Til Strukturkommissionen. Også udgivet som kronik i JP dags dato. Vedhæftet 3 fakta-ark med rådata.

Når man sammenligner udbyttet af praktiserende læger i de tre nordiske lande, viser det sig, at systemer, hvor de praktiserende læger selv driver klinikker, er de mest velfungerende.
Hvordan skal fremtidens danske sundhedsvæsen se ud? For øjeblikket arbejder Sundhedsstrukturkommissionen med dette spørgsmål, for der er en række udfordringer for vores sundhedsvæsen, som skal løses. Alle bolde er i luften, også almen praksis, og måske er der store forandringer i vente.
Har vi brug for inspiration, kan vi blot kigge på de skandinaviske lande. På mange måder er vi ens, både politisk og økonomisk, men almen praksis er organiseret forbløffende forskelligt i de tre lande.
Kan vi lære noget af vores skandinaviske kolleger?
I Danmark er 96 pct. af lægerne selvstændige erhvervsdrivende, der selv deltager i patientarbejdet eller er ansat i sådan en klinik, ca.
1 pct. regionsdrevne, og ca. 3 pct.
drives af koncerner, der ejes af (udenlandske) kapitalfonde. Disse tilsammen 4 pct. har typisk vikarer ansat af kort eller længere varighed, hvorved antallet af borgere uden fast læge i dag er ca. 250.000.
De 96 pct. selvstændige lægeklinikker er fra en til otte læger, men typisk to-tre. Der er i snit 1.650 patienter pr. læge, som gennemsnitlig har 1,3 praksispersonale til hjælp.
Pris i 2022: 10,5 mia. kr. - svarende til omkring 5 pct. af sundhedsbudgettet.
Herudover ingen egenbetaling. Den danske befolkning er på 5,9 mio. mennesker, dvs. almen praksis koster det offentlige ca. 237 euro pr. indbygger.

I Norge har kommunerne forpligtigelsen til at sørge for den almene medicinske lægehjælp (allmennlegetjenester).
Ca. 80 pct. af lægerne (fastlegen) er selvstændige, mens 20 pct. er ansatte, hvor det sidste tal er stigende. De selvstændige har gennemsnitlig 0,8 praksispersonale, mens de kommunalt ansatte har 1,2 personaler. Den gennemsnitlige patientliste for de norske fastleger er på omkring 987.
Der er en tendens til, at ansatte læger har en kortere liste, og det indikerer, at almen praksis, hvor lægen er selvstændig, bliver drevet mere effektivt end de steder, hvor lægehusene (legekontorerne) er kommunalt drevne. Patienterne er altid tilmeldt en navngiven læge, hvorved kontinuiteten bliver høj.
Herudover er alle kontraktligt forpligtet til at levere en dag om ugen til forskellige kommunale opgaver, hvis kommunen ønsker det.

Ca. 216.000 nordmænd har ikke en fast læge, men i stedet adgang til en vikar. Pris: 17 mia. norske kroner, svarende til ca. 6 pct. af sundhedsbudgettet. Dertil en vis egenbetaling. Den norske befolkning er på godt 5,4 mio. mennesker,
dvs. almen praksis koster det offentlige ca. 266 euro pr. indbygger.

I Sverige er under 5 pct. selvstændige praksislæger (privatpraktiserande läkare). Hovedparten, nemlig 65 pct., er regionalt ansatte.
Resten, omkring 30 pct., er ansat i koncerner (vårdføretag), der kan være ejet af udenlandske kapitalfonde.
75 pct. af lægerne har deres egen patientliste, men pga. stor lægemangel er det kun omkring 25-30 pct., der har en fast egen læge. Listelængden er gennemsnitlig på 2.200 patienter. Patienterne kan frit vælge at konsultere andre lægeklinikker (vårdcentraler) end deres egen. Udgiften til almen praksis i Sverige er 36,5 mia. svenske kroner, svarende til 20 pct. af sundhedsbudgettet, men dette tal rummer også visse dele af rehabiliteringsindsatsen uden for sygehus.
Den svenske befolkning er på ca.
10,5 mio. mennesker, dvs. almen praksis koster det offentlige ca. 303 euro pr. indbygger.

Den norske model for almen praksis (fastlegeordning) sikrer alle borgere opfølgning af en fast læge, og når det fungerer, er det den bedste måde at organisere almen lægetjeneste til en befolkning på. Vi ved, at kontinuitet i læge-patientforholdet reducerer antallet af henvisninger til speciallægehjælp, mindsker behovet for lægevagt, og det reducerer også den relative risiko for at dø. De faste læger håndterer 90 pct. af alle henvendelser selv uden behov for viderehenvisning.
Der er meget ansvar for en læge, og hvilke opgaver der gives til lægen, har ingen regulering. Vi savner en overordnet organisering, der kan varetage lægens interesser og prioriteringer.
Rådet fra de norske praktiserende læger til Danmark er at sikre læge-patientkontinuitet og bevare en kapacitet, så alle opgaver, der kan løses inden for almenmedicin, varetages af en læge, der kender patienten. Bæredygtigheden i en offentlig sundhedstjeneste i velfærdsstaten afhænger af en organisering med almenlægen som gatekeeper for at sikre alle borgere lige adgang til nødvendige sundhedstjenester og bedst mulig sundhed.
Helprivate aktører, der sælger sundhed som en vare, bør ikke kunne bruge de offentlige sundhedskroner og må reguleres.

Sverige har en mindre grad af læge-patientkontinuitet end de andre skandinaviske lande og en stor lægemangel trods meget personale og lange patientlister. Lægen er

typisk ansat offentligt eller i koncerner, og der er stor, løbende udskiftning mange steder. Begge dele bidrager til ringe kontinuitet, og lægen har dermed ikke noget stærkt personligt ansvar for behandlingen.
Da ansvaret ikke er entydigt placeret, betyder det, at man skubber problemerne videre til andre, og patienterne ikke ved, hvor de skal henvende sig, hvis de har brug for en læge. Som en reaktion på de manglende læger er der indført "netläker" (online-læger) samt specialiserede sygeplejersker inden for f. eks. kol eller diabetes, hvilket giver en fragmenteret omsorg.
En anden udfordring er, at store koncerner "vårdføretag" etablerer sig på området, hvorved nærhed til patienten går tabt.
De svenske myndigheder (Socialstyrelsen på vegne af regeringen) er efter et grundigt analysearbejde kommet frem til, at en patientliste på 1.100 er passende - det giver et konkret politisk mål at arbejde efter.
D et vigtigste råd fra Sverige baseret på vores nationale erfaringer må være, at hvis Danmark skal omstrukturere almen praksis, så skal I ikke give køb på principperne om egen læge, og at lægen er selvstændig. Denne model er med til at fastholde det personlige ansvar for patienterne. Fra svensk side misunder vi Danmark for, at I har et sådant system og en tradition for det.

Selv om vi i Skandinavien på mange måder har sammenlignelige samfundssystemer, så har vi alligevel valgt forskellige modeller for, hvordan vi organiserer det nære sundhedsvæsen - altså almen praksis. Anbefalinger til Danmark fra vores svenske og norske kolleger er i hvert fald, at vi skal holde fast i, at lægen er selvstændig, og at det er den praktiserende læge, der er gatekeeperen på sundhedsområdet.
På den måde kan vi også sikre, at læge-patientkontinuiteten opretholdes, da den har en stor betydning for patienternes helbred.

Erfaringerne fra Norge og Sverige er, at de steder, hvor almen praksis er ejet af lægerne selv, der bliver de drevet mere effektivt end der, hvor det offentlige driver klinikken.
I Norge har en læge typisk knap 1.000 listepatienter, og i Sverige er anbefalingen omkring 1.100 patienter - i Danmark er tallet i dag 1.650. I Danmark er det politisk besluttet, vi skal have 5.000 praktiserende læger i 2035, hvorved vi vil opnå en gennemsnitlig liste på 1.180. Der er dog ikke nogen samlet plan eller finansiering på plads endnu. Antallet af hoveduddannelsesstillinger til specialet er øget til 350 pr. år, men beregninger fra PLO/ DSAM viser, at hvis målet skal nås, behøver vi 400 pladser. Især fordi en pæn brøkdel af speciallægerne i almen medicin

ikke går ud i almen praksis, men bliver ansat i sygehusfunktioner, der også behøver disse dygtige generalister med helhedssyn.

Bæredygtigheden i en offentlig sundhedstjeneste i velfærdsstaten afhænger af en organisering med almenlægen som gatekeeper for at sikre alle borgere lige adgang til nødvendige sundhedstjenester og bedst mulig sundhed.

GETTING A BASIC UNDERSTANDING OF HOW GENERAL PRACTICE IS BUILD UP.
In the 5 Nordic countries, the most GPs are publicly funded. Beside that, we have an uprising activity from insurance based GP services, which is an add-on for some patients.
These questions relates only to the publicly funded GP sector.

1) How is the ownership of the GP medical clinicians:
- Self-employed (including doctors working for a self-employed GP) <5%
- Employed by municipality/region/state >70%
- Other possibilities like employed by chain groups/capital funds 20-30%, more in the cities and less in the rural areas
- If there is a mixture of different types, what is the most common system. Maybe you can give an estimation of the fraction of each, ie how many doctors are employed in each way

2) Continuity of care
- Do you have patient lists? App 75% of all doctors have their own list
- And is it for each Doctor or for the whole medical clinic? All patients are listed in a clinic, mostly based on geographic area, but also free of choice. There is a great lack of GPs so approximately 50% of patients do not have their own doctor (but can sometimes see a locum instead)
- How many doctors are typically working in each medical clinic? Average and range: 1-4 doctors in rural areas, 15-25 doctors in big cities. Average 6-10 doctors.
- If you do not have lists, is there another way how the patient will know which clinic he should attend? Even with lists, patients can seek healthcare wherever they want, online or other healthcare centers.
- If you do not have lists, how many patients will there be on average pr. GP on a national base. Lists are on average 2200 patients, ranging from 1250-4000.

3) Staff
- How much staff do you have pr. GP on average, including both clinic staff like nurses and secretary staff. For every doctor, there are 1-2 nurses (including midwifes and child healthcare nurses); 0,3 physioterapists (in many health centers); 0,3 psychologists or counselor; 0,15 occupational therapists (not at every health center, many health centers, many health centers don't have, especially the smaller ones, depends also on the region); 0,5 assistant nurse and 0,5 medical secretary.
- Who decides the number and types of staff at the clinic, and who hires? GP or others. For public owned clinics, it is the regional management that decides based on the assignment that primary care receives from politicians which competencies are needed. In private clinics, the head of the health center has the opportunity to decide for himself.
  All clinics are dependent on the compensation that they receive from the region.

- Who makes the work instructions for the staff? GP or others. In Sweden, the staff have no specific work instructions. The primary care/clinics are assigned tasks that are described in "cookbooks" (both political tasks and from health care system managers),

that can change every year and the payment for what we do. More medical decisions are made out of recommendations, guidelines and such.

4) Work assignments

- Are GPs obliged to work in the out-of-office hours/emergency? (how much) Yes, with a few exceptions (Stockholm). On call during night for elderly care patients, death certificates and certificates for mental treatment without consent (tvångsvård). Also every middle-large sized city has a urgent after hour care, usually in between 18.00-22.00. Usually all doctors take part once or twice a month and get extra payments.

- Are GPs obliged to work on other locations than their clinic, like eg nursing homes, schools, municipality offices, workplaces? (where, how much) Nursing homes are part of the medical centers, all the patients are listed and medical rounds are done regularly. Child healthcare/public health nurses are a part of medical centers and patients are listed and GP attend on regular basis. Schools hires their own doctors but mostly GPs doing it part time.
- Are GPs taking care of prophylactic care of little children and pregnant women? Antenatal care is done mostly by midwifes in the medical centers, GP visits when the medical expertise is needed. Child healthcare/public health nurses are a part of medical centers and patients are listed and GP attend on regular basis.
- Are GPs gatekeepers for (most of) the secondary sector, or can patients walk directly into an emergency department Patients can walk into the ER but will mostly (and in daytime) need a referral unless arriving in an ambulance.
- Are GPs gatekeepers for (most of) the primary sector, or can patients walk directly into a clinic for another specialty like e.g. a cardiologist? GPs are gatekeepers, referrals are required.
-

5) How much is the yearly budget for the publicly financed general practice? In general, primary healthcare take 20% of the total budget for healthcare. It differs a lot from region to region and depends on how primary care is defined. It is not always the GP clinics, it can also be something else, for example rehabilitation.

6) Continuing education (ie courses after getting your specialty)

- How is it funded? Annual amount and who pays. Differs a lot but in general GPs can have internal education 4 hours a month, external education 5 days a year, paid by the employer.
- Who decides the content? Internal education usually organized by a GP with special interest or primary care pharmacists or the employer. External education is up to the GP to decide, choose and plan. Employers pay, it is part of the budget, there is nothing linked specifically to individual doctors.

7) Quality work

- How is it funded? Annual amount and who pays
- Who decides the content?

Quality work is done on each clinic, and is included in regular compensation, nothing extra. It is seen as a natural part of regular work.

8) Research
- How is it funded? Annual amount and who pays
- Who decides the content?
- Researcher apply for money from government and funds. Everyone needs to fund their own work but can also decide the content. If content is odd, it might be harder to find funders.

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GETTING A BASIC UNDERSTANDING OF HOW GENERAL PRACTICE IS BUILD UP.
In the 5 Nordic countries, the most GPs are publicly funded. Beside that, we have an uprising activity from insurance based GP services, which is an add-on for some patients.
These questions relates only to the publicly funded GP sector.

Denmark:

1) How is the ownership of the GP medical clinicians:
- Self-employed (including doctors working for a self-employed GP): 98 % (95 %). 3 %-point are owned by doctors who partners with (/acts as a "straw man"/"nominee" for) a capital fund/chain
- Employed by region: 1 %
- Other possibilities like employed by chain groups/capital funds – 1 % officially owned by capital funds/chain groups. But there is also 3 %-points more as described above

2) Continuity of care
- Do you have patient lists? Yes
- And is it for each Doctor or for the whole medical clinic? For the whole medical clinic
- How many doctors are typically working in each medical clinic? Average and range Average: 2,2 GPs – range from 1 to 8. (in average there is around 1.650 patients pr GP's in clinic).
- If you do not have lists, is there an other way how the patient will know which clinic he should attend?
- If you do not have lists, how many patients will there be on average pr. GP on a national base

3) Staff
- How much staff do you have pr. GP on average, including both clinic staff like nurses and secretary staff – 1,3 employees pr GP. (Personnel has been on the rise the last 5-7 years around the same time as General practice took over the treatment responsibility of a large number of patients with a chronic disease from the hospitals in 2018.
- Who decides the number and types of staff at the clinic, and who hires? GP or others, if selv-employed: the GPs themselves
- Who makes the work instructions for the staff? GP or others, the GPs

4) Work assignments
- Are GPs obliged to work in the out-of-office hours/emergency? (how much) From 1. January 2024 GP's in parts of Denmark (3/5 regions, Region Nordjylland, Region Midtjylland og Region Syd)) are obliged to work in the out-of-office hours from 16-23 and in weekends until 23 (today they also have the obligation at night). In the two other regions there are no obligations.
- Are GPs obliged to work on other locations than their clinic, like eg nursing homes, schools, municipality offices, workplaces? (where, how much) No

- Are GPs taking care of prophylactic care of little children and pregnant women? Yes

- Are GPs gatekeepers for (most of) the secondary sector, or can patients walk directly into an emergency department We are gate keepers for the secondary sector
- Are GPs gatekeepers for (most of) the primary sector, or can patients walk directly into a clinic for another specialty like e.g. a cardiologist? We are gate keepers for (most of) the primary sector

5) How much is the yearly budget for the publicly financed general practice?
Approximately 10,5 billion DKK. approximately 8,4 % of the publicly funded health care cost. Direct health care costs include primary and secondary health care sector (Hospitals, GP's, practice sector in general including physiotherapists, psychologist and more) financed by the regions. They do not include residential long-term care and rehabilitation, cost held by the municipalities.

6) Continuing education (ie courses after getting your specialty)
- How is it funded? Annual amount and who pays Around 120 mio. DKK payed by a fund financed through the agreement between PLO and Danish Regions (Thereby in practice payed by the Danish Regions/public funded)
- Who decides the content?
A fund who is made by the two agreeing parties (PLO and Danish Regions) – "Fonden for Almen Praksis".

7) Quality work
- How is it funded? Annual amount and who pays Around 60 mio. DKK. Payed by the Danish Regions/publicly funded
- Who decides the content?
Fonden for Almen praksis / GP's themselves. There is an organizational setup established between the two parties: KiAP (Quality in General Practice)

8) Research
- How is it funded? Annual amount and who pays Around 60 mio. DKK. Payed by the Danish Regions/publicly funded
- Who decides the content? A large part of the money finance established Research units for General Practice which are linked to the universities in Denmark. The units have a relatively high degree of autonomy to conduct extensive research within the general practice field. Moreover "Fonden for Almen Praksis", have a research pool (around 2 mio. Dkk) that can be applied for.

GETTING A BASIC UNDERSTANDING OF HOW GENERAL PRACTICE IS BUILD UP.
In the 5 Nordic countries, the most GPs are publicly funded. Beside that, we have an uprising activity from insurance based GP services, which is an add-on for some patients.
These questions relates only to the publicly funded GP sector.

NORWAY:

1) How is the ownership of the GP medical clinicians:
- Self-employed (including doctors working for a self-employed GP)- approximately 80% of the regular GPs
- Employed by municipality~~/region/state~~ – 20% and growing
- Other possibilities like employed by chain groups/capital funds – not allowed but we have a alternative among those who are self-employed: we call it a "8.2 avtale". The GP is self-employed, but the municipality owns and runs the office. The nurses and other staff are employed by the municipality. We do not know ecavtly how many GPs have this agreement, but maybe 20% - also growing a lot
- If there is a mixture of different types, what is the most common system. Maybe you can give an estimation of the fraction of each, ie how many doctors are employed in each way -have done

2) Continuity of care
- Do you have patient lists? Yes – average 1000 patients per list. Those who are not sels-employed have shorter lists (maybe average 600-700 inhab)
- And is it for each Doctor or for the whole medical clinic? For each doctor
- How many doctors are typically working in each medical clinic? Average and range 5 GPs – range from 1 to 16/17
- If you do not have lists, is there an other way how the patient will know which clinic he should attend?
- If you do not have lists, how many patients will there be on average pr. GP on a national base

3) Staff
- How much staff do you have pr. GP on average, including both clinic staff like nurses and secretary staff – approximately 0,8 pr GP, the municipality offices have higher: 1 or 1,2
- Who decides the number and types of staff at the clinic, and who hires? GP or others, if selv-employed: the GPs, if municipality: the municipality (often with cooperation with the GPs)
- Who makes the work instructions for the staff? GP or others, the GPs

4) Work assignments
- Are GPs obliged to work in the out-of-office hours/emergency? (how much) yes, all GPs have an obligation in their contract to participate in emergency care but how much varies a lot. Some of the GPs in laarger towns do not have any out of hours, some GPs in small municipalityes have out of hours work every second or third day all year around. We have an aggrement that it should not be more than every 4 th day, preferably every

6 th day. This means a lot of duty, but of course not always a lot of work if it is a small place with less than 1000 inhabitants. A lot to be said about this, needs a lot more of explanation.

- https://lovdata.no/dokument/SF/forskrift/2012-08-29-842/KAPITTEL_5#§30

> § 13. *Fastlegens plikt til deltakelse i legevakt*
>
> Fastlegen plikter å delta i:
> a. Kommunal eller interkommunal legevakt utenfor ordinær åpningstid.
> b. Kommunens organiserte øyeblikkelig hjelp-tjeneste i kontortid, herunder tilgjeng ivaretakelse av utrykningsplikten.
>
> Deltakelse i kommunal legevakt eller interkommunal legevakt utenfor ordinær åpningstid kommer i tillegg til andre allmennlegeoppgaver kommunen kan pålegge fastlegen å utføre, jf. § 12.
>
> Kommunen kan frita fastlegen fra plikt til legevaktdeltakelse etter første ledd bokstav a, når legen av helsemessige eller vektige sosiale grunner ber om det. I denne vurderingen tas det særlig hensyn til lege over 55 år.
>
> Fastlegen har rett til fritak til legevaktdeltakelse etter første ledd bokstav a når legen:
> a. er over 60 år
> b. er gravid i de tre siste måneder av svangerskapet eller når graviditeten er til hinde
> c. ammer barn som er under ett år.
>
> Fastleger som har hatt rett til fritak fra deltakelse i legevakt i henhold til tidligere angitte aldersgrense i fjerde ledd bokstav a, har rett til fortsatt fritak frem til 1. januar 2014.

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- Are GPs obliged to work on other locations than their clinic, like eg nursing homes, schools, municipality offices, workplaces? (where, how much) yes – 7,5 hours a week – but this also varies from 0 to more

> § 12. *Fastlegens deltakelse i andre allmennlegeoppgaver i kommunen*
>
> Fastlege i fulltidspraksis kan pålegges å delta inntil 7,5 timer per uke i andre allmennlegeoppgaver i kommunen, for eksempel i helsestasjons- og skolehelsetjenesten, sykehjem og fengsler. Før pålegg gis skal kommunen søke å inngå frivillige avtaler om utføring av disse oppgavene. Fastlegens deltakelse i administrative møter med kommunen skal iberegnes i de 7,5 timene.
>
> Fastlegen og kommunen kan inngå avtale om andre oppgaver som skal inngå i de 7,5 timene, jf. første ledd.

- https://lovdata.no/dokument/SF/forskrift/2012-08-29-842/KAPITTEL_5#§30

- Are GPs taking care of prophylactic care of little children and pregnant women? Yes
- Are GPs gatekeepers for (most of) the secondary sector, or can patients walk directly into an emergency department We are gate keepers,
- Are GPs gatekeepers for (most of) the primary sector, or can patients walk directly into a clinic for another specialty like e.g. a cardiologist? If you do not concider the all private ones, we are gatekeepers
-

5) How much is the yearly budget for the publicly financed general practice?
I think 17 mrd NOK

6) Continuing education (ie courses after getting your specialty)
- How is it funded? Annual amount and who pays We have a trus that you might get refund from (Legeforeningen) and for those emplyed by the municipality they pay some
- Who decides the content?
Directorate of Health, but in cooperation with our specialist comitees

7) Quality work
- How is it funded? Annual amount and who pays It is the responsibility of the municipalities, bur we have not got a good system for that yet. Every GP office works with this very little or much.. We have this Center of quality improvement (where I am chariman of the board and Nils Kristian a board member) SKIL - https://www.skilnet.no – and the GPs get refund from a trust for days spent on this work.. SKIL is a foundation that receives money from the state budget, 8.6 million this year and they also get money from other places
- Who decides the content?
SKIL

8) Research
- How is it funded? Annual amount and who pays This is a very complicated question. There are many ways researcher get money, we have general medical assessment units at the universities, we have a research council with increased attention to the need for research in the primary healthcare service, the municipalities and the regional health organizations contribute something - but the most important source of funding for general medical research is still our General Medical Research Fund (AMFF), which receives money through the normal tariff negotiations. I am chairman of AMFF as well, and Nils Kristian a board member. 18 millioner NOK this year.
- Who decides the content?
- those who grant the money

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