system, the average number of patients per contract is 1,200 patients. The contract sets out terms and conditions, including pay, and seeks to ensure that other duties, such as public health provision, are undertaken. The contracts also stipulate a

\textsuperscript{6}At around 10,000 people, municipalities are the size of an average London ward
requirement for the provision of home visits, although some GPs are not yet providing this service.

**GP Numbers have been boosted**

3.11 The Committee heard that one of the major blocks to good primary health care was the lack of GPs, with doctors having to be imported, largely from other Scandinavian countries. In 1992, the Government instituted a programme to recruit more GPs. This was achieved by:

- increasing student numbers, the annual intake of students has risen from 310 (1992) to 600 (in 2000)
- increasing financial assistance for the 800 students who study abroad (mainly in Poland and Germany)
- support measures for GPs in rural areas – including the use of “Dr Nos”, locums from other Scandinavian countries
- centres of excellence to provide continued development of doctors, specialisation in aspects of GP medicine and peer support.

3.12 This resulted in an increase in the number of doctors being trained and Norway has started to export doctors. However, newly qualified doctors preferred to move into hospitals and areas of prestige medicine so the Government used controls on the distribution of practice licences to limit the number of doctors in hospitals. These measures have been successful, with the number of GPs steadily increasing.

3.13 When the Registered GP Scheme was implemented about 265,000 people were without a GP, with a particular shortage in the rural districts. However there has been a gradual reduction in the number of available RGP contracts without a medical practitioner from 349 in January 2001, to 297 at the implementation of the scheme, to 112 by the end of February 2004

3 There are some 3,800 available contracts

7 The latest data show that the number of people not assigned to a regular GP had fallen to 68,000. Doctors from Scandinavian countries, such as Denmark, travel as locums to northern fjord areas of Norway (known locally as Doctor Noes) with such regularity that residents in these areas have, in effect, have good contact with a doctor.

**Monitoring and Administration**

3.14 There is no formalised local monitoring of the quality of practices, although the Local Medical Officer does provide an informal monitoring system because municipalities are small enough to give regular personal contact between the officer and doctors. There is also a liaison body where representatives of local doctors have regular meetings with the municipalities.

3.15 The RGP Scheme is administered by the National Insurance Administration (NIA). The NIA has access to the Official Registers, which list all of Norway’s population and has an infrastructure of offices and information dissemination in every country. From November 2003, emergency rooms and hospitals have been able to use the internet to access details of a patient’s registered G.P.

8 The role of the National Insurance Administration is set out in more detail in Appendix 3
3.16 When the scheme was implemented in February 2002:
- 74% of the population applied to register with a particular GP and close to 90% of those applicants got their first choice of doctor
- 25% relied on the state allocating them to a list
- 0.5% of the population chose to remain unregistered
- 7.4% chose a RGP in another municipality than the one in which they lived.

3.17 A major role of the NIA is to deal with requests to change GPs and to ensure correct information for per capita payments. Between 30 000 and 45 000 inhabitants change GP each month. Over half of the changes are involuntary, caused by the RGP reducing the practice size or closing the practice. Voluntary changes of doctor initiated by the citizens themselves reduced after the introduction of the RGP scheme. From 2002 to 2003 the number of changes was reduced by 21 000 from 189 000 in 2002 to 168 000 in 2003.

Outcomes of the Scheme

3.18 There have been three main outcomes:
- The number of people without a regular GP has fallen
- Waiting times are down
- Doctors believe that they can do a better job with a regular list of patients

3.19 A waiting time of 2-3 weeks to see a doctor was common prior to the introduction of the scheme. This has improved, with more same-day or next day slots being available. Preliminary research has shown that waiting times are not dependent on the length of a doctor’s list; we were told by one commentator that it was due to the way a GP organises the practice.\(^9\)

3.20 A number of research projects studied the effects of the reform\(^10\). The key findings are that:
- the reform was generally welcomed by both patients and GPs
- patient satisfaction rose after the reform
- continuity of the patient-doctor relationship was important in determining satisfaction
- GPs believed that they could offer a better service with high levels of regular customers
- The majority of GPs were content with their list size
- The majority of patients surveyed were content with waiting times.

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\(^9\) Dr Bovim, Local Medical Officer for Oslo
\(^10\) The detailed findings of the research are summarised in Appendix 4
In conclusion

3.21 The Committee’s day visit to Oslo, Norway allowed it to discuss a series of initiatives introduced by the Norwegian government designed to meet many challenges similar to those we face in London. There are no easy, quick-fix lessons we can copy, particularly as the UK is moving away from a definite and personal relationship between patient and an individual doctor, to a more group approach, where primary health services are provided by the practice, and patients are treated by any doctor at that practice. Nonetheless, it is clear that Norway’s success in reducing GP shortages, by increasing training places for doctors and by ensuring that new doctors take work as GPs rather than in hospitals, has boosted patient access and satisfaction.
Appendix 1: Background to Sweden

Sweden has a population of approximately nine million people, just under 20% of whom are over 65 (the 7th highest proportion of elderly in the world) with an average life expectancy of 79 years.

Sweden has a reputation for an enviable standard of living under a mixed system of high-tech capitalism and extensive welfare benefits. However in the early 1990s the country experienced budgetary difficulties and high unemployment, which led to a scaling down of services provided by the different branches of government.

Government and Legislation

There is a three-tier system of Government, national, county councils and municipalities which was set up under the 1866 constitution. The 21 County Councils (Landsting) are responsible for healthcare and transport. The 290 municipalities (Kommune) have responsibility for social care and education, health and the environment. Planning is a mandatory function for the Municipalities so the high number of them in a small area sometimes means that it is hard to implement major projects such as transport systems. Municipalities also have housing companies, which own roughly a quarter of all dwellings.

Local self-government is reinforced by locally collected taxes. An average tax rate of 30% tax raises 82% of the tax revenue. Higher earners then pay additional income tax to central government. There is also a controversial system of equalisation between county councils, decided at national level.

The central government cannot impose new responsibilities on local authorities unless they can be financed without raising taxes locally. On the other hand, if Government policy enables municipalities to provide a service more cheaply, the Government reduces their grant to a corresponding extent.

The national government passes framework legislation, such as the Health Care and Social Services Acts, which is then interpreted by the local authorities. The legislation does not give individuals any rights or impose any obligations on local government. For example, each county council has to provide good healthcare for its citizens, but it is up to the individual council to interpret what good health care is and what is offered. Postcode prescription is therefore common.
Appendix 2 Medical Arrangements in Oslo

The Committee was given a case study of medical arrangements in Oslo. Oslo City Council is a unitary authority (with responsibilities of both the municipalities and the counties) and has a population of half a million people. Recent reforms mean that Oslo has less autonomy, as hospitals are now run centrally (across the boundaries of municipalities).

The City Council, which is directly elected, appoints a government of ‘commissioners’ who are the political leaders of the various departments within the Council. The Council also appoints 15 district council administrations with four being directly elected. The District Councils have a budget from the City which they decide how to spend. There can be friction between the city and the district councils due to the different responsibilities for social services, primary health care, nurses and schools. The population size of the urban districts varies between 26 – 45 000.

Oslo has marked social differences based on geographical locations, with the east of the City being poorer. For example, life expectancy for men varies by ten years between west and east Oslo. In some GP practices up to 24% of patients are from BME background. The municipality pays for professional translators, but the practicalities of finding a translator can create delays. Before the introduction of the Regular GP system a proposal to pay GPs according to the deprivation of their area (based on the Jarman index) was considered. This would have given GPs in the poorest area double the salary of other GPs.

Oslo has one hospital for treating acute illness, accidents and injuries with GPs on call. The municipality has also opened its own emergency department which is open all day and has three satellite late night/weekend drop-in centers which are open between 4pm–11pm. These centers give services similar to those provided by a GP or NHS Walk-in Centres. The main department has a nurse-staffed telephone advice line. The nurse will advise a patient whether to go to the centre or whether one of the three car-based doctors would make an acute visit. There are also plans to establish a telephone contact centre akin to NHS Direct. The municipality financed the centre by renegotiating its contract with the hospitals but it has led to GPs decreasing the number of home visits, as they claim that patients can use the emergency centre.

Dr Finn Bovim, the local medical officer in Oslo who provides public health services, believes that the advantages of new GP contracts were:

- Better health services to elderly and disadvantaged groups
- Better cooperation
- Better overview of patients’ health including hospital contact
- Patients seem to be creating more demands
- Doctors have more responsibilities although doctors are divided as to whether this is an additional burden or makes their work more interesting

Visit to a GPs Surgery with Dr Finn Bovim, Local Medical Officer:

The clinic is in a deprived area of the City. It is located in a rented building which also provides other services including an ante-natal clinic. The doctors’ lists remain separate but have joint payment of facilities and additional staff (medical secretaries) and offer
cooperative working. Eighty per cent of the per capita payments and 20% of activity based payments go to run the clinic.

The practice has an on-site lab, with blood samples for more complicated tests being sent daily to the hospital with results sent back that afternoon via e-mail. However hospital appointments cannot be booked by e-mail – it is still done by a referral letter from the GP. Ninety percent of the GPs are online. The surgery was built by Oslo City Council when doctors were directly employed and provided services not covered by private GPs – such as social medicine.

GPs usually don’t have nurses, instead they have Medical Secretaries who have some medical training and act as receptionist and carry out minor procedures such as blood tests. Municipalities manage nurses, particularly those delivering nursing care, which means that nursing and GP care are divided at municipal level.

Receptionists have 18 months training both in receptionist’s skills and simple medical procedures such as taking blood samples and blood pressure.

The waiting list for appointments varies from a week to three weeks. There is a lot of variance in Oslo with one centre with a four-week list. Dr Bovim as the local medical officer does not have the power to persuade centres to reduce their waiting times. Most GPs in Oslo do have vacancies on their list.

He does not have power but does monitor and report to the City politicians. Oslo’s new contract did have to follow the contract negotiated nationally, but Dr Bovim believed the national contract was as good as that which could have been negotiated locally.
Appendix 3 National Insurance Administration (NIA)

The Regular General Practitioner (RGP) Scheme is administered by the National Insurance Administration (NIA) as it has access to the Official Register, which lists all of Norway’s population with their current address, and has an infrastructure of offices and information dissemination in all the municipalities. People have to inform the registrar if they change their address. The usually accurate data from the national register enables the number of phantom patients to be reduced. However there is a problem in keeping track of asylum seekers as they move more frequently and are less likely to be accurately registered.

Nineteen local RGP offices were set up in each county and the work of the NIA covers three key issues:

1) To update the information about the RGPs in the IT System including: contract information, information about each contract such as maximum list size and specialisms; and information about each new contract and which contracts are ending.

2) To update information about each GP’s list, including changes due to requests to change RGP. In the first months after the reform about 45,000 changes were made per month, this figure has now stabilised at approximately 30,000 a month. Requests are mainly made via a dedicated phone number, but the public can also e-mail, write or make a personal visit. The request can be made to any NIA Office, which will refer it to the local RGP office. In practice there is no waiting time to transfer to another RGP and if the doctor’s list is open the change is undertaken immediately. The new RGP/patient “relationship” is valid from the first day of the following month. The local RGP offices do not run waiting lists for practices, instead if a list is full the patient will need to reapply the following month.

3) The NIA calculates the monthly per capita payments. The reports are generated by the IT system and distributed to the municipalities which are responsible for the payment of the fees.

All RGPs receive a monthly report about their lists. This information is on paper or CD Rom and the NIA is investigating a way to send the lists electronically. Each time a person is registered to a RGP the doctor and patient receive a confirmation letter. The RGP will also be contacted whenever their list closes or opens.

Updated information about the scheme, including a list of registered GPs by municipality and the status of their lists is published on the NIA’s website. Although downloadable forms are available on the site, it is not possible to change RGP on line although this is being investigated.

A quarterly report is compiled which shows for each municipality: the number of registered GPs; the total capacity for maximum list sizes, the number of patients registered; the number of open lists, vacancies on open lists and details about specialisms. Information about the sex and age of patients is also provided. Some information is also made public.
Appendix 4 Research into Norway’s Regular GP Scheme

1) Lian 2003: Patient Experiences of the General Medical Services before and after the Introduction of the Regular General Practitioner Scheme, Institute of Social Medicine, University of Tromsø

The main objective of the study was to compare patient satisfaction with GPs before and after the introduction of the scheme. The study was based on a postal survey sent to a random sample of inhabitants in Northern and Eastern Norway. A total of 1,133 questionnaires from 2000 and 1,141 from 2003 were included in the analysis (58 % of the sample).

In 2003 a majority of the respondents answered that they had not experienced any changes in the primary medical services. Among the ones who had experienced changes, a majority assessed the services as having been better than before.

From 2000 to 2003 there was a significant increase in the proportion of respondents who answered that they were confident to get help if needed (46% to 55%). The overall proportion of people who were very satisfied with their general medical services increased from 32 to 44%. The proportion of people who felt well trusted and respected by their GP rose by 4% to 54%.

The majority of the respondents were very satisfied with the physician’s language qualifications or communication although there was a fall in the people who were happy with the distance to their doctor’s practice (65% in 2000 and 55% in 2003).

Respondents were increasingly very satisfied with most aspects of the doctor-patient relationship but only some aspects of accessibility. More patients felt trusted and respected by their GP; this was measured by achieving eye contact with the doctor, receiving necessary information, being listened to by the doctor, consulted concerning possible treatment and they felt that the doctor took into consideration what was important to them. More patients were very satisfied with the waiting time for getting an appointment, waiting time at the doctor’s practice and the consultation time.

Satisfaction levels for the accessibility of GPs based on the availability of phone consultations, language qualifications or communication and the distance to the doctor’s practice fell from 22% to 16%. Responses did vary depending on the size of the municipality in which the respondents lived. In 2000, the inhabitants in municipalities with less than 5000 inhabitants were more satisfied with the general medical services, particularly in regard to patient accessibility than inhabitants in larger municipalities. A minority reported the long waiting time for an appointment and too little time per consultation. However, the 2003 survey showed a lower rate of satisfaction in small municipalities particularly the indicators on accessibility.

In 2000, 25% of respondents had consulted a doctor whom they’d never seen before, a figure which had fallen to 15% in 2003. In 2000, 62 per cent of the respondents considered the doctor they most recently consulted as their regular doctor while in 2003 this amount increased to 80 per cent.

The authors concluded that there are clear connections between the rates of satisfaction and structural factors such as stability in the medical services and size of
municipality. Aspects of the doctor-patient relationship such as continuity and equity in educational levels seem to have an influence on patient satisfaction.


Data were collected by means of two national questionnaires in 2000 and 2003 which were sent to a random sample of 43,784 inhabitants in 2000 and 36,426 in 2003 with a response rate of 43.6 % and 41% respectively. The survey measured satisfaction with access and satisfaction with the physician and the actual treatment. The results were very much the same as in the Lian study and were mainly positive:

The study showed that the level of satisfaction with the general medical services had been high before the reform was introduced. This was particularly the case with regard to the satisfaction with the doctor and the actual treatment. There was a small positive change in these indicators from 2000 to 2003. There was a larger positive change in the indicators for satisfaction with access to the services, which had the lowest scores before the reform.

The main finding was that the population seem to be more satisfied with the current physician-to-population ratio in the district and the shorter waiting time for an appointment.

There were no changes with regard to the emergency services. Respondents in large and medium-sized municipalities reported the highest increase in satisfaction with access.

The proportion of people who had used more than one GP during the last year decreased from 38 % in 2000 to 29% in 2003.

3) Grytten, Skau, Sørensen and Aasland: General Practitioners Work Situation One Year After The Introduction Of The Regular GP Scheme In Norway (Journal of the Norwegian Medical Association 3/2004)

An extensive questionnaire survey among Regular GPs was carried out during the autumn of 2002. A total of 2,306 RGPs returned the questionnaire (70 % response rate). The study looked at their degree of satisfaction with the recently introduced list system.

The study suggests that there are enough regular GPs in Norway and that most are satisfied with the new system. About 60 % of RGPs were satisfied with their list size, about 21 % said that they would have preferred longer lists and about 19% would have preferred to have fewer patients on their lists.

About half of the regular GPs felt that they have enough time for each patient, while about one third would have liked to have some more time. Doctors were able to fit emergency cases into their daily schedule, although this varied with list size. About 50% believed that the scheme had not given them a better insight into their patients’ medical needs or better treatment options. However, most GPs believe that they can do a better job when the practice has a high proportion of regular patients.
4) Carlsen/Norheim, Rokkansenteret: The medical practitioner’s role as gatekeeper in the Regular General Practitioner Scheme.

The study investigated how GPs assess the reform’s influence on their discretionary decisions as gatekeepers. The investigation was carried out in Oslo and Hordaland, a western county. The mainly qualitative study gathered data during the spring of 2002 via 11 structured focus group interviews with 81 GPs, supplemented by questionnaires.

The study showed that about 73 % (59) of the regular GPs were satisfied with the scheme and there was a special emphasis on the clearer division of responsibility between the physicians. Other positive aspects identified were the better control with the treatment and medical follow-up of patients, and extended responsibility for their own patients as part of a list population.