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Assessing the role of GPs in Nordic health care systems

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Abstract

Purpose – This paper examines the changing role of general practitioners (GPs) in Nordic countries of Sweden, Norway and Denmark. It aims to explore the "gate keeping" role of GPs in the face of current changes in the health care delivery systems in these countries.

Design/methodology/approach – Data were collected from existing literature, interviews with GPs, hospital specialists and representatives of Danish regions and Norwegian Medical Association.

Findings – The paper contends that in all these changes, the position of the GPs in the medical division of labor has been strengthened, and patients now have increased and broadened access to choice.

Research limitations/implications – Health care cost and high cancer mortality rates have forced Nordic countries of Sweden, Norway and Denmark to rethink their health care systems. Several attempts have been made to reduce health care cost through market reform and by strenghtening the position of GPs. The evidence suggests that in Norway and Denmark, right incentives are in place to achieve this goal. Sweden is not far behind. The paper has limitations of a small sample size and an exclusive focus on GPs.

Practical implications – Anecdotal evidence suggests that physicians are becoming extremely unhappy. Understanding the changing status of primary care physicians will yield valuable information for assessing the effectiveness of Nordic health care delivery systems.

Social implications – This study has wider implications of how GPs see their role as potential gatekeepers in the Nordic health care systems. The role of GPs is changing as a result of recent health care reforms.

Originality/value – This paper contends that in Norway and Denmark, right incentives are in place to strengthen the position of GPs.

Keywords Denmark, Sweden, Norway, Health care, GPs, Medical profession

Paper type General review

Introduction

For the past two and half decades, I have been intrigued by Europe's systems of universal health care coverage and the relatively general satisfaction of its citizens. At the same time, various forces – an aging population, increased health care costs (from 8.5 to 9.7 per cent of GDP), improved access to health care through innovation in medical technologies, high rates of cancer deaths and demands by patients for more choices and better quality care – have forced the Nordic countries of Sweden, Norway and Denmark to rethink about their health care delivery systems.

Literature review

As Saltman (2014, p. 1) has described, "Nearly every health care system in Western Europe is currently under pressure to re-think its future strategy and health policy direction". In the aforementioned Nordic countries, a system of payment that involves

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diagnostic related groups (DRGs) has been introduced, privatization in health care has been promoted and most important, primary health care has been expanded. At the same time, patients have been given more choices in accessing health care.

Literature is replete with studies on how these new challenges are altering the nature of health care in publicly run health care systems, where over 80 per cent of health care financing is through the public sector, that is, generally through a tax-based financing system.

Primary health care is defined simply as a "sector of health services where general practitioners (GPs), nurses, physiotherapists, and other professionals commonly work together at health centers" (Arvidsson, 2013, p. 26). It is viewed as first-contact, continuous, comprehensive and coordinated care provided to patients (Arvidsson, 2013). The benefits of primary care cannot be overstated. After all, previous studies have shown that by its very nature and structure, countries with a well-developed primary care sector that involves general practitioners or primary care physicians have on average 20 per cent lower health care costs without lowering the medical quality. Furthermore, it is reported that the availability of GPs leads to better health outcomes and reduces the health care inequalities that currently exist (Arvidsson, 2013; Iversen and Ma, 2011; Hansen and Holst, 2014).

Among Scandinavian countries, primary care is much more accessible in Denmark and Norway. A mixed capitation and fee-for-service method of paying general physicians in Denmark has ensured that everyone has a primary care physician. While Nordic countries can boast of universal access to healthcare, Denmark has the highest public satisfaction with health care, thus reflecting the value placed on accessibility of primary care. If Danes have experienced much satisfaction with their health care system, is it possible that the other countries (Sweden and Norway) have done the same with relative success?

Objectives

This paper addresses the interesting topic of how the three Nordic countries are addressing the goal of universal access to health care in the face of mounting health care costs and an increasing political assault on the welfare states in Europe. Over the past decade, a number of factors has changed the practice of medicine. There is an increasing focus on the quality of medical care and the increasingly centralized control by governments. Anectodal evidence suggests that physicians are becoming extremely unhappy in this environment. Understanding the changing status of GPs will yield valuable information for assessing the effectiveness of Nordic health care delivery systems. There are a few systematic data on trends in physician satisfaction, particularly for those practicing in the primary care sector in Norway, Denmark and Sweden.

Specifically, this paper's objectives are as follows:

- Further development of concepts and hypotheses required for understanding the changing status of GPs.
- The collection of timely empirical data on some of the major systems and processes involved in evaluating GPs in Nordic health care systems.
- The use of existing literature to assess the usefulness of the concepts on the medical profession.
- Ways to strengthen the role of GPs in the overall health care delivery systems.

Methods

This study aims to explore the perspectives of Nordic physicians (GPs, specialists, Norwegian Medical Association representatives and health care administrators of these countries). Specifically, we were interested in exploring the views of physicians regarding the recent health care legislations in their respective countries, health care costs and the role of GPs as gatekeepers. We also explored their current work settings and the degree of professional autonomy experienced by physicians. Furthermore, we explored their views on DRGs as a cost-effective strategy in health care and discussed what they perceive to be future trends in health care. We used the snowball approach to obtain data from in-depth interviews in the summer of 2014 with health care providers, GPs and specialists, representatives from the Danish regions and Norwegian health centers and representatives from the medical boards in Sweden, Denmark and Norway. The interviews were conducted at hospitals, government offices and a hotel. Each interview was audiotaped with permission and was transcribed. The interview lasted for 1-2 hours. Content analysis was performed on major themes on the interview transcripts.

Findings

GPs in Nordic health care systems

We will proceed by first discussing the position of GPs in each of the three countries, thus making sure to identify laws passed to regulate the working environment of GPs. We will attempt to identity common themes and patterns for each country and evaluate the role of GPs by incorporating ethnographic work by the author.

A few systematic studies have examined the role of GPs as cost control managers in health care delivery systems in the aforementioned Nordic countries. Studies by Godager *et al.* (2009) have shown that GPs in Norway have become less concerned about their gatekeeping role, but rather do all they can for their patients to not lose them. This is because a part of their remuneration is linked to the number of patients they have. With the notable exception of primary care physicians in the British National Health Services (BNHS), relatively little research has been conducted to explore the potential role of GPs in these Nordic health care systems.

More than 90 per cent of health maintenance organizations in USA use primary care physicians as gatekeepers, whose role is to authorize access to specialty, emergency and hospital care and to all aspects of diagnostic tests. Franks and Clancy (1992, p. 425) defined gatekeeping "as occurring whenever patients need health care and select a doctor (primary care physician or specialist) to guide them through the system". They further argued that "The care from primary care physicians may be superior to that from specialists […] as they are more likely that specialists to provide continuity and comprehensiveness [of care]" (Franks and Clancy, 1992, p. 426). Furthermore, as they asserted, "Gate keeping has come to imply the medically limited and bureaucratic function of opening or closing the gate to high-cost medical services" (Franks and Clancy, 1992, p. 425).

Many previous studies on Nordic health care systems have suggested that the role of GPs has not been well integrated into their overall health care delivery systems. This seems as true in these Nordic countries today as it was in the early 1990s. If GPs in the BNHS have played a much greater role in the English health care system as fund holders, is it possible that the GPs in these Nordic countries have done so in the

twenty-first century? In fact, one study has suggested that GPs in the Danish health care system have achieved a status akin to a fund holder's status of British GPs (Abelsen and Olsen, 2012). There is no doubt that a GP's role represents one of the significant innovations in Nordic health care systems in the last two decades. At the same time, the exact role of a GP in the medical division of labor is uncertain. It has been argued that although a GP's role is a significant innovation in the medical division of labor, it is unclear whether GPs have made a unique contribution to health care in these Nordic countries. A GP, as we all know, is a deliberately planned occupation. In my previous study in Sweden, I argued that GPs reported enhanced social and economic status within their medical profession (Quaye, 2007). They seemed to be seeking increased responsibility, respect and autonomy in the medical decision process. An examination of GPs' role in these Nordic countries will provide valuable information for understanding the current role of GPs in overall health care in these Nordic countries.

Sweden, GPs and reforms

From the Swedish Seven Crowns Reform in 1971, where the counties became the main providers of primary care services, to the 1992 Stockholm model and the Family Doctors legislation, the GPs in Sweden have had a checkered past. As discussed by Saltman (2014, p. 4):

> The 1983 Dagmar reform further reduced the position of GPs as independent contractors to one of public employees and with that any incentive for GPs to enter into private practice.

However, in 2007, with the introduction of the so-called Vardval Reform in Sweden (Care Choice Reform), GPs were encouraged to enter into:

> […] private practice which by design allowed patients more choice of both private and public primary care centers, allowing the counties to contract with increasing numbers of new private for- profit and not- for- profit primary care providers (Saltman, 2014, p. 4).

Despite this, the system of payment has not changed, as GPs are still paid through public funds, and the remuneration for working either in the private or public markets remains the same. In fact, it was suggested that in 2012, "Patients sought out private providers for 50 per cent of all primary care visits in Sweden" (Saltman, 2014, p. 10).

The article "Setting priorities in primary health care" (Arvidsson *et al.*, 2012) has reported the examination of different approaches to priority setting in the Swedish health care system with a focus on primary care. According to the Swedish National Priority Setting Commission Report (1997, p. 4), "all priority settings must be guided by three principles- human dignity, cost- effectiveness and protecting the hallmark of the solidarity principle". Arvidsson studied primary care centers in Sweden and discovered that "Patients in general assigned a higher priority than staff for especially acute/minor conditions" (Arvidsson, 2013, p. 5). For GPs alone, cost effectiveness had the highest association, while for the health care staff in general, it was the severity of the health condition. This is in contrast with the commission's expectation that cost effectiveness should have the lowest ranking in priority setting.

That study has wider implications for how GPs see their role as potential gate keepers in the Swedish health care system.

When asked the question "What challenges are faced by GPs?", a 25 year old female GP in Sweden responded by saying "There needs to be more coordination between GPs and specialists". She argued that " There is a danger that with these recent privatization

efforts, more money will be siphoned from public health to private health care with wider implications for the health care system". She also called for more GPs to be trained and more attention to be paid for patient monitoring and involvement. On the question of how privatization is affecting the medical profession, she responded that:

> Generally, more health centers are public, so there are very few private GPs. If you want to set up a private health clinic in Sweden, you have to apply to the county council, and the patients are paid the same way whether you are in public or private. The money going to the health care center is the same. You cannot bill the patients (Arvidsson, 2014).

When asked the question "Do you see GPs as gatekeepers?", another GP with 35 years of medical practice responded by saying "We do not have it in Sweden". In response to the question, "How can the GPs role be strengthened?", he stated that "The GP system does not work. To have good primary care means having more GPs. At the moment, we have shortages of GPs". He also called for better coordination and integration between primary and secondary care.

Another female GP with 36 years of medical practice responded to the question "How do you see your role in the Swedish health care system?" by saying "I see myself as a gatekeeper, facilitator, and coordinator for patients' health care needs. I oversee their problems and diseases".

She answered the question "What is your view on priority setting/rationing?" by saying "I think we should have a system for rationing health care. The money is not enough to do everything in health care".

Upon being asked "Do GPs have good relationships with specialists?", she said, "It all depends. If you are in remote areas, the relationships are very good. This is because they realize they need the GPs to refer patients. But in bigger cities, the relationships are not very good". She answered the question "What are the major challenges facing the Swedish health care system?" by saying "The hospitalization of patients is not well-managed and the older folks fall through the cracks. Hospitalization makes the health care very expensive". When asked how strong are GPs in Sweden, she said:

> The GPs in Sweden are not very strong. If you compare the GP in Sweden with that in Norway in terms of clinical freedom and autonomy, the autonomy of GPs in Norway is higher than it is in Sweden. The hospital doctors here are better off than the GPs (Malin, 2014).

GPs in Norway

So what is the status of the medical profession in Norway? Do Norwegian GPs see themselves as better off than Swedish GPs? We address this in the following text.

Norway, a country of 5.5 million people, has a health care system that is typical of all Nordic countries. Health care in Norway is regarded as the responsibility of the Norwegian welfare state. In terms of financing, Norway has one of the largest shares of public financing of health services per capita in the world (Norwegian Directorate of Health, 2012). In its health care system, the allocation of resources and the delivery of health services are semi-decentralized, because the responsibility for providing health care services is divided between the state and the 435 Norwegian municipalities. The municipalities are responsible for providing primary care services, while "the state's five regional health care (RHA) authorities are responsible for delivering specialized health care" (Molven, 2002, p. 2). Under the local authority (Municipal Health Care Act, Section 1), "The municipalities [have the responsibility] to take necessary steps to

provide essential health services to all who live in the local area or stay on a temporary basis". Under this act, "the municipalities shall provide health services by employing suitable persons or by making […] the necessary contractual agreements with private providers of the required services". In this vein, private GPs have a contract for their services with the municipality. Primary care is financed from municipal taxes, block grants from the state and other funds earmarked by the state. According to Molven (2002), capitation payments account for 30 per cent of a GP's income, and the rest comes from fees-for-service and other additional out-of-pocket payments by patients. On the other hand, most specialist care at hospitals is financed through block grants (60 per cent) by the state, and 40 per cent is roughly based on the amount of health care activity (Sagan *et al.*, 2013).

These financing models have broader implications for "doctoring" in Norway. Norway has approximately 20,000 active physicians. These physicians include GPs and hospital physicians (Wesnes *et al.*, 2012). Regular GPs (RGPs) account for 5,000 physicians. Specifically, under the 2001 nationwide reform, all Norwegians were expected to register with a RGP. The goal was to strengthen the primary health care sector and therefore ensure that RGPs play the role of gatekeepers in the system. As mentioned earlier, having RGPs to serve as gatekeepers is intended to reduce overutilization of health services and excessive use of specialists. The patient list system also introduced a system of reimbursement in which physicians received 30 per cent of their income in the form of a per-capita-based fee from the municipality, and the rest 70 per cent is activity based, which includes consultation fees for-fee-for-service reimbursement from the National Insurance Service (Carlsen and Norheim, 2003). The payment formula has no doubt strengthened the position of RGPs in their dealing with specialists.

Views on DRGs

Previous studies have pointed out that RGPs are now influenced by both economic and social incentives, as their remuneration is linked directly to the number of patients they have on their list (Carlsen and Norheim, 2003). The role of an RGP in Norway also includes issuing sickness certificates and prescriptions covered by the National Insurance Service. In addition, they are more inclined to respond to the demands by their patients. In a study examining the impact of financial incentives on RGPs in Norway, Iversen *et al.* (2009) observed that RGPs with patient shortage were more likely to increase the services they provided for their patients to increase their earnings, and thus they have become less concerned with their gatekeeping role. Because the reform allowed their patients to change their RGP at least three times a year, RGPs have been forced in some situations to "bend the rules" to accommodate the needs of patients and thus are less concerned with their GP status as gatekeepers (Carlsen and Norheim, 2003;Iversen *et al.*, 2009; Abelsen and Olsen, 2012). Anectodal evidence provided by the Norwegian Medical Association show that RGPs on the whole earn more than hospital doctors (Abelsen and Olsen, 2012).

When a medical specialist with specialization in gastrointestinal medicine at a local Oslo hospital was asked about the payment structure at his hospital, he explained that "The hospital that I work at has a certain percentage of the money provided by the regional health authority (RHA) and the rest through diagnostic related groups (DRGs)".

On asked whether the DRG payment system is a good way of allocating health care resources, he responded by saying:

> I am not sure. We have not discussed it very much because I think it covers [DRG] the cost in that right way, but sometimes it does not, especially in the case of transplants. We do not have a direct link to the economic system because we have our salary and no one tells us that we should produce so and so.

When asked "What is the waiting time for elective surgery?", he replied, "It depends. With cancer surgery it is about six weeks. We have the same care guarantee here as in Sweden, but it is not always practical". When the specialist was asked "Do you have any contacts with primary care physicians? Is there a referral system?", he said:

> Yes, they send patients to us. We have no direct contacts with them. I know for example that in Germany, it is very important for the hospital doctors to maintain a strong relationship with the GPs because they refer patients to the hospital but that is not what happens here.

When asked to comment on the relationship between GPs and hospital specialists, he stated that:

> The relationship is good. I do not see any problem. I do not know what they [GPs] say, but of course they can be frustrated because it may take a longer time for their referred patients to be treated. There is no economic incentive for GPs when they refer patients to hospitals. The only frustration that I see is that they may have to wait for 2 weeks before their patients can have an x-ray appointment for example.

Another specialist on oncology when asked about the system of reimbursement in the hospital, he responded by saying "I am on fixed salary, so I do not have any incentives. My salary remains unchanged. I am also a professor so I am minimally reimbursed".

On his views on DRG as a system of payment, he said:

> For this hospital it is a real problem for inpatient care, as DRG is based on average costs and, because we have complicated cases, what is reimbursed is not adequate for the services that we provide.

When asked if the DRG is a good system for allocating health care resources, he replied by saying:

> I am not quite sure what is the best way. The DRG is the least best solution at this time. I was at Hersey in Pennsylvania and I saw how the nurses entered the codes into the system. I thought it was very inefficient since I think there should be a way to average the cost rather than counting everything. One may be accurate, but I am not sure how helpful that accuracy is to overall health care. For me, DRG is OK and there are mechanisms which if you wish can allow you to select patients based on the cost but not on the needs of the community. For private hospitals, this has been the case for selecting healthy patients and leaving the municipal hospitals with the most difficult patients.

Future trends in health care in Norway

When asked to identify two major challenges facing the Norwegian health care system, he stated that cancer treatment costs are a major concern. At the moment, he declared:

> We are trying to address cancer treatment options more efficiently. This means we have created cancer slots (about twenty- eight classifications) based on severity and time schedule

> offered. We also lag behind in medical technologies, for we have to fight for every item we have.

Regarding his view of the relationship between GPs and hospital physicians, he stated that:

> It differs from hospital to hospital. Some hospitals have some mechanism to meet with GPs beyond referrals. In this hospital, we communicate very little with GPs, as we get our patients from other hospitals but not from GPs.

When asked "Is DRG a good system for allocating resources?", he responded after a rather long pause by saying "Yes, it is not a big share of how resources are allocated to hospitals. It does give the hospital some incentives to do more and allows hospitals to compare performance across providers". Regarding RGPs, he argued that in Norway:

> RGPs are in a much more powerful position than the hospital doctors, given the nature of the payment system. The salaries among GPs are higher than that of the specialists. That is quite unusual. I think this was because we have had problems recruiting GPs.

On the question whether RGPs serve as gatekeepers in the Norwegian health care system, he responded by saying "It's a weak gatekeeper system since you need referral to outpatient care but you can still go directly to the eye specialist without referral, although you will have to pay for it yourself".

When a Swedish GP who is currently working as an occupational specialist in Norway was asked "How would you describe the status of the medical profession in Norway?", she said, "I think it is very strong and almost all medical doctors are members of the medical association. After all, physicians in Norway negotiate their fees with the government. In general the doctors in the hospitals are salaried by the state and the GPs are salaried by the municipalities, but a portion of their fees come from patients and the rest are paid through fee-for–service". To the question, "Are RGPs better off than hospital doctors?", she replied by saying:

> This is a very interesting question. We looked at doctor's satisfaction by different levels of measures (income, clinical freedom etc.) and concluded that GPs scored higher in general. The GPs are satisfied but they are also lonely. Other studies from abroad report more problems.

Another Norwegian GP who does not actively practice was asked to comment on whether private health insurance is the wave of the future. He responded by saying:

> People in Norway are worried that the Norwegian welfare state will collapse at some point, so they are buying these private insurance plans to cushion the likelihood of either denial or reduction in benefits when they get sick in 20 years time, for example.

> There are also private specialists and fully private hospitals but they are funded by public money because they either have contracts with the municipalities or with the RHA through the state.

When asked "How would you assess the role of the Norwegian medical association in dealing with the state?", he suggested that the association has a strong influence and stated:

> I am a member, but not active. They have a dualistic role and they are explicit and open and concerned with the professionalization of medical care. They are doing a good job for their members. The medical association, if they desire, can get a meeting with the Ministry of Health within 24 hours. They have easy access to the power corridors at all levels.

When asked to describe the relationship between the RGPs and the hospital doctors, he said:

> I think it is very good. I compare this with my impressions from other countries. I think it was 12 years ago. There is definitely a divide but the routine communication and easy referral are improving and the time is more respectful both ways. This is subjective and it is based on my own interaction with my colleagues. Thirty years ago, I would have said that the RGPs were seen as second class citizens but not anymore. There has been an active policy to increase the status of RGPs by establishing it as a specialty and they earn the highest salaries than the specialist. That is shocking. If you really want to make more money, you work 50 hours as a RGP. On the other hand, hospital doctors think that RGPs are not doing a good job based on the cases that come to them. They surmise that they refer too much or they do not refer when they should be doing so. On the other hand, the RGPs think that the hospital doctors are not service-minded and that they do not take time to review their referrals and they do not give reports back that are well-written.

Regarding the use of DRG as a system for allocating health resources, he responded by saying:

> I do not know. I will need to look at some research but I think it has been ideologically driven. For example, when we have the left [in power] the DRG portion of the reimbursement payment system is reduced and when the conservative come to power, the DRG portion is increased. We know that the DRG system has been exploited and it is well publicized that Norwegian doctors and hospitals have found smart ways of coding so it triggers more funding. Others argue that DRG improves efficiency and productivity. Whether that is true or not, I do not know. I will be somewhat skeptical. I do not think it has any effect on how physicians perform but it may have some effect administratively on how states assess performance to improve the system and to trigger more money.

On asked to reflect on the challenges faced by the Norwegian health care system, he revealed the tension between those health care workers who express frustration over losing clinical autonomy and those who look for new paradigm by pointing out that the local and national administration are meddling in health care. He said:

> Some doctors and nurses are frustrated over the reporting that they have to undertake in order to support the system. They claim that the reporting mania shifts the focus in a negative way away from cl patient's clinical needs. I had the same frustration when I practiced 20 years ago and that was during the time that the DRG was introduced and we were told to record the diagnoses. As a medical doctor I was not interested in coding and it is something happens today as well. I am worried that we are becoming increasingly Americanized. We are increasingly taxing the responsibility of health care on the individual. I have some responsibility for my smoking but to suggest that because of that you are not going to pay for health care worries me. We are not yet there. The idea of solidarity is under fire.

> The discussion so far has detailed the changing status of medical profession in Norway and Sweden. I have argued that the role of GPs has been changing with new policy directives from the governments in both countries. While the status of GPs seems well developed in Norway, can the same be said for Denmark? It is to this discussion that we turn next, that is, Danish health care system and GPs.

Much like Norway, health care in Denmark is the responsibility of its regions. Five regions were created in 2007, thus replacing the 14 counties. They are financed through block grants as well as activity-based financing from the municipalities and the state (Sagan *et al.*, 2013). More than 80 per cent of total health care expenditures is financed by

taxes. Direct user fees account for only 15 per cent of the total. User charges are mainly applied on dental services, physiotherapy and medications (Statistics Denmark, 2009, p. 1). At the same time, it has been estimated that the amount of employer-sponsored supplementary health insurance has increased by almost a million Danes (Statistics Denmark, 2009). The five regions have on average a total of DKK 100 billion annually to cover the provision of health care. The regions also manage public hospitals. The five regions are Copenhagen (1,702.388 million), Zealand (819,071), Southern Denmark (1,200,858), Central Jutland (1,262,115) and Northern Jutland (579,787) (Hansen and Holst, 2014).

The 98 municipalities are financed through income taxes and block grants from the state and inter-municipal transfers. They are responsible for disease prevention, health promotion, care and rehabilitation performed outside hospitals, district nurses, children, and dental services (Hansen and Holst, 2014).

In the Danish health care system, GPs are the gatekeepers. Currently, there are approximately 3,600 physicians in primary practice, 950 medical specialists, approximately 3,000 dentists, 270 chiropractors, 850 psychologists, 2,500 physiotherapists and 840 podiatrists. Under the current system, patients choose their own GP within their geographical area. Data suggest that 9 out of 10 patients consult their GP at least once a year. GPs are private independent contractors. They contract their services with their region, and the Danish Medical Association negotiates fees every year with the state.

We held a focus group interview with people from the Danish regions. When asked if GPs are influenced by financial incentives (form of a bonus), they said:

> Yes, in a reverse way they do. Patients are allowed to go to their GPs as many times as they want, but the GP can help to ensure that the patients are not over-utilizing the services that they can within their contract. But they do not get a bonus. Rather, GPs contract for much they are paid, if they spend more on patients than it is allocated, then their fees are reduced.

When asked "Do GPs in Denmark have autonomy and power?", they replied by saying:

> […] yes, as GPs are allowed to refer as many patients as necessary. But if a region sees too many referrals, it obviously asks questions about the high rate of referrals. But the GPs still have a lot of power in the health care system.

However, there has been discussion as to whether or not user fees should be introduced when patients visit their GPs, given the belief that patients overutilizing the services. Those opposed argued that introducing user fees will discourage the use of health services and lead to situations where patients do not show up or delay medically necessary treatments. In 2009, the aforementioned regions introduced email consultation to manage a reduction in the number of face-to-face consultations by patients. However, this did not yield the intended result. A reform introduced caps the regions pay for health services in a year, since the GPs have no financial incentive for keeping the cost down, and the patients have unlimited access to health care. These caps might undermine the autonomy of GPs. From the perspective of the Danish Medical Association on the question of the status of the GPs, an informant responded that "There is a certain amount of trust that patients have in their GPs that they will not under-treat or over-treat them for financial gain". When asked how GPs spend the money allocated to them, one of the interviewees noted that the regions do not directly supervise a GP's

work. Rather, what they need from GPs is data on what they are doing and its likely impact on patients. She said:

> The goal is not to monitor them but to help plan disease treatment management for patients and also to address issues relating to hospital bed capacity, should that be necessary.

With the exception of ear, nose and throat specialists, all Danes are expected to use their GPs for the referral to most specialists.

Future trends in Danish health care

When respondents were asked to predict the future structure of Danish health care systems, all participants mentioned that cost is the major challenge faced by the system. Another point that was raised pertained to whether the regions should be in the business of providing health care at all or whether that responsibility should be left to the state. One respondent said:

> In the last few years we have had to reduce the size of the health sector and as a result some people were forced to retire and the system was reorganized to meet the mounting cost.

When asked "how much is health care reform in Denmark dictated by the government in power?", all respondents said that it does not change very much. After all, all the major political parties embrace the principle of universal access to care. For example, the new hospital expansion plan was developed by the previous center-right government, and the current social democratic regime has continued it. However, the one-month care guarantee was something the new government did not agree with, and thus it was abandoned. Another change was that local government (municipality) co-financed health care, which was introduced in 2007. The goal was to focus more on preventive care, rehabilitation and reducing the length of stay in hospitals. To achieve this, the municipalities are reimbursed through yearly agreements with the government. The local governments favour this co-financing, but individual municipalities are against it since they surmise that this arrangement is not working, and they further argue that there is not enough money to cover expenses. The regions believe that there should be some collaboration between the regions and the municipalities, but not the same as that currently configured.

At present, the five regions are involved in different experiments to set up incentive systems that reward improvements in health care. For example, in the Central Jutland region, six hospital departments (approximately 12 per cent of somatic hospital activity in the total region) are involved in a project in 2014 and 2015. With their funding, there will be no activity levels to be met. Rather, they will measure certain quality indicators individually selected by the six departments. The result of this experiment may provide a framework for priority setting in the health care system.

As alluded earlier, health care cost, high cancer mortality rates and economic pressures have forced these Nordic countries to rethink their health care systems. Several attempts have been made to reduce health care costs, while at the same time holding to the principle of universal access to healthcare. These have been achieved through market reforms and the introduction of financial incentives, such as competition and the use of DRGs as a way to allocate heath car resources. In both Norway and Denmark, approximately 40-50 per cent of hospital reimbursement by the state or regions has come in the form of DRG payments. There has been an increase in out-of-pocket payment by patients, and there have been signs of greater

economic and social inequalities in health care provision. In all these changes, the position of GPs in the medical division of labor has been strengthened, and patients now have increased and broadened access to choice. The issue is how to effectively coordinate care at both primary care and secondary/hospital levels to ensure that patients are not using the health care resources unnecessarily. As stated by Saltman (2014, p. 14):

> There is increasing pressure on health systems across the developed world to link inpatient and outpatient services to a broad range of primary health care and social services, with the stated goal of creating a "seamless web" of appropriately targeted and delivered services for patients generally and for the elderly in particular.

Will these Nordic medical professions and especially the GPs live up to this challenge? The evidence suggests that in Norway and Denmark, right incentives are in place to achieve this goal. Sweden is not far behind. With its recent reform of priority setting, it is clear that the fundamental structures are in place for an even greater role of the GPs in the Swedish health care delivery system.

Discussion

This paper has reported the views of physicians in three Nordic countries. Most GPs interviewed see their role as that of a gatekeeper that holds down health care cost. While some hospitals favoured the use of DRGs as a system of reimbursement and effective cost control measure, some physicians were ambivalent about its effectiveness. Regarding recent reforms in health care, GPs, specialists and health care administrators and members of the medical profession in these countries hinted at the possible "loss of autonomy". GPs in Norway and Denmark boasted that they have better working conditions and more autonomy than their counterparts in Sweden. In my interviews with GPs and others in the Nordic health care systems, the general view seems to be a gradual move to a two-tier system – basic coverage for all and additional supplementary insurance or contributions by those who are in a position to afford other care. What I forsee in these systems is greater privatization given the need to control health care cost.

There is no doubt that the investment made by Nordic health care planners in developing and strengthening the position of GPs as gatekeepers is laudable and long overdue. The GPs' role due to its potential benefit as an agent of cost control is clearly important. As we better understand the changes taking place in the twenty-first century, a better understanding of the medical division of labor and the role of welfare states in shaping this will become increasingly important.

Conclusion

The study sheds light on the changing status of the medical profession in the Nordic countries of Norway, Sweden and Denmark. It makes the claim that the fundamental structures in health care remain intact despite economic and budgetary pressures. Other countries can learn from the experiences of these countries, as they fashion systems that will allow them to control health care cost, while at the same time, improving the quality of care for patients. The study is limited by its small sample and reliance on a small set of physcians referred through snowball sampling. A larger quantitative study of physcians in these countries would yield further useful information for governments and health care planners. Nevertheless, this paper

offers a window into what other countries can learn from the Nordic success in providing universal health care for its citizens. The position of GPs in Norway and Denmark is a novelty and a lesson for Sweden. Now is the time for Sweden to embrace the gatekeeping role of GPs.

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