# In Search of Solutions: Stakeholder Perspectives on the Norwegian GP Crisis

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# Abstract

Norway is currently grappling with a severe shortage of general physicians (GPs), a crisis that has profound implications for its unique healthcare system. Norway's vast and sparsely populated territory, coupled with long distances between the hospitals, places an even greater emphasis on the importance of the GPs. They are not only crucial for maintaining accessible healthcare but also for managing referrals and ensuring seamless healthcare journeys in central and rural areas alike. In this single-case study, I have investigated the underlying problems of Norway's public GP scheme, Fastlegeordningen (FLO), by interviewing a wide range of stakeholders with direct experience of the crisis, including GPs, politicians, administrators from public specialized healthcare providers (Helseforetak), municipal, and national bureaucracy, private sector, as well as student and labor associations. The study seeks to understand their perceptions of the crisis and potential solutions, including the possibility of liberalizing EU/EEA medical authorization. To my knowledge, this is the first comprehensive qualitative research paper on the country's GP crisis to date.

Through a grounded bottom-up approach, the inductive analysis illuminates the inherent and wide-ranging complexities of the crisis, both in terms of causes and implications. A key finding is that the crisis can be viewed as a symptom of dysfunctional vertical lines of communication between the national healthcare administration and the municipal health services that administer the FLO. This dysfunction appears to stem from a sustained New Public Management-influenced focus on economic professionalization and managerialism, which has undermined its medical competence. Over time, this imbalance has compromised the national administration's resources and capacity to adequately detect, interpret, and address the issues plaguing the FLO. NPM reforms have also contributed to a fragmentation of knowledge. This was illuminated upon investigating the national administration's strict approach in providing EU/EEA authorization, as the relevant professional capacity had been transferred to the regional health trusts (RHF) that are responsible for the country's medical foundation program (LIS1). In the absence of the RHFs' control, the Directorate's capacity is limited to strictly abiding by the current criteria, with no room for flexibility.

***Keywords:*** *Norwegian GP Crisis, Fastlegekrise, Fastlegeordningen, General Practitioner Recruitment, Healthcare Policy, EU EEA Medical Authorization, Temporary Employment Agencies, Healthcare Workforce Aging, Labor Immigration, Scandinavian Healthcare, Bottlenecks in Medical Education, New Public Management (NPM), Grounded Theory, Qualitative, Inductive Research, Wicked Problems*

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Jørgen Dysvik Bjørke

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# Abbreviations

| | |
|---|---|
| ALIS | LIS3 specialization in general medicine. Necessary for achieving GP authorization |
| AF | Allmennlegeforeningen (Norwegian General Practitioner Association). The Norwegian Medical Association's branch for general medicine |
| BEON | Beste effektive omsorgsnivå (Best Effective Care Level) |
| EEA | European Economic Area |
| EU | European Union |
| FLO | Fastlegeordningen (National GP Service) |
| GP | General Practitioner |
| HF | Helseforetak (Health Trust) |
| HoD | Helse- og omsorgsdepartementet (Ministry of Healthcare) |
| KBU | Klinisk Basisutdannelse (Post-graduation medical practice required for medical authorization in Denmark) |
| KS | Kommunesektorens organisasjon (Norwegian Association of Local and Regional Authorities) |
| LIS1 | Lege i spesialisering. First-level internship of postgraduate medical specialization. Equivalent to UK's Foundation Program |
| LIS2 | Second level of medical specialization. Focuses on internal medicine |
| LIS3 | Third and final level of medical specialization, where physicians make their ultimate decision on the area of expertise |
| NMF | Norsk medisinstudentforening. Norwegian Medical Students Association. The student branch of the Norwegian Medical Association |
| NOKUT | Nasjonalt organ for kvalitet i utdanningen (National Agency for Quality Assurance in Education) |
| NOU | Norges offentlige utredninger (Norwegian Public Review) |
| NPM | New Public Management |
| OECD | Organization for Economic Cooperation and Development |
| RHF | Regionalt helseforetak (Regional Health Trust) |
| UDI | The Norwegian Directorate of Immigration |

# 1. Introduction

## 1.1. Setting the stage

"*Wherever the art*
*of medicine is loved,*
*there is also a love*
*of humanity.*"
– Hippocrates

On August 1st, 2022, the Norwegian General Practitioner Association (AF) released a report presenting fresh statistics, showing some 235.000 (or 1 of 24) citizens had not been assigned a general practitioner (Klev 2022). This trend has only been exacerbated in recent years, rising steadily since 2018, when 79.000 lacked an assigned GP (Allmennlegeforeningen 2022). There are also significant regional differences, as citizens without an assigned practitioner rise to almost 11 % in the most rural county of Troms and Finnmark, compared to 0,006 % in the capital, Oslo (Klev 2022; SSB 2022). These numbers represent a core issue in the Norwegian healthcare system, as it simultaneously has become increasingly dependent on the functioning of the National GP Service (FLO) through recent digitalization-related measures (Sørensen & Berg-Olsen 2021, 31). Norway possesses a long-stretched territory characterized by a dramatic and inhospitable arctic landscape, with low population density and long distances between hospitals (Brandstorp 2013, 165). GPs, therefore, play a crucial part, especially in more rural areas. They effectively act as gatekeepers for the specialized health services, being the main actor of referrals and medical check-ups (Schøyen 2021, 253).

The Labor-Centre-led government recognized the severity of this issue in its proposed annual budget for 2023, allocating some unprecedented 690 million NOK to the GP service (Regjeringen 2022). With its proposed 2023 budget, the government aims to address recruitment issues, as well as initiate research on improving the healthcare service for future generations (Regjeringen 2022). Still, it appears not to address short-term measures for immediate relief. For while it takes years to educate new GPs, the pressing need for accessible quality healthcare continues. The question arises then: Are such long-term strategies sufficient in addressing the immediacy of the crisis? What I argue we must consider is the root of this crisis – *why* – the FLO is struggling with recruitment. Such inquiries necessitate an in-depth

examination of the structural and systemic factors contributing to the current state of the GP crisis, as well as an exploration of immediate, viable options. We must critically assess whether the current focus on future strategies adequately addresses the current reality and whether more could be done to navigate this immediate challenge, even as we plan for a better future.

Recruiting EU-educated GPs (both migrants and Norwegians) may be considered a natural short-term option. However, the issue of recruitment becomes even more evident when examining the current practice of authorizing foreign-educated health personnel. The main legal body for foreign education and skill recognition in Norway is the Norwegian Agency for Quality Assurance in Education (NOKUT). However, educational recognition is not sufficient for migrant (and foreign-educated Norwegian) physicians and GPs. In addition, they must also meet the criteria of authorization from the Directorate of Health. These criteria range from required working experience and training throughout the course of their education, the academic composition of the degree, and level B2 written and oral Norwegian, to name a few. All the above-mentioned criteria require extensive documentation. Furthermore, the Directorate of Health stresses that the criteria for authorization are even stricter for individuals with educational backgrounds outside of the EEA (Helsedirektoratet 2021a; Helsedirektoratet 2022).

While these criteria may appear reasonable at first, it has, for instance, left several Danish-educated physicians without authorization (Enghaug 2022; Hamre 2021; Einangshaug 2022). Much of the concerns are related to work training and experience requirements, where Danish physicians do not get their working period approved. The Directorate of Health argues this is due to Danish universities, despite also requiring significant periods of practice before reaching authorization, are using a slightly different approach than Norway in their medical education, where this practice is not integrated into the degree itself (Einangshaug 2022; Helsedirektoratet 2021b). However, if there is such an urgent lack of GPs in the Norwegian public health sector, it might be time to re-evaluate the current practice for short-term relief?

In this thesis, I will utilize a grounded bottom-up approach in order to provide insights into both the causes and implications of the Norwegian GP crisis, as well as explore possible short-term solutions, including the possibility of liberalization in the practice of EU/EEA medical authorization. We will listen to the experiences and reflections of the GPs themselves, as well as individuals working for various stakeholders within the healthcare sector that are affected by the GP crisis. In so doing, I aim to shed light on the nuances and complexities of the situation, the underlying challenges facing the healthcare sector, as well as potential short-term solutions.

## 1.2. Research Question

This thesis is driven by the following research question:

> *"What are the perceptions of various stakeholders on the Norwegian GP crisis, what short-term solutions do they suggest in addressing the crisis, and how do they perceive the potential of liberalizing EU/EEA medical authorization?*

The specific emphasis on *stakeholder perceptions* is an important feature of the research question, as it effectively narrows down the scope of both the investigation and the methodology. This focus permits a qualitative approach that allows for an in-depth exploration of individual preferences, thoughts, and experiences, providing us with detailed insights that might otherwise be lost in large-scale quantitative analyses. The richness of qualitative data enables us to understand the nuances of the crisis at hand from the perspectives of those directly involved. Simultaneously, this provides a degree of flexibility for the researcher and maintains practical feasibility. By not being too broad, e.g., analyzing recruitment problems in the country's healthcare sector more generally, the research question allows for a comprehensive yet manageable exploration of this significant and timely issue.

Another feature of the research question is that it does not clearly necessitate a specific theoretical approach. This is a conscious choice, as it would allow me to study the crisis from a "grounded" inductive bottom-up approach. This methodological approach involves setting theories aside and focuses on how individuals engage with the studied phenomena. All data is attained through first-hand sources, such as in-depth interviews, and the data analysis is meant to identify categories and how they relate to each other (Dey 2008, 1).

As we will see in this thesis literature review in section 2, there has only been conducted a limited amount of research on the Norwegian GP Crisis at the time of writing, and the few papers that exist appear to cover very specific aspects of the crisis, rather than looking at the broader picture. Although the crisis' outward appearance may appear simple, primarily being an issue of recruitment, the government's sudden and unprecedented budgetary increase could point towards more complex, underlying structural and systemic issues that require a multi-dimensional analysis. These factors are what I argue underline the appropriateness of the grounded methodological approach.

## 1.3. Clarification and Scope Conditions

The scope of the thesis covers the Norwegian public health sector stakeholders that are involved in the GP crisis. Figure 1 displays the chains of responsibility in Norwegian Healthcare following the Coordination Reform of 2012. This reform will be presented in detail in chapter 5.1.4., but in brief, the Coordination Reform aimed to improve cooperation between various levels within the healthcare service by focusing on the 'Best Effective Care Level' (BEON) and redefining the responsibilities of municipalities and specialized health services, while emphasizing the role of the GP Service in coordinating care (Veggeland 2013b, 85-86). These organizations are all stakeholders reliant on the National GP Service, and vice versa. My selection criteria are, for this reason, representatives of these actors and other parties involved with them. Additionally, in the same respect, representatives of labor and interest associations, members of parliament, and temporary employment agencies have also been included.

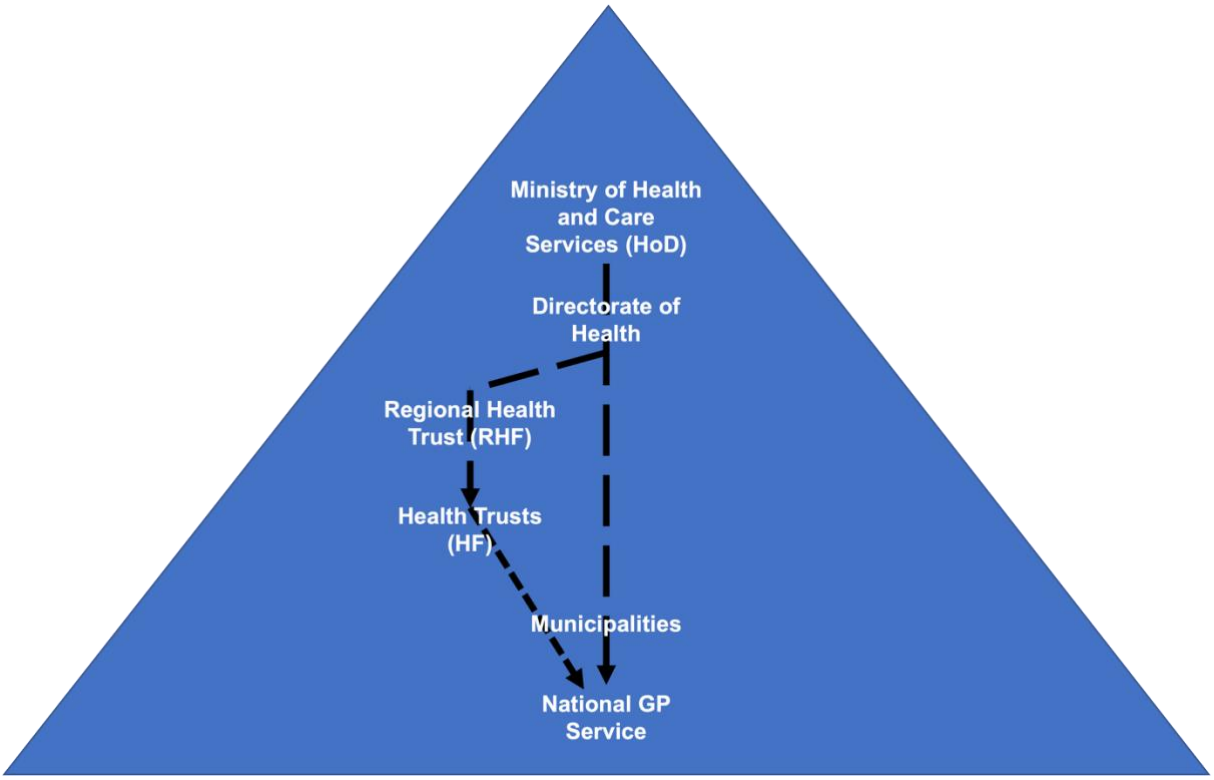


**Figure 1:** "Multilevel Interaction Model of the National GP Service" based on Veggeland (2013b, 86).

The sample itself will be based on a *strategic selection*, which refers to sampling where units are selected along the way of the study and not in beforehand. This gives room for considerable flexibility for the researcher compared to a statistical population where the sample is

randomized. As new units are selected and provide a foundation for further selection and data for analysis, the goal is that the accumulated knowledge will make it clear what new units might be relevant and interesting to include in our sample (Grønmo 2017, 113).

Regarding the data collection method, I will use a semi-structured in-depth interview approach with open-ended questions and a flexible interview guide. This includes the main themes of discussion and should be sufficiently extensive and specific so that the researcher gathers relevant information for the study. On the other hand, it should also be uncomplicated and general so that the interview may still be carried out flexibly (Grønmo 2017, 168). This framework fits the research question well, as it makes it possible to address the various explanations for the obstacles provided by the various actors. This will consequently be beneficial for hypotheses creation and theory building, which is the aim of this research proposal.

## 1.4. Structure of the Thesis

I have structured the thesis into several sections, each playing an important part in building a comprehensive understanding of the Norwegian GP Crisis.

Following this introductory chapter, Chapter 2 presents the Literature Review, where we will examine the historical development of immigration policy in Norway, Scandinavia, and beyond, followed by a review of the existing literature specific to the Norwegian GP Crisis.

Chapter 3 outlines a theoretical framework relevant to this study. While the grounded approach relies on an inductive data analysis, I argue that one should acknowledge that research does not occur in a vacuum. Therefore, it remains valuable to contextualize and address the research findings within established theories in the discussions section. By doing so, I aim ato facilitate a holistic understanding by bridging the gap between my research findings and existing knowledge in the field.

In Chapter 4, we delve into the Methodological Framework of the thesis, where I will discuss the overarching methodological approach, data collection, and methods of analysis. This chapter also addresses the ethical considerations of my research approach and discusses the validity and reliability of the results.

Chapter 5 presents the reader with a historical background of the Norwegian healthcare system. This provides the reader with the necessary context to understand the current crisis.

Chapter 6 houses the analysis of the research data, exploring the various stakeholder perspectives on the GP Crisis. We will explore various aspects, like recruitment issues,

bottlenecks, implications of the crisis in various areas, EU/EEA medical authorization, and the role of private actors. The analysis is concluded by an overarching model that summarizes the various themes, codes, and sub-codes of the analysis, as well as their role in the crisis.

In Chapter 7, the discussions section, we will answer the research question, interpret the findings, and discuss their implications. This chapter will also discuss the alignment of these findings with previous research and theories. Finally, it will also address research limitations as well as provide suggestions for future research.

Finally, chapter 8 provides the conclusion of the thesis, summarizing the key findings and their implications for both the healthcare sector and the broader field of study.

# 2. Literature Review

It appears to be a lack of literature on immigration in relation to the GP crisis. There is, however, existing research on these topics separately. In this literature review, I will first present research on the historical development of immigration policy in Norway and Scandinavia more generally. I will then display literature on the Norwegian GP crisis, as well as research concerned with the practice of authorizing EU/EEA health personnel.

## 2.1. The Historical Development of Immigration Policy in Norway, Scandinavia, and Beyond[1]

In year 2014, OECD released a report that investigated the current state of affairs when it came to recruiting immigrants in Norway. It found that high-skilled migrants who come to work in the country tend to leave (2014, 15-16). Researchers point towards various reasons but suggest this group faces specific obstacles that are not encountered by the local labor force. A perhaps paradoxical explanation points toward ineffective and time-consuming hurdles concerning education and skill recognition. In turn, this may lead to downward occupational mobility, where high-skilled immigrants take jobs for which they are either over-qualified, or which are irrelevant to their professional background (Sonniks 2014, 3; Søholt 2016, 25; Westad 2020, 4). Furthermore, the OECD report also highlights a problem where employed high-skilled

[1] Section 2.1 (excluding subsection 2.1.1) was previously included in a research proposal submitted for Sampol388 at University of Bergen as part of the development process for this master's thesis. The material has since been adapted and expanded with some minor changes for use in this thesis with the permission of the course instructor.

migrants decide to leave because their spouses, who usually are highly educated and talented themselves, struggle to find relevant work (2014, 16).

An interesting observation is the fact that Norway accepts a large and growing number of international students, where many decide to leave upon graduation. OECD argues this is due to a lack of work experience opportunities throughout the studies, as well as lacking information regarding possibilities of employment after their studies (2014, 16). Another prevalent obstacle to employment is connected to the informal employment structures of the Norwegian labor market. Many jobs in Norway are not listed and are communicated through networks, of which migrants often are not part of (Søholt 2016, 26).

Looking at the recent labor market trends in Northern Europe more broadly, a study by Häusermann, Kurer & Schwander displays how labor market vulnerability is spreading into the highly educated segment of the European labor market (2014, 235). Their analysis also shows what appears to be a shift in the preferred labor market policy preferences between the highly skilled insiders and outsiders, where insiders opt for stronger labor market protection whilst outsiders opt for more generous unemployment benefits. Exploring how these developments affect high-skilled migrants' prospects for employment is therefore of interest in this regard. Finally, connected to migrants' lack of political representation, a study in America finds that "natives turn to occupational licensing regulations as occupational-specific protectionist barriers to skilled migrant labor competition" (Peterson, Pandya & Leblang 2014, 45).

According to a 2017 Norwegian Public Review (NOU) report by the Ministry of Justice, Norway had a larger share of highly educated migrants than the OECD average in that year. This trend has persisted for over 40 years, which the Ministry argues is explained by pull factors, such as technological development. This heavily favors highly educated employees. The Norwegian Central Statistics Bureau (SSB) also reported in 2015 that 70 % of migrants in Norway have at least a high-school diploma (Justis- og beredskapsdepartementet 2017, 61-62).

The country is considered attractive for high-skilled migrants as there is a high demand for high-skilled workers and offers a compressed wage structure. Compared with other OECD countries, Norway has, in recent years, become a major labor immigration country, mainly from EEA countries, only exceeded by Switzerland with respect to inflow as a share of the population (2014, 15-16).

Another interesting study, although arguably somewhat outdated, is a report released by the National Statistical Bureau (SSB) in year 2009, which examined various variables concerning immigration. The SSB researcher, Olsen, was puzzled over why there is a lower

percentage of migrants working in the state as compared with the private sector. While acknowledging the limitations of the available data, his findings suggested that migrants generally tended to favor the private sector over the public sector and that the professional backgrounds of migrants generally do not center around the public sector (Olsen 2009, 3-4). The Norwegian labor market serves as a good empirical case to explore when diving into the obstacles high-skilled migrants face when seeking employment, as it, in turn, may help us better understand broader global patterns concerning this area.

### 2.1.1. Immigration in Scandinavia from the Post-War Era Onwards

Research on the evolution of labor immigration to Scandinavian countries indicates that Norway's experiences are mostly shared with those of its neighboring countries. For both Norway, Sweden, and Denmark, the 1970s appeared to mark the end of their liberal approach to labor migration that had characterized the post-war era. Heavy legal hurdles were put in place, effectively limiting immigration to mainly refugees and family reunions (Jakobsen, Korpi & Lorentzen 2019, 306; OECD 2014, 66; Boräng & Cerna 2017, 130-131). OECD argues that the sudden shift was caused by the oil-crisis-related recession that took place in the 70s (2014, 66). All three countries have historically enjoyed a high labor union density, and the crisis led to a shift in these actors' position on labor migration, which influenced policy development. Furthermore, the policy developments in the Scandinavian countries often affect each other. The OECD report names an example where Sweden and Denmark in 1971 passed legislation requiring labor migrants to have a job offer prior to immigrating, with Norway following suit (2014, 66).

In 1975, the Norwegian parliament followed its neighbors in imposing a temporary labor immigration stop, which was extended and finally became permanent in 1981. Just as with its neighbors, only a few exceptions were allowed. In Norway's case, only "in demand" occupations, was allowed immigration, with strict requirements. Contracts could not extend for over one year, and working conditions, such as wages, had to meet the same tariff agreements as for the natives. Furthermore, the contracts had to be written in the migrants' own language, and the percentage of a firm's workforce of foreigners could not exceed 25 %. Additionally, the migrants had, as a minimum, to be literate in their own language, as well as the employers being responsible for providing housing (OECD 2014, 66-67). The practice appeared to be similarly strict in Sweden, which heavily emphasized that it was the employers' responsibility to ensure the welfare of the migrants. It was stressed that the costs of immigration were not to be passed on to the taxpayer. The Swedish case, however, was somewhat more peculiar in its rigidness.

There, immigrant membership in unions was mandatory. Moreover, the unions had the power to revoke working permits if they found it did not meet their criteria of pay or working conditions (Boräng & Cerna 2017, 132).

The state of the immigration regime of the Scandinavian countries remained similarly restrictive until the turn of the millennium (OECD 2014, 67; Jakobsen, Korpi & Lorentzen 2019, 307; Boräng & Cerna 2017, 67). It should, however, be mentioned that the immigration act, *utlendingsloven*, was introduced in Norway in 1988. The Norwegian Directorate of Immigration, UDI, was created the same year as part of it. Although the directorate today is tasked with processing the applications of immigrants, its original purpose was limited to easing the strain on local governments on tasks concerning the reception of refugees and asylum seekers (OECD 2014, 67). That being said, it was not until the beginning of the 21st century the immigration policies of the Scandinavian countries started to deviate. Studying the policy developments in the Danish immigration legislation in a Scandinavian context, Jakobsen, Korpi & Lorentzen found that Denmark took a "stick" approach, Sweden a "carrot" approach, and Norway a middle ground (2019, 307).

In 1999, Denmark was the first Scandinavian country to cut benefits for migrants. The policy reconfiguration was aimed at increasing the employment of this group. Part of the rationale for achieving this goal involved incentivizing immigrants to accept less attractive jobs (Jakobsen, Korpi & Lindstrøm 307). Sweden, initially ranked by the OECD as one of the most restrictive countries in terms of labor migration policy, initiated an unprecedented U-turn in 2008, making it one of the most liberal. (Boräng & Cerna 2017, 122).

## 2.2. Literature on the Norwegian GP Crisis

The problem of recruitment in the Norwegian GP service is nothing new. Already in 2013, Jan E. Kristoffersen, former physician and Head of Quality at Akershus University Hospital HF, warned that Norway's GP service is beset with multifaceted issues. Problems included an aging workforce and medical graduates refraining from specializing in general medicine. This was, from his view, caused by an ever-so-increasing workload and working hours since the introduction of the GP service in 2001 (Kristoffersen 2013, 125). Economically speaking, the 2001 reform itself was quite successful in terms of cost control. However, its introduction of various micromanagement-styled incentive systems had, in his view, impacted the state's will for service innovation and professional development (Kristoffersen 2013, 126). Another

problem negatively impacting recruitment is the lacking possibility of moving up in the ranks due to the GP profession's static nature (Kristoffersen 2013, 127).

Other issues impacting the recruitment of physicians more generally were raised in the same publication by Helen Brandstorp, a Ph.D. at the Arctic University of Norway. Brandstorp shed light on the reform of LIS1 in 2013, which is the Norwegian equivalent of the UK's Foundation Programme. The reform effectively brought an end to Norwegian medical student graduates' automatic right to medical internships. The former system was best described as a lottery, which Brandstorp argued made it possible for more rural areas to present themselves to young physicians before starting their specialization. This was, in Brandstorp's view, necessary, as the foretaste of practice that medical students receive throughout their studies is limited to the university hospitals in their city of study (2013, 148). These students, therefore, have a limited understanding of the benefits of working in the districts, such as the possibility to work more independently and broadly. This stands in contrast to the hierarchical structure of the hospital wards in the major hospitals. In this regard, Brandstorp points towards the "the salmon stream effect," which refers to a phenomenon where physicians who served their medical internships in the districts are argued to be more likely to move back or work in a similar place to where they worked as an intern (Brandstorp 2013, 151). This appears to be a popularized term in this setting (Storvik 2014; Straume 2018, 4; Stølen, Lofthus & Mevold 2020). It originates from the phenomenon where wild salmon return and spawn in the same location as their birthplace (Wærås 2018).

With the introduction of the new application-based system of recruitment in the LIS1, the possibility of individual assessments and tailored arrangements ceased. In the new system, the internships are handled, more or less, as conventional job applications, which, according to Brandstorp, brings its own concerns. This includes the traditional issues of differential treatment, nepotism, and favoritism (2013, 150). Other concerns are linked to the different grading systems of medical courses used at Norwegian universities. Some universities provide grading in all courses, whilst others simply state 'approved' or 'disapproved.' Brandstorp argues this will provide medical students from the graded systems with an advantage in the recruitment process, as it will make it easier for them to stand out (2013, 150). A group of recruitment experts tasked with evaluating this new system, furthermore, considered it as more unjust compared to the previous lottery model and brought attention to potential issues facing graduates having foreign surnames. This group also argued it would make it difficult for Norwegian students with foreign diplomas in recruitment processes, as they had no chance of

networking and making themselves attractive for potential employers throughout their studies (Brandstorp 2013, 150).

The last problem with the reform raised by Brandstorp (2013) concerned the end of the right to apply to LIS1 for Norwegian medical graduates from several EU/EEA countries. As a result, the affected graduates must either finish the Foundation Program in their host countries or go straight to unsupervised healthcare positions, finding themselves being stuck in gatekeeping positions, e.g., in emergency wards (Brandstorp 2013, 148). This primarily affects students from European countries that have not integrated medical practice into their medical degrees (Brandstorp 2014, 156). In other words, in countries where graduates do not receive medical authorization before having served in the Foundation Program.

### 2.2.1. Digitalization Efforts, GP Perspectives, and Deloitte Audit

In more recent research, there exists some literature on the possible causes and implications of the Norwegian GP crisis. In a 2021 study, Sørensen & Berg-Olsen looked specifically at the impacts of the Norwegian government's recent digitizing efforts in healthcare services. The aim of this reform was to better meet patients' needs concerning availability and effectiveness in the provision of healthcare. Despite receiving positive responses from patients, the reforms were firmly criticized by the GPs themselves (Sørensen & Berg-Olsen 2021, 2).

After conducting several in-depth interviews with GPs, the study's findings suggest this group found themselves excluded during the designing process of the new digital systems of communication and user interfaces. The informants described they experienced the reform as a product of lacking communication between the national government and the field-level GPs. The respondents themselves expressed that they were not opposing digitizing as a concept. However, they were critical of how the government implemented this process, particularly due to the lack of opportunities for GPs to critique and provide feedback on the proposed changes. The interviewed GPs expressed that such inclusive strategies were essential for such reforms to succeed (Sørensen & Berg-Olsen 2021, 23, 45).

The main finding of Sørensen & Berg-Olsen's study was that the GP crisis appears to stem from a deficient understanding from the government's part on the GPs' needs and challenges (2021, 48). In this case, it was linked to how the digitalization of healthcare has resulted in an increased workload on an already strained GP service and was viewed as yet another thief of time. This, again, was argued by one respondent as impacting the already struggling recruitment: "This [workload] has resulted in many simply giving up, retiring

without being replaced by new physicians – since young physicians do not dare to enter" (Sørensen & Berg-Olsen 2021, 30-31).

A 2022 audit report by Deloitte on City of Bergen's behalf made similar findings on the capacity and coverage of the municipality's GP service. City of Bergen has set a goal of a minimum of 5 % list vacancies in its GP service. However, since January 2021, the highest percentage reached was 0,6 %. Periodically in both 2021 and 2022, it has been as low as 0 % (Deloitte 2022, 21-22). In other words, few to none GPs in Bergen, Norway's second most populous city, have had the capacity to cover new citizens. Just as Sørensen & Berg-Olsen's (2021) study suggested, the municipality struggles to recruit young GPs, and ¼ of its existing labor force is over 60 years old and approaching retirement (Deloitte 2022, 6). Several interviewed felt City of Bergen did not adequately address the issue of aging in the workforce and considered this to be a grave issue. 73 % of 127 GPs in the municipality reported in a questionnaire they considered quitting. In interviews, several expressed they considered quitting due to work pressure (Deloitte 2022, 36). Many expressed that the GP service involved working overtime hours far into the evening in order to handle excess paperwork and electronic consultations. This concern appeared to be especially prevalent for those serving adjunct positions in either the municipality and urgent care (Deloitte 2022, 29).

Another issue appears to be the availability of substitute physicians for GPs who have legitimate reasons for absence, e.g., sick leave for child, sick days, maternity leave, and annual leave. According to the framework agreement between KS (Association of Norwegian Local and Regional Authorities) and the Norwegian Medical Association (Legeforeningen), the municipality is obliged to provide substitutes in periods of temporary physician shortages (Deloitte 2022, 4). In Deloitte's questionnaire, however, 48 % of respondents reported that it was, to a large extent, hard to appoint a substitute in cases of long-term absence. On a side note, the majority of respondents also expressed that their medical clinics had good experiences with colleagues covering for each other during shorter periods (Deloitte 2022, 31).

City of Bergen has introduced several measures addressing its GP service. One of the measures, which appears to be the most positively received by the respondents of Deloitte's questionnaire, is the municipal buy-out guarantee for newly established GPs who are unable to sell their practice (Deloitte 2022, 53). Another well-received measure is securing minimum income for freshly started GPs until they have their lists filled, where the municipality will guarantee the income of a list equivalent of 700 citizens. Many young physicians consider it a high risk to take over a list of patients. These measures are hoped to lower the threshold for new

doctors to start a practice (Deloitte 2022, 47, 53). Other measures include compensating costs involved with sick leave for child, granting list reduction for GPs expressing such desire, and increasing the hourly rate for supervising doctors undergoing GP specialization (Deloitte 2022, 53).

The Deloitte report also commends City of Bergen for having implemented various administrative measures in its FLO office, but these appear, from Deloitte's point of view, as flawed and lacking capacity (2022, 40). The municipality has also created a GP Committee (Allmennlegeutvalget) in order to facilitate better cooperation between the municipality and its GPs, where Deloitte notes that few GPs choose to attend in spite of attendance being required (2022, 41, 58).

# 3. Theoretical Framework

In spite of the inductive, grounded approach utilized in the data collection and analysis of this thesis, it is nonetheless important to acknowledge and consider the influence of established theories. In this chapter, I will, therefore, include and discuss theoretical perspectives that were found of relevance to the research question, which will be revisited and discussed in the later stages of the thesis. We will begin with Lindbeck & Snower's (1989) classic, "Insider-Outsider Theory." We will then move on to "Historical Institutionalism," an overarching theoretical umbrella, where we will focus specifically on "Critical Juncture Theory." The last theory that will be addressed is Rittel & Webber's (1973) classic, "Wicked Problem Theory."

## 3.1. Insider-Outsider Theory

Lindbeck & Snower's (1989) theoretical work on "insiders" and "outsiders" within the labor market seeks to explain the power dynamics between the employed and unemployed. Their findings may be of relevance as they might serve as a foundation to better understand the Norwegian state's apparent reluctance to liberalize its framework of authorizing foreign-educated physicians.

The term "*insiders*" is to be understood as employees who have been working for a relatively long time. Throughout their employment, they have built up substantial working experience, which is believed to provide them with leverage that provides them with job security. The term "*outsiders*," on the contrary, refers to those who are either unemployed or whose job situation is characterized by job precariousness, often working in the "informal

sector" (Lindbeck & Snower 1989, 1; Rueda 2005, 61). Lindbeck & Snower argue that insiders, for the following reasons, have more clout in their working relationships and negotiations with their employers, which hinders outsiders from employment (1989, 1).

First and foremost, recruitment and initiation periods are costly processes that may deter managers from replacing their existing staff, in spite of the outsiders being willing to underbid them in terms of compensation. The insiders may also gain job security through employment protection legislation that establishes legal hurdles. Another point relates to union membership, which bears strong influence in terms of negotiations on wages and working conditions, as well as the threat of collective action through strikes (Lindbeck & Snower 1989, 1-2). In this way, Lindbeck & Snower argue the insiders heighten the stakes by creating what they refer to as "labor turnover costs" (1989, 3). Another common argument holds that work effort falls when a reduction in job security takes hold. The argument goes that much of the working effort amongst the employees of an organization comes due to expected rewards through future remunerations, such as promotions or raises. If the employers, then, were to replace high-wage insiders by underbidding low-wage outsiders. This could then, in turn, potentially damage the working morality and effort of their workforce, thus outweighing the saving labor costs and further raising the turnover costs (Lindbeck & Snower 1989, 119).

### 3.1.1. Unions and Migrant Rights

Lindbeck & Snower stresses that their contribution to the insider-outsider theory should not be understood primarily as a means of analyzing union behavior, as hiring-and-firing costs may also be present without union intervention (1989, 9). Still, the authors argue their contribution to the field plays a significant role, as it provides a more nuanced understanding of union behavior, strategy, and motivation within the labor market. A prevalent example of this is unions' "clout," provided by threat credibility, and the magnitude of labor turnover costs (Lindbeck & Snower 1989, 10). So how may this theoretical framework translate into unions in relation to migrant rights?

Common belief has it that labor unions tend to resist immigration as it may threaten the native workforce (Boräng, Kalm & Lindvall 2020, 558). The argument holds that immigration may provide an excess supply of labor that has the potential to push down wages. Especially if these workers are not unionized. In that sense, one could say that unions facing such situations are prone to exclusionary behavior, as well as pushing forward restrictive labor market policies on immigration (Boräng, Kalm & Lindvall (2020, 558). Boräng, Kalm & Lindvall, on the contrary, argue that unions' exclusionary reputation towards immigration stems from the fact

that most of the existing research on this relationship builds on small samples and/or shorter timespans (2020, 558). This, in turn, may paint a premature representation of the actual association between these stakeholders. By studying long-term historical data from the Global North (including Norway), Boräng, Kalm & Lindvall (2020) make some compelling findings that challenge this conception.

The results of Boräng, Kalm & Lindvall's statistical analysis shows the relationship between unions and the social and economic rights of migrants is both dynamic and context-bound, suggesting that unions are neither inherently exclusionary nor inclusionary toward immigration (2020, 558). To better understand the dynamics at play, the authors present a theoretical model that, over time, compares the social and economic rights of natives and migrants between countries with high union density to countries with low union density (Boräng, Kalm & Lindvall 2020, 560). Their model assumes that in labor markets with stronger unions, there will initially be a spike in citizens' social and economic rights. Over the short term, migrants' rights in such instances are lagging behind. Over time, however, this group will eventually also experience a significant rise in rights. Boräng, Kalm & Lindvall explains this phenomenon by suggesting that labor unions, first, will prioritize securing basic social and economic rights for the workers constituting their membership base (2020, 599). However, once such prevalent rights are secured, more attention will be drawn to migrants to prevent unfair treatment, discrimination, and unfair competition. Putting this into perspective, the graph indicates that, in instances of weak unions, the rights of citizens do not experience many developments. As the citizens' basic social and economic needs are not met, not much attention is subsequently given to the rights of migrants (Boräng, Kalm & Lindvall (2020, 599).

## 3.2. Historical Institutionalism

Why do some countries transition to democracy, whilst others remain with hybrid or authoritarian regimes? How do social regimes and welfare states develop, and why do certain economic regimes emerge? Historical institutionalism involves the study of how organizational and institutional configurations are formed and change over time. Social scientists of this tradition attempt to identify how long-term processes shape specific political outcomes, with a particular focus on historical events that caused these developments to happen in the first place. This methodology stands in stark contrast to alternative approaches that examine specific settings independently (Pierson & Skocpol 2002, 693).

According to a historical institutionalist, the room for significant institutional change is low during periods of normality, referred to as a state of equilibrium. This equilibrium then is theorized to remain until the occurrence of a *critical juncture* (Steinmo 2012, 129). A critical juncture is defined as a relatively short period, often caused by greater exogenous or endogenous shock, that causes a severe break in this normality. During such periods, the institutional restraints on political action are significantly relaxed, making it receptible to more dramatic political change (Capoccia & Kelemen 2007, 342-343; Steinmo 2012, 129). Such structural shocks may be of the economic, cultural, ideological, or organizational kind. Examples of shocks of this magnitude are economic crises, revolutions, wars, etc. (Capoccia & Kelemen 2007, 343; Steinmo 2012, 123).

The argument is that when normality and the state of equilibrium eventually return, so do also the "powerful inertial "stickiness" that characterizes many aspects of political development" (Pierson & Skocpol 2002, 700). In other words, as the window of opportunity is closing, one risks that the dramatic political changes made during the shock get cemented or "institutionalized."

As the state "departs" from its original course, a critical juncture may trigger feedback mechanisms that reinforce the continuation of a political path into the future (Ebbinghaus 2005, 16; Pierson & Skocpol 2002, 699). As this pattern gradually receives societal acceptance, it gets institutionalized (Ebbinghaus 2005, 15). The general idea is that once a political actor has set on to such a path, it may be challenging to reverse the course, leading to what is known as *path dependency* (Pierson & Skocpol 2002, 699-700). This, in turn, may result in unforeseen consequences as the path "locks in," leading to irreversibility (Ebbinghaus 2005, 10). Initially modest liberalizing reforms, like the Soviet Union experienced in the 70s and 80s, may end up getting institutionalized, unintendedly spiraling into more serious democratic reforms. Conversely, a policy of serious crackdown on immigration in the aftermath of an economic crisis may be hard to reverse once a labor shortage emerges. A similarity in both of these examples is that departing from a path may be difficult as the path has become deeply embedded in public opinion, organizations, and institutions (Pierson & Skocpol 2002, 700). Pierson & Skocpol argues that such political processes may lead to *threshold effects*. As these paths often initially bear little significance and appear relatively modest, as time passes, they gain a critical mass, which eventually may trigger major political change (Pierson & Skocpol 2002, 703). For instance, the overthrowing of an authoritarian regime or a labor market crisis.

## 3.3. Wicked Problem Theory

A daily part of legislators' and government organizations' work is related to high-volume problem-solving. This entails a fairly standardized procedure of identifying a problem, comparing possible responses and risk analysis, adopting a solution with the relevant institution, and, lastly, evaluating the implementation (Head & Alford 2013, 711-712). If we apply this framework to the ongoing GP crisis and the theme of this thesis, we see that the Government acknowledged a problem with recruitment in the 2023 proposed annual budget (Regjeringen 2022). Here, it appears an evaluation has taken place, resulting in significant funding for mid-to-long-term solutions. However, there appears to be a lack of shorter-termed initiatives for instant relief. Why are no further measures taken to re-evaluate the current state of the practice of authorizing EU-educated physicians? This brings us to the theory of 'Wicked Problems.'

Some of the problems that legislators and government organizations encounter are of such an inherently complex nature that they may be deemed incomprehensible and resistant to solutions. Better-known examples include climate change response, natural resource management, and cybernetics (e.g., artificial intelligence). However, in some instances, also healthcare policies can be understood in terms of 'wicked problems' (Head & Alford 2013, 716). The term emerged in the 70s when several disciplines were discussing the implications of complex policy problems and the unforeseen consequences of policy intervention in more uncertain areas (Head & Alford 2013, 712). The general idea was that modern society had evolved to become more pluralistic rather than homogenous. This was also true for the problems legislators and government organizations now had to grapple with. As the current state of societies progressed, economic problems and social problems could no longer be understood and addressed in isolation. For scientific analysis, gathering more information alone was not sufficient to comprehend the major problems our society faces today. A top-down approach was, therefore, less amendable now, and problems could no longer be resolved through "engineering." This was seen as a radical reversal of traditional expert-driven rational comprehensive planning in solving problems (Head & Alford 2013, 713). Wicked problems are generally understood as matters that concern multiple stakeholders with varying interests, institutional complexity, and areas characterized by fragmentation and gaps in reliable knowledge (Head & Alford 2013, 716). Negotiations and consensus of shared understandings of such problems between the involved stakeholders are, therefore, just as important for both its definition and possible solutions (Head & Alford 2013, 718).

In this part, I will begin by presenting Rittel & Webber's (1973) primary characteristics of 'wicked problems' and a framework for measurement. Thereafter, I will set forth Head & Alford's (2013) compelling discussion on the implications of 'wicked problems' and understanding it in relation to New Public Management (NPM). I will then proceed with putting forward the authors' proposed strategy for "solving" 'wicked problems.'

#### *3.3.1.1. Characteristics and Measuring*

In Rittel & Webber's (1973) article, "Dilemmas in a General Theory of Planning," the authors provide a ten-point list of characteristics that can be used to identify 'wicked problems.' This article has since proved influential and is also used in Head & Alford's discussion (2013, 713).

According to Rittel & Webber (1973), 'wicked problems' are characterized by the following ten features:

1. *There is no definitive formulation of a wicked problem*
2. *Wicked problems have no "stopping rule" (i.e., no definitive solution)*
3. *Solutions to wicked problems are not true or false, but good or bad*
4. *There is no immediate and no ultimate test of a solution to a wicked problem*
5. *Every (attempted) solution to a wicked problem is a "one-shot operation"; the results cannot be readily undone, and there is no opportunity to learn by trial and error*
6. *Wicked problems do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan*
7. *Every wicked problem is essentially unique*
8. *Every wicked problem can be considered to be a symptom of another problem*
9. *The existence of a discrepancy representing a wicked problem can be explained in numerous ways*
10. *The planner has no "right to be wrong" (i.e., there is no public tolerance of experiments that fail)*

(Rittel & Webber 1973, 161-167 in Head & Alford 2013, 714).

At its simplest, it could be argued that the short-term lack of GPs in the FLO may simply be relieved by liberalizing the legislation and practice for authorization. However, it is first, when considering it in light of Rittel & Webber's (1973) ten characteristics, that one may start to grapple with the mere complexity such a reform would entail. Especially point 5 and 10, which state that attempted solutions are a "one-shot operation," the consequences cannot be readily

undone, there is no opportunity to learn by trial and error, and there is no public tolerance of experiments that fail (Rittel & Webber 1973, 163, 166). Both the Directorate of Health and the FLO represent fundamentally trust-based institutions. The various modernizing reforms throughout the last two decades have only exacerbated this situation. The newly delegated responsibilities make it so the GPs presently can be considered the "doorkeepers" of the specialized healthcare service (Berg-Olsen & Sørensen 2021, 36; Schøyen 2021, 253). In other words, the breach of trust through a scandal resulting from an attempted reform would be potentially devastating to the Directorate of Health's reputation. As Head & Alford rhetorically asks: "If [wicked problems] are virtually impossible to comprehend and any solution throws up more problems, then why bother?" (2013, 732).

The 7th point of Rittel & Webber's list of characteristics states that "Every wicked problem is essentially unique" (1973, 164). This also implies they will vary in complexity, or 'wickedness' (Head & Alford 2013, 712). Head & Alford, therefore, presents a scale where problems in the first end are considered Type 1, "tamer," whereas the other end is considered Type 3, "simply wicked" (2013, 716-717). A problem is considered Type 1 if both the definition and solution are clear for the decision-maker. In contrast, a problem is considered Type 3 if it is both ill-defined and the solution is unclear. A Type 1 problem might be a deteriorating road that needs renovation. The problem is quite clearly defined, and the Ministry of Transport knows which contractor to contact in order to resolve the issue. Regulating Artificial Intelligence, on the other hand, presents a far more complex problem, a Type 3. Riddled with diverse perspectives and uncertainty, it has engaged multiple stakeholders. What is the threshold for something being considered 'intelligent' both morally and technically? And, maybe even more complex of a matter, how may it be regulated? If we try to fit the problem of authorization of GPs with EU diplomas into this scale, we will find that it fits into neither of these extremes. Head & Alford, therefore, proposes Type 2, where the definition of the problem is clear, but the solution is not (2013, 716-717).

### 3.3.2. New Public Management and Wicked Problems

New Public Management (NPM) may be interpreted as a method and thought where traditionally market-oriented principles are implemented into public administration. By introducing elements of competition and business-like methodologies, such reforms aim at enhancing public administration (Jensen 2013, 32-33). In this manner, NPM is intended to overcome some of the flaws of traditional public administration through measures such as cost control, professionalizing the management, clear goals, and benchmarking (Head & Alford

2013, 719; Jensen 2013, 33). In the healthcare sector, NPM reforms often entail privatization and exposing areas of operations to competition, re-structuring the public health organization into state-owned enterprises managed through market-oriented economic principles and accounting, and introducing result benchmarking and reporting to name a few (Jensen 2013, 36).

The increased competition seeks to create a more service-oriented mindset where the customers – the patients – are in focus (Christensen et al. 2014, 203). Such frameworks can, for instance, be promoted through incentivizing measures such as per-unit-financing, in which the patients themselves more freely can decide on the hospital, whether private or public, of which they wish to receive treatment (Veggeland 2013a, 14). Moreover, by introducing more professional management and result-centered benchmarking and reporting, NPM reforms aim to cut costs and promote fiscal discipline through a system of rewards and sanctions (Christensen et al. 2014, 203). These are what Head & Alford refers to as *managerialism* and *contractualism* (2013, 719).

*Managerialism* in NPM is characterized by results management (Head & Alford 2013, 719). This involves orienting senior-level staffing towards general managerial skills before professional or technical field knowledge. As part of the effort to improve efficiency, the public-sector management in question will place a heavier focus on performance through coordination mechanisms, organizational structure, fiscal management, and rewarding results. *Contractualism* in NPM refers to the introduction of competition between service providers, also with a goal of driving efficiency and effectiveness (Head & Alford 2013, 720).

Head & Alford argues that managerialism and contractualism in NPM explain the system's inability to deal with wicked problems (2015, 719). First, this type of managerialism assumes that public organizations have established objectives, operate in a politically supportive environment, and have control over the resources and capabilities necessary to achieve them (Head & Alford 2013, 720). In the presence of wicked problems, however, these strengths may not be as applicable. Second, the authors argue that managerialism causes fragmentation of knowledge, which is further exacerbated by contractualism. The extent to which corporate management tends to hold managers responsible for a specific set of programs may result in a situation where programs that are normally deeply interconnected with respect to certain wicked problems are isolated from each other. Head & Alford argues this fragmentation, in turn, may spread tensions between program-based subcultures and conflicting policy priorities, which, in the end, spark conflicts within and between public agencies (2013,

720). This fragmentation is then believed to be further exacerbated through contractualism, where competition may undermine these agencies' willingness to cooperate and share important information and ultimately withhold insights relating to wicked problems (Head & Alford 2013, 721).

#### *3.3.2.1. Strategies for Dealing with Wicked Problems*

To tackle wicked problems, Head & Alford argues the government must accept the realities that wicked problems present (2013, 722). They are characterized by their complexity. The problems themselves are often ill-defined, and the potential outcomes involve much uncertainty. Moreover, there may be conflicts and disagreements among the multiple stakeholders involved, who often have different biases, neither necessarily being "right" or "wrong." The two theorists, therefore, argue that the start of any solution must entail acknowledging that calls for more research and more science are not a sufficient response in itself. Other measures are required.

Head & Alford brings Schon & Rein's (1994) approach of "frame reflection" into their discussion (2013, 723). This logic also regards wicked problems (referred to as "endemic problems") in social policies as not amendable through regulation or further research. Instead, it regards that the various involved stakeholders' disputes instead should be regarded as "different "frames" and value perspectives, rather than in disagreements about scientifically verified knowledge" (Head & Alford 2013, 723). The search for a solution should, therefore, be rooted in negotiation between the involved actors' concerns (or "frames") in order to reach a common understanding of both the problem and possible solutions.

In other words, a proposed solution must be built upon collaboration and coordination. Collaboration to establish a dialogue between the different frames and coordination to overcome managerialism. How may such a framework work in practice? Head & Alford draws attention to an initiative modeled in the Dutch civil service (2013, 731). Here, two program ministries were established in 2007 with the hope of achieving "horizontally and vertically coordinated thinking and action" (Karré, Van der Steen & Van der Twist 2013, 63). The ministries were responsible for broad outcomes, one of them being the integration of immigrants into society. In order to fulfill these responsibilities, the program ministries were required to tap the capabilities and human resources of other ministries. This was practically feasible thanks to generous "pool budgets" (Karré, Van der Steen & Van Twist 2013 in Head & Alford 2013, 731-732). The Dutch example is interesting, as it displays how the problem of accountability in NPM managerialism and collaboration may be overcome through devolving

responsibility to a third party, such as program ministries. A generous pool budget for this initiative will, furthermore, relieve the financial burden and results-driven focus from the actors involved, which is argued to prevent them from tackling wicked problems.

# 4. Methodological Framework

In this chapter, I will present the methodological framework of the thesis. The chapter will start with an explanation and arguments for the choice of 'qualitative single case study' as the thesis' overarching methodological approach. I will then proceed with explaining the choice of 'semi-structured interviewing' as the main method of data collection and 'qualitative content analysis with coding' as the method of data analysis. Subsequently, I will present the research process of the data collection. The chapter will then conclude with some reflections on ethical considerations, validity, and reliability.

## 4.1. Overarching Methodological Approach

Social science research involves the systematic application of methodological approaches to gathering empirical evidence of relationships within and between societies. This evidence can then be analyzed to gain insights onto patterns (Grønmo 2017, 18). The specific methodological approach that should be utilized for a study depends on both the aim of the study, as well as the sort of data that is available. The first distinction is typically whether one should apply a *qualitative* or *quantitative* methodology. Gerring (2012, 362) defines quantitative methodologies as "any inference based on large numbers of dataset observation, that is, statistical analysis," and qualitative methodologies as "inferences based primarily on a few dataset observations (insufficient to form the basis for statistical analysis and/or lots of causal-process observations)."

As Gerring's (2012) definition indicates, the two groups of methodologies have both strengths and weaknesses associated with them. Gerring states that "size matters, for it means that more evidence is available to test a given hypothesis" (2012, 365). This refers to the concept of *statistical generalization*, where we can analyze large-N data to test hypotheses or theories. Large-N refers to a large, randomized number of respondents or observations, which is thought to represent the universe that is being studied (Grønmo 2017, 101). However, statistical generalizations require that certain criteria are met. First, that there are enough respondents or observations for the data to satisfy as a genuine representation of the universe (George &

Bennett 2005, 17; Grønmo 2017, 101). Second, that the data is quantifiable so it can be analyzed through statistical operations (Grønmo 2017, 137).

As was apparent in the literature review, there is a lack of academic research on the Norwegian GP crisis and, therefore, also data. In addition, since I aim with my thesis to understand stakeholder perspectives on the Norwegian GP crisis, as well as identifying what they perceive as the best solutions, a qualitative methodological approach is more suitable.

Qualitative methods lack the quantitative strengths of statistical generalization in favor of greater in-depth knowledge about the theme in consideration. As there are strict requirements for statistical samples, a researcher utilizing qualitative methodologies gains more flexibility on which participants are most relevant for a particular study, both from a theoretical and analytical point of view. The strength of qualitative methods, therefore, is *theoretical generalization*, where the researcher aims to develop or expand on concepts, hypotheses, and theories that, from a theoretical point of view, are assumed to apply to a given universe (Grønmo 2017, 102-103). This can be achieved through *inductive* research designs, which utilize "bottom-up" approaches where the empirical analysis starts on a lower level, from where the researcher can generate theories and hypotheses that can be applied at a higher level (Moses & Knutsen 2012, 22).

### 4.1.1. Single-Case Study

The specific method that I will apply in this thesis is a qualitative single-case study. Lewis & Nicholls define case studies as the "exploration of multiple perspectives which are rooted in a specific context," where data on these perspectives may be derived through various data collection methods and accounts (2014, 66). Case studies' integration of various perspectives is argued to contribute to building an in-depth understanding of the subject in consideration (Lewis & Nicholls 2014, 65). This corresponds well with the thesis' research question, investigating the perceptions of various stakeholders on the Norwegian GP crisis.

George & Bennett commend case studies as a technique for their potential to achieve high conceptual validity, ability to foster new hypotheses, and capacity to explore causal complexity (2005, 19). The researchers argue that, despite statistical methods' potential to identify deviant cases that may lead to new hypotheses, quantitative methodology lacks definitive ways of identifying new hypotheses. This argument is then exemplified by the use of data mining, where the researchers still are limited by those variables they already thought to

code in a database (George & Bennett 2005, 21). George & Bennett believe this exemplifies a clear strength of case studies:

> *"When a case study researcher asks a participant "were you thinking X when you did Y," and gets the answer, "No, I was thinking Z," then if the researcher had not thought of Z as a causally relevant variable, she may have a new variable demanding to be heard"* (George & Bennett 2005, 20).

Here, the researchers display the strengths of case studies and qualitative methodologies more generally in generating new hypotheses and theoretical generalizations. However, George & Bennett (2005) also recognize that case studies as a methodological approach involve important trade-offs and limitations that the researcher should be aware of (George & Bennett 2005, 22).

The first involves *Selection bias*, which refers to a bias in the assignment of representatives of a study that can happen when a sample is not sufficiently randomized. As the sample risks not fully representing the population in the study, it can compromise the results and provide incorrect conclusions (Gerring 2012, 249). George & Bennett acknowledges that problems of selection bias also are prevalent in qualitative research, but not in the same way as for statistical research (2005, 23-24). Instead, in qualitative case studies, researchers run the risk of letting their foreknowledge of the values of variables, or cognitive biases on hypotheses, influence their selection of case studies and the selection of informants. In the worst case, the researcher can, on such remarks, find misleading confirmation of a theory that either does not hold at all or only holds for one specific case (George & Bennett 2005, 24).

Another linked issue concerns the lack of representativeness in case studies. Researchers conducting case studies should avoid making claims that their chosen cases represent a population, as the goal is to generate in-depth knowledge on one particular phenomenon rather than to generalize findings to a broader population (George & Bennett 2005, 30-31).

George & Bennett argues that the abovementioned critiques have accumulated in a skepticism that is especially directed towards single-case studies. Critics are more specifically concerned about how such research designs might lead to ill-founded conclusions as a result of errors in measurement, as there is no variation in the dependent variable (George & Bennett 2005, 32). The authors' counterargument is that such research designs are useful for theory development and testing by comparing multiple observations within a single case. George & Bennett maintains there exist various influential studies within comparative politics utilizing such research designs that have yielded great results (2005, 33).

## 4.2. Analytical Method

The analytical method that will be applied in this study follows one of the most influential methodologies utilized in qualitative social science, *Grounded Theory*. Aiming to produce theories that seek to explain social processes or actions, researchers following this methodological approach study the data collected from participants who have firsthand experience with such phenomena (Ormston et al. 2014, 14).

Identifying analytical categories and their dimensions, as well as the relationship between them, is at the core of Grounded Theory (Ormston et al. 2014, 14). This can be achieved through what is commonly referred to as a *qualitative content analysis*. Here, the researcher systematically analyzes both the content and the contexts of the data with the aim of identifying underlying themes. The researcher will, in this process, focus on how these themes are treated or presented throughout the data material, as well as their frequencies (Spencer et al. 2014, 271). This is a helpful approach to gaining an overview of stories, arguments, and positions that are prevalent within the data material (Grønmo 2017, 142). This involves a continuous process of data collection and conceptualization until the researcher reaches a desired point of 'saturation.' This refers to the point where the researcher has collected enough data and knowledge to understand the main themes and patterns relevant to the study, where further data collection is expected not to change the fundamental understanding of the theory in development (Spencer et al. 2014, 271).

### 4.2.1. Limitations and Challenges

Critics of the use of Grounded Theory in social science raise several concerns similar to the abovementioned critiques on case studies and qualitative methodologies more generally. Commonly raised concerns involve subjectivity in the analytical process, ambiguity in the guidelines, and challenges in determining theoretical saturation.

Berger (2015) raises various concerns about subjectivity in qualitative research and, more specifically, how research can be exposed to reflexivity. Berger contends that this, first, may happen when the researcher also has experienced the phenomena as the participants being studied: "Bringing the researcher into the researched carries the danger of researcher's self-involvement to the degree that it blocks hearing other voices" (2015, 224). Here, the researcher may run the risk of "pushing" the informant's stories in certain directions and imposing their own perspectives rather than letting them tell their stories.

Berger also highlights a second scenario where the researcher transitions from an outsider's role to that of an insider throughout the study (2015, 226). This may, in turn, influence the narratives told by the study participants. In my study's case, for instance, there could be an issue if the Ministry of Health caught interest in my thesis and asked if I would write it on their behalf. Berger's final concern addresses potential pitfalls when a researcher has no personal familiarity or experience within the area under investigation (2015, 227). This may, for instance, limit the researcher's ability to truly understand the experiences involved in being in the same situations as the informants have experienced.

Dey (1999, 14) problematizes ambiguities in the guidelines, as well as challenges in determining theoretical saturation, as examples of current issues in Grounded Theory. Furthermore, Dey discusses the debates on Grounded Theory as an alternative approach to deductive forms of theorizing and the issue of "rigid rules" in understanding the values of the method (1999, 14, 16). Dey asks: "How much scope does grounded theory allow for adopting preconceived conceptual frameworks for an aid of analysis?" and claims it is a paradox that the methodology based on "interpretation" in the debates proves to be "too hard to interpret" (1999, 23). I agree with these reflections and would argue that a degree of theoretical deduction is necessary in order to maintain coherence in the research. In this sense, a balance between inductive and deductive approaches can provide a more comprehensive understanding of the phenomenon under study while also accommodating the flexibility and adaptability that Grounded Theory offers.

## 4.3. Data

### 4.3.1. Interviewing as a Research Method

Yeo et al. describe in-depth interviewing as an integral part of qualitative research methodology and a powerful tool to generate descriptive knowledge and insight into people's social worlds (2014, 178). Influential ethnographers, such as Malinowski, emphasized the importance of engaging with individuals to understand their perspectives (Yeo et al. 2014, 178). In-depth interviews allow scientists to delve into the experiences, motives, and attitudes of people and, in this way, gain insights into worldviews beyond their own.

A common misconception is that in-depth interviews are merely a form of conversation. There are, however, apparent differences, both regarding objectives and the function of the scientist and the respondent (Yeo et al. 2014, 178). In a conversation, the parties involved typically engage in a casual, informal conversation without any clear agenda or goal. In an

interview, however, a researcher aims to gain detailed information on a respondent's experiences, motives, and opinions to better understand her perspectives. The researcher and respondent's roles are hence more clearly defined than in a casual conversation (Yeo et al. 2014, 178-179).

My thesis provides a comprehensive exploration of the Norwegian GP crisis, revealing various new perspectives and nuances. In-depth interviewing is a powerful tool to get insights into the stakeholders' own reflections. Furthermore, by using a semi-structured approach, one can ensure that the informants themselves can lead the conversation toward topics of their own interests and simultaneously ensure the interview covers the main themes (Grønmo 2017, 141).

### 4.3.2. Selection Criteria and Recruitment

In contrast to statistical selection criteria, where the aim is to generate a representative sample of a given universe, qualitative research utilizing strategic selection enjoys significantly more flexibility. Strategic selection does not rely on the randomization principle. Instead, the researcher systematically assesses what units are most relevant and interesting from a theoretical point of view, as the goal is a theoretical generalization (Grønmo 2017, 103).

When establishing my core selection criteria for informants, I chose to follow the Multilevel Interaction Model of the Coordination Reform and drew inspiration from a similar model presented by Veggeland (2013b, 86). Figure 2, presented in section 1.3, displays the chains of responsibility in Norwegian healthcare following the Coordination Reform of 2012. This reform will be presented in detail in Chapter 5.1.4. In brief, the Coordination Reform aimed to improve cooperation between various levels within the healthcare service by focusing on the 'Best Effective Care Level' and redefining the responsibilities of municipalities and specialized health services while emphasizing the role of the GP Service in coordinating care (Veggeland 2013b, 85-86). These organizations are all stakeholders reliant on the National GP Service, and vice versa. My selection criteria are, for this reason, representatives of these actors and other parties involved with them. I have, therefore, also included representatives of labor and interest associations, members of parliament, and temporary staffing agencies.

I have employed diverse and creative recruitment strategies to secure informants from each of these actors, ensuring representation of the various perspectives. These strategies range from contacting these organizations directly through email, connecting with relevant individuals through LinkedIn, sending emails to individuals who had engaged in media conversations, suggestions from my supervisor, and contact through mutual connections. In some cases, the informants themselves have suggested who I should get in contact with. This

is another positive of Strategic Selection Criteria, as it enables the researcher flexibility, not only in the method of recruitment but also in allowing informants to be identified throughout the data collection process rather than being predetermined (Grønmo 2017, 113).

When contacting potential informants, I provided a brief presentation of my thesis, why I considered them relevant actors and the main themes and talking points that an interview would cover. When I received a positive response, I scheduled an interview and provided them with a formal information letter, together with a form of informed consent (Appendix 1). It was relatively easy to get in touch with interested informants who were eager to share their views on the GP crisis. Often, the representatives I got in touch with were individuals holding senior positions. The list of informants is as follows:

| Name or Pseudonym | Affiliation | Position | Type of interview |
|---|---|---|---|
| Thore Simonsen Jakobsen | Flåten Doctor's Office, Bjørnafjorden Municipality | FLO GP | Physical |
| Anna Handal Hellesnes | Association of Norwegian Students Abroad (ANSA) | President | Teams |
| Harald Gunnar Sunde | Finnmarkssykehuset HF | Medical Director | Teams |
| Hilde Brit Christiansen | Helse Vest RHF | Director of Workforce Management and Technology | Teams |
| Merethe Brattetaule | Primary Care Unit, City of Bergen | Leader | Physical |
| Erlend Sæther | Norwegian Medical Student's Association (NMF) | Leader | Teams |
| Iren Mari Luther | Division for Health and Social Care, Fagforbundet, LO | Leader | Teams |
| Bård Hoksrud | Progress Party (FrP) | MP | Teams |
| Ståle Christian Ofte | Dr. Dropin | GP and Clinic Manager | Teams |
| "Julie" (Anonymous) | Directorate of Health | Employee | Teams |

The inductive approach utilized in this study significantly contributed to the analysis, helping me uncover areas that might not have been adequately addressed previously in relation to the GP crisis. However, despite multiple attempts to contact MPs in the Health and Social Parliamentary Committee from both the governing Labor Party and the main opposition Conservative Party, I was not able to recruit any additional parliamentary informants. I was also unsuccessful in getting a response from KS (Association of Local and Regional Authorities). In addition to these, an interview with the Ministry of Healthcare could not be conducted. They

indicated a preference for providing formal written statements through designated spokespersons rather than engaging in individual conversations about the various themes of this thesis.

While the absence of direct input from the Labor and Conservative party, KS, and the Ministry represents a limitation in the study, the list of informants for this study remains comprehensive, covering multiple levels of authority within the Norwegian healthcare system. This ensures a rich and diverse understanding of the Norwegian GP Crisis from those working directly in the field and those involved in administrative and policy roles.

### 4.3.3. Interview Guide Design

The goal of an in-depth interview is to achieve width and depth in our understanding surrounding the topic under investigation. Yeo et al. (2014, 190) describe it analogically in terms of "cartography," where the interviewer's role is to survey unchartered islands. That is, the respondent's world or experience of phenomena.

In-depth interviews fundamentally revolve around open-ended questions, contrasting with the simplicity of dichotomous and closed questions, prompting yes/no or single-word responses (Yeo et al. 2014, 191). This permits the researcher to better understand the world from the respondent's point of view without predetermining the possible response outcomes through narrow questions (Patton 2002, 21). Dichotomous and closed questions can, however, regardless, be useful tools to pin down specific details that are important to understand the respondent's accounts. E.g., their age, location, date, or time during specific events (Yeo et al. 2014, 191). This can, then, be followed up with detail-oriented probes, such as "who," "where," "what," "when," and "how" questions, to establish a better understanding of certain experiences (Patton 2002, 372-373).

There are potential pitfalls in the interview guide that the researcher should be aware of. The first is that one should avoid asking leading questions as they can unduly influence the answer. This can be avoided by asking neutralized, open and non-judgmental questions (Yeo et al. 2014, 191-192). Second, one should be aware of how previous responses may impact our behavior, which can influence the answers. E.g., laughter, facial expressions like skepticism, etc. (Yeo et al. 2014, 192). Third, although providing background information to justify certain questions at times may be necessary to clarify their relevance, the researcher should explain this in simple terms so that the question itself does not get obscured (Yeo et al. 2014, 192). Finally, it is important that the language of the interviewer is at the same level as the respondent.

This means that the researcher should not talk in a bureaucratic or academic language if the respondent answers in casual language. This is important to facilitate mutual respect and avoid a condescending tone (Yeo et al. 2014, 193).

Most of the interviews are structured in the four main themes based upon the literature review and topics brought up in relation to the GP crisis in the media. These are "Issues with recruitment," "Bottlenecks in LIS1 and Universities," "EU/EEA Medical Authorization," and "Temporary Employment Agencies." Before starting with the first theme, I ask an open-ended question to establish their view on the cause of the GP crisis and with a follow-up question on the solutions they deem necessary. These first two questions make it possible to already early on discussing any new talking points that they bring to attention. I have then proposed various questions under each of the themes to keep the conversation going. However, since this is a semi-structured interview, the order of these questions is not pre-set, and some can be skipped if the conversations are drawn in other directions. I have tailored the interview guides for each interview, and one translated version can be found in "Appendix 2," since the interviews themselves were held in Norwegian.

### 4.3.4. Transcription and Empirical Data Analysis

The audio recordings of the interviews were made through the in-built Voice Memo app on my iPhone for the in-person interviews and the video-recording function in Microsoft Teams for the online interviews. I then proceeded with manually transcribing the interviews

Since the interviews averaged around 40 minutes, I accumulated a large amount of text material, around 13 pages for each interview. In order to facilitate a proper qualitative content analysis of these vast materials, I opted to use the leading qualitative data analysis software, NVivo 12 (Edhlund & McDougall 2016, 11). Software programs can help the researcher bring more systematic approaches to their qualitative analysis (Tjora 2021, 253). NVivo is a tool to organize and analyze qualitative data from a variety of sources and helps the researcher to bring order and structure to the data (Edhlund & McDougall 2016, 12). This is thanks to its intuitive design that lets the researcher organize quotes from the transcripts into various containers, "nodes," which then can be further divided into sub-containers, "codes" (Edhlund & McDougall 2016, 12-13). As such, NVivo is not an *analysis program* in itself, as it does not perform the actual analysis, like R and STATA. Instead, it works as a tool to help researchers systemize their qualitative data into the main themes (nodes) and their underlying categories (codes) (Woolf & Silver 2017, 2). As such, it is argued that software for analyzing qualitative data may contribute to transparency, accuracy, and trustworthiness in qualitative research. Furthermore,

it enables the researcher to systematically handle relatively extensive datasets and "chaos" in the empirical material (Tjora 2021, 253).

## 4.4. Ethical Considerations

Maintaining good research ethics is a fundamental part of conducting qualitative research. It entails treating the participants with respect and dignity, as well as ensuring their rights throughout the duration of the project (Webster, Lewis & Brown 2014, 78). It is important that the researcher already, from the early stages of the study, establishes a good working relationship with the participants, which is based upon mutual trust and genuine communication. This can additionally help to ensure the participants will be more willing to share their experiences, including any challenges or difficulties, with the researcher (Janesick 1994, 211).

An integral principle in qualitative research, which draws on the abovementioned concerns, is that of *informed consent*. This entails that the informants should be given adequate information for them to be able to effectively decide whether they would like to participate in a given study (Webster, Lewis & Brown 2014, 87). Webster, Lewis & Brown (2014, 87-88) hold that a consent form should effectively communicate the purpose and aims of the study; the individual or organization conducting the study; that participation is voluntary and can be withdrawn at any time; what participation will involve, e.g., an interview; the duration of the study; broadly what topics will be covered; information on confidentiality and anonymity; how these will be maintained; how, and for how long data will be stored; and who will have access to it.

I followed Webster, Lewis & Bryon's (2014) guidelines when structuring the forms of informed consent for this project, and an example can be found in Appendix 1. It follows a standardized and GDPR-compliant formula provided by the Norwegian Agency for Shared Services in the Education and Research Sector (Sikt 2023). The consent forms remained relatively similar for all respondents. The only exception was the part of the section "What does participation involve for you?" where I went into detail on the main themes and examples of questions that will be asked, as this would vary across the interviews concerning their respective backgrounds.

The project is approved by the System of Risk and Compliance, RETTE, under project ID S2214. RETTE is the University of Bergen's (UiB) organ for ensuring oversight and control on the handling of personal data in research projects (UiB 2023a). As the majority of my

respondents held senior positions, I chose not to anonymize all the responses by default. However, all respondents were offered the option to anonymize their responses. Out of the 11 respondents, one opted for anonymization. Furthermore, all respondents were made aware in the consent form that they could, at any point in the project, opt for anonymization, as well as modify or withdraw their statements.

I followed UiB's guide for data storage in the handling of the audio recordings and transcripts (2023b). The recordings and transcripts were stored in UiB's organizational OneDrive under the category "yellow" to restrict the data from unauthorized readers. Extra steps of protection were made for the anonymized respondent from the Directorate of Health, where the respondent's name was replaced by a pseudonym. This transcription was saved under the category "red," which means that only I had access to the transcription through two-factor verification. When I provided a copy of the transcription to the respondent, as well as when I analyzed the transcripts in NVivo, I used password encryption on the documents and files. The Teams recordings are automatically saved with restricted access in UiB's cloud.

## 4.5. Validity and Reliability

In different ways, the concepts of validity and reliability refer to the robustness and credibility of research evidence. Furthermore, the concepts can address whether the evidence can be used to make broader statements about a given universe or phenomena, a process known as 'inference.' *Reliability* concerns the replicability of research findings, whereas validity addresses to what extent the findings give an accurate representation of the population or phenomena being studied (Lewis et al. 2014, 354).

### 4.5.1. Reliability

With regard to reliability, scholars have, on numerous accounts, questioned if replication is possible in qualitative research. Due to the usually complex phenomena that are studied using qualitative methods, it is often argued that it is impossible to attempt replication. Especially given the unavoidable impact on the context in which the research was conducted and the degree to which that could impact the results (Lewis et al. 2014, 355). I find these concerns to accurately reflect the reservations I have regarding the generalizability of my research findings. My study reflects an ongoing political issue. Significant political developments have occurred throughout the duration of the study, and it is safe to assume that further evolvements will occur in the near future. It is, therefore, unreasonable to attempt to replicate these findings. It is for

similar reasons that pursuing reliability in qualitative research at times is completely avoided (Lewis et al. 2014, 355).

### 4.5.2. Validity

Validity involves the correctness or precision of the research evidence. To better understand these aspects of validity, it is helpful to consider two key dimensions, 'internal' and 'external' validity. *Internal validity* concerns whether the study is conducted in a proper manner where the conclusions drawn can be said to accurately capture and represent the people or phenomena being investigated (Lewis et al. 2014, 356; Grønmo 2017, 254-255). External validity, on the other hand, refers to the degree to which the generalizations drawn on the results could be extended to the broader population or other settings (Lewis et al. 2014, 355).

With regard to external validity, it is important to stress that transferability is not an all-or-nothing concept. Lewis et al. (2014, 357) argue that there is no point in drawing wider inferences from one's findings if we are not already confident that the concepts and relationships described in the findings are fully grounded in the data. External validity encompasses several dimensions. For instance, it may refer to the extent to which the respondents' statements can be said to represent their respective organizations or whether the study's findings could be said to represent other countries experiencing an acute GP shortage. My aim with the interviews has been for the respondents to present their personal reflections and experiences rather than necessarily explicitly representing the view of their employers. They are individuals that only represent themselves, which may not necessarily reflect the views of their colleagues. As far as broader generalizability goes, the findings presented in this thesis have no foundation in representing other countries. The findings could, however, provide value to research on other countries in similar situations with various clues or hypotheses that could be explored.

In order to secure high internal validity in the research findings, the researcher must prevent the data material from being influenced by either recognizable or potential biases that may lead us to draw ill-founded conclusions (Gerring 2012, 83; Lewis et al. 2014, 357). Steps I have taken, in addition to a considerate structuring of my interview guide, all the transcriptions have been sent and approved by the respective informants. They have been given the opportunity to provide revised versions and provide comments. Additionally, at the later stages of the analysis, I provided all respondents with a copy with marked quotations in order to ensure that their views had been presented in an accurate and fair manner. These additional steps allowed the informants to confirm the authenticity of their statements and interpretations

derived from them. This both ensured the academic integrity of my thesis, as well as strengthening its internal validity.

# 5. Historical Development

Schøyen (2021) describes the Norwegian healthcare system as a "predominantly tax-financed, public system, underpinned by an aspiration of geographical and social equity" (2021, 247). This, Schøyen explains, is a common theme of the Nordic healthcare systems, providing comprehensive and widely accessible welfare services to its citizens, regardless of where one is settled. However, when considering both geographical size and population, the distribution of healthcare resources in Norway appears more strained. In the Netherlands, for example, with a population of 17.5 million and an area of 41 513 $km^2$, there are eight hospitals and ten "top-clinical" supra-regional hospitals. On the other hand, Norway, with its modest population of 5.4 million spread across a long-stretched and challenging territory of 383 186 $km^2$, only has six equivalent university hospitals (Brandstorp 2013, 165; Helse Stavanger HF 2022; World Bank 2021). As a result, no other country with a GP service deploys its general practitioners in multifarious capacities. FLO is viewed as a mere continuation of a long-established practice so the practitioners can cover all functions of the health care service, which historically was deemed necessary in order to effectively cover remote areas (Kristoffersen 2013, 111). It is, therefore, widely viewed as a cornerstone and gatekeeper for the specialized health services, serving as the primary role for referrals (Kristoffersen 2013, 111; Schøyen 2021, 253). Covering a vast territory with the second-lowest population density in Europe after Iceland, understanding the historical development of the Norwegian healthcare system serves as a good starting point for comprehending the country's GP crisis (Eurostat 2022).

### 5.1.1. 1814-1945: From Local Autonomy to State Responsibility

After four centuries as a subordinate member of the Danish (and Swedish, 1397-1523) union, Norway adopted a liberal constitution and established its first modern parliament in 1814. In spite of being forced into a loose personal union with its Swedish neighbor lasting until 1905, the 19$^{th}$ century saw the creation of a multi-tiered system of government in 1837. In combination with the passing of the 1860 Public Health Act, this awarded significant autonomy to the municipal and national administration in the provision of healthcare (Schøyen 2021, 248). As part of the legislation, all municipalities were obliged to establish a board of health, which granted significant discretion and autonomy on the local level and bolstered the position of medical professionals on the national level (Schøyen 2021, 248).

After gaining its independence, the parliament passed the Sickness Insurance Law in 1909. It introduced the first compulsory health insurance, covering around 1/3 of the active workforce, which covered patient fees upon hospitalization (Schøyen 2021, 249). Three years later, the Public Medical Services Act was passed, introducing a hierarchical system with a state-level director of medical services and subordinate county and district doctors serving both advisory and oversight locally (Schøyen 2021, 248). As part of the act, the number of medical districts was increased to 372 by 1914, each obtaining its own medical committees headed by a primary medical officer. This, according to Schøyen, significantly improved the primary care services in poorly served rural areas (2021, 248). It did, however, still not provide central or regional authorities powers to control the development of the hospital system, where, by 1930, 70 % of capacity was covered by municipal or county-owned hospitals, 20 % by private institutions, and only 8 % by state-owned hospitals. Schøyen, therefore, argues tendency of localism in the hospital system was driven by local interests and needs rather than a clear national strategy (2021, 248). Health services and public health were, however, growingly regarded as the state's responsibility before 1945, which the researcher believes was contributed thanks to pioneering by privately run humanitarian and religious associations (Schøyen 2021, 248).

### 5.1.2. 1945-2000: Universal Health Insurance and Primary Care

In the post-war period, various legislations saw a steady increase in national health insurance coverage, and by 1956, Schøyen argues it had reached the point where one could speak of it in terms of universal coverage (2021, 249). However, the premiums and coverage varied disproportionately on one's income. Today's recognizable National Insurance Scheme (Folketrygden) was strengthened only with the introduction of the scheme's standardized contribution, which was set at a fixed percentage of wages in 1971, according to Schøyen (2021, 249). The hospital system also saw great reforms with the 1969 Hospital Act, which transferred ownership to the counties. This restructuring came in an attempt to offer equal rights, care, and benefits nationwide. It did, however, as a consequence, bring a tendency of centralize units to larger hospitals, sparking local disputes with regard to local hospital closures, localization, and functions, which we still see to this day (Schøyen 2021, 250).

1982 was the year of the next major structural reform with the Municipal Health Services Act, which unified all areas of primary care delivery at the municipal level (Schøyen 2021, 250). Before its implementation in 1983-84, GP practice was loosely regulated, often involving so-called "combi doctors" practicing curative medicine alongside their public medical

duties. Any authorized physicians could, at this point, settle anywhere and practice as GP and send invoices to the social insurance. These factors combined were argued to cause GPs to congregate around the cities, comprising primary care access for rural areas. This reform would gradually introduce a scheme where GPs had to sign practicing contracts with the municipalities to obtain social insurance reimbursement. The intention was that this would strengthen local democracy, cost controls, and primary care in the districts (Kristoffersen 2013, 115).

In addition to the social insurance reimbursement, GPs were compensated through per-unit financing, co-payments from patients, as well as an annual municipal operating allowance. The Municipal Health Services Act was, however, only met with moderate success. Between 1985-88, the municipalities only saw a modest 10 % increase in GPs with contracts, and the rural areas did not see a significant strengthening of their GP service (Kristoffersen 2013, 115-116). Research suggests the causes were multifaceted. Some physicians in the larger cities started to run entirely privately without social insurance reimbursement, and due to the increasing costs of obtaining new GPs with the new system for the municipalities, it was often more ideal to opt out (Kristoffersen 2013, 115-116; Schøyen 2021, 253). By 2001, however, this system became the norm with the introduction of the FLO (fastlegeordningen – the National GP Service Scheme).

### 5.1.3. 2000-2010: National GP Service Scheme and Hospital Reform

To strengthen the GP service and prevent a tendency of patients constantly changing doctors, the government introduced the FLO and assigned citizens to a fixed GP. The government's goals were largely met with the introduction of the scheme. Citizens participating in the scheme were, furthermore, limited to a maximum of two switches of their assigned GP per year (Kristoffersen 2013, 116). From its humble beginnings with its predecessor in the 80s, the FLO was met with positive public approval after five years of trials in various municipalities (Aarseth 2001, 1755; Kristoffersen 2013, 115). By the end of May 2001, 80 % of the population had opted into the scheme, with only 0,5 % explicitly wishing to stay out (Aarseth 2001, 1755).

2001 also saw the passing of the Hospital Reform, which resulted in the central government taking ownership and responsibility for all public hospitals and specialized healthcare services from the counties (Schøyen 2021, 261). This reform organized the hospitals and specialized health services in various smaller healthcare companies (HF - helseforetak), which are owned by four larger regional autonomous healthcare companies (RHF - regionshelseforetak), who answered to the Ministry of Health (Helse- og omsorgsdepartementet). Schøyen argues this comprehensive reform clearly rested on NPM

principles, "establish[ing] quasi-markets with all public hospitals becoming autonomous enterprises, operating under the Ministry of Health's supervision" (Schøyen 2021, 257, 262). The aim was to address persistent issues with long waiting lists, lack of transparency, costs, and geographically uneven provision of healthcare services (Schøyen 2021, 262). Subsequently, however, the researcher asserts this reform did not produce the anticipated cost-effective advantages, and the RHF's centralizing nature has pressurized the government on several occasions to override closures and relocations of localized health services, e.g., obstetrics, maternity care, or emergency wards (Schøyen 2021, 263).

### 5.1.4. 2012: The Coordination Reform

The last significant structural reform of the Norwegian healthcare service was the Coordination Reform (Samhandlingsreformen), which was implemented on January 1st, 2012. The reform itself sets a framework for realizing the cooperation between various levels within the healthcare service, following the principle of 'Best Effective Care Level,' dubbed BEON in Norwegian. It was heavily influenced by the UK's "Health Action Zones" of the 90s (Veggeland 2013a, 18).

The Coordination Reform, on the one hand, involved municipalities being delegated increased responsibilities in the provision of primary healthcare and treatment of its citizens. On the other hand, specialized healthcare would now focus on advanced treatment and diagnostics. At the heart of the reform was the GP Service, which was responsible for coordinating hospital treatment with the municipal healthcare services, the latter of which was responsible for rehabilitation (Veggeland 2013a, 18).

Goal and result management plaid a significant part in the Coordination Reform, in line with NPM. This, in turn, was argued by critics, such as Veggeland (2013a), to bring various considerations and problems. The reform was argued to be ethically challenging, for instance, with regards to how "coordination" also may be synonymous with "getting rid of responsibilities," where the hospitals may transfer patients too early to the municipalities for rehabilitation (Veggeland 2013a, 20). This also follows a concern with the new financial model of the reform being activity based. This could then possibly lead to situations where hospitals and municipalities might get into conflicts over treating more "unprofitable" patients (Veggeland 2013a, 19). Another critique brought up was the extra reporting costs associated with goal and result management. NPM cost controls come with reporting, coding, measurement, and administration, which, in turn, result in additional costs (Veggeland 2013a,

21). Researchers, such as Hagen & Tjerbo, therefore, argue analogically that "cost controls eat NPM for dinner" (2013a, 66).

# 6. Analysis

In the subsequent sections, I will present the findings derived from the conducted interviews. The analysis is comprehensive and provides deep insights into the multifaceted nature of the Norwegian GP Crisis. By applying a qualitative content analysis, I have systemized the data through hierarchical coding. This involved identifying main themes, assigning corresponding codes, and further refining the analysis with sub-codes. This systemic arrangement will also guide the structure of the presentation of the analysis.

We start by exploring the most extensive theme, "Recruitment." Following this, we delve into "Bottlenecks," "EU/EEA Medical Authorization," and finally, "Temporary Employment Agencies." This chapter concludes with a summary that features a visual model, Figure 2, that encapsulates the analysis, illustrating the interplay between the various themes, codes, and sub-codes in the context of the GP Crisis.

## 6.1. Recruitment

### 6.1.1. Causes

The first category we will delve into in relation to recruitment is potential causes that were brought up by the informants throughout the interviews. In order to systemize the various types of areas that were brought up to my attention, I decided to divide them into four main areas: Working conditions, the LIS1 Reform, dialogue amongst the various stakeholders, and public discourse.

#### *6.1.1.1. Working Conditions*

Throughout the interviews, no other causes for the GP crisis were more frequently discussed by the informants than that of the working conditions. All of the informants brought this topic up in our conversations, with the natural exception of the president of ANSA, as this area goes beyond her expertise. It appears that the workload is considered a major concern for most of the informants. Financing of the FLO, right to leave and time off, and access to supervision will, however, also be visited later in this section.

#### *6.1.1.1.1. High Workload*

In his personal reflections, the NMF President, Sæther, suggested that the heavy workload might have come as a result of the success story of the FLO:

> "*When the FLO was introduced around the turn of the millennium, it was a very good idea. That one should have one GP who knows who you are. It appeared to work. The patients got to know their GPs, and it improved the user experience. Since this was so successful, one had another well-intended idea to transfer more areas to the GPs. However, in the process, the GPs have had a steadily increased workload. More and more responsibilities are being transferred from the specialized health services to the municipal primary care. The GPs know their patients.*"

When Sæther refers to the transferring of responsibilities from the specialized health services to the municipal primary care, he refers to the 2012 Coordination Reform. This viewpoint is also held by Julie, who believes the Coordination Reform unintentionally led to a framework where the hospitals could "push" responsibilities onto the municipal primary care:

> *"The number of sicker patients in the municipalities that the GPs had to care for have steadily increased, and more associated paperwork. It has quite frankly become too much. And the "gold" that the ALIS educate themselves for, the patient contact, has steadily decreased."*

Working as a GP before the Coordination Reform, Sunde experienced that the amount of paperwork was relatively manageable during his tenure. He usually set off two hours every Sunday to get by any paperwork left over from the previous weeks. In contrast, Ofte said he, after the reform, had to work two to three hours overtime every afternoon in order to handle the paperwork from his consultations when he worked as a substitute in Osterøy Municipality.

Julie mentioned that there around the year 2009, ahead of the reform, had been conducted an international survey finding that Norwegian GPs maintained a high level of work satisfaction and did not wish to quit, compared to countries such as Sweden and the Netherlands. Sunde himself maintained that there were queues for employment in the FLO upon establishing his office in the district municipality of Kirkenes in the year 2000.

Urgent Care duty were also brought up by several informants as a problematic part of the FLO. In addition to following up on their own patients, GPs in the FLO are by law responsible for staffing the Urgent Care services in their respective municipality and must set off about 1-2 days a month for this duty. Brattetaule said this came on top of their full-time jobs as GPs. The GPs that I interviewed had differing opinions on this aspect. Recalling his period working as a GP in the remote municipality of Stokmarknes, Jakobsen said urgent care provided him with great variation in his work. Ofte agreed on this aspect but expressed that it was not

entirely to his preference and that he would have appreciated getting the option of not having that responsibility:

> *"It's not always easy to stand alone with those responsibilities. Hol was quite far away from the closest hospital, but it is, fortunately, close to an air ambulance station, which made one feel a bit safer if very serious things were to happen."*

Ofte considered the Urgent Care duty as one of the most important reasons for his ultimate decision to leave the FLO in favor of working as a private sector substitute. Brattetaule recognized that Urgent Care duty is a known challenge that is expressed by their GPs. At the same time, she maintains that this is a national scheme and is how Urgent Care is set up nationally. Brattetaule mentioned that Bergen Municipality did attempt to be accommodating for GPs with special needs. Since the majority of their GPs were close to retiring age, and the municipality would ensure they could stay in work for as long as possible in light of the problem with recruitment, GPs over 55 years of age could opt out of Urgent Care duty. Pregnancy, sickness, and serious social needs were also considered valid reasons for opting out. Furthermore, acknowledging that the GPs working in the municipality's FLO are too few to meet the needed capacity for Urgent Care, Brattetaule said Bergen had hired enough external physicians to cover about 60 % of the afternoon and evening shifts.

The final topic brought up by some of the respondents in relation to workload was what they considered to be a "generational shift" in expectations of working conditions from the young generation of GPs. When listing LO and Fagforbundet's political stance on necessary measures for the FLO, Luther said that one of them concerned working hours:

> *"The GPs must have working schedules that are sustainable. They must be able to live a normal life outside of work. This is expected by the younger generation. They do not wish to follow the 24/7 working lifestyle that my generation grapples with."*

The Director from Helse Vest, Christiansen, shares this understanding and considers the generational perspective as an integral part of understanding the problem of recruitment in the FLO:

> *"I believe that we're standing in a generational shift. And I believe that the generation of the GPs that once established the FLO many years ago have a different perspective than the young that now are entering the service."*

In light of this perceived generational shift, it is crucial to explore alternative approaches to managing the workload of GPs. Luther, who has a background as a Nurse Manager for a hospital, and now leads LO and Fagforubndet's branch of medical professionals, implied that

several of the responsibilities currently handled by GPs instead could be followed up by other groups of healthcare workers:

> *"Numerous aspects of a GP's work could be supported by other groups of healthcare professionals. Monitoring chronically ill and various types of biological sampling doesn't necessarily need to be performed by the GPs themselves."*

To ensure safety and quality in the provision of primary care, Luther holds that these groups should work together and share responsibilities and recommends that the GP's work instead should be centered on the tasks that only they can and should do. Hoksrud also mentioned in his interview that if the current trend of the lack of recruitment persists, the government needs to have an honest discussion on what responsibilities and services the GPs should care for and to what extent responsibilities could be transferred to nurses and other personnel in the GP Offices. He believed, however, that this would not be an ideal situation but that we nevertheless need be open to looking at how we can improve these aspects of the FLO.

Christiansen also suggests that the government, with such insights in mind, must consider alternative approaches to dealing with the crisis. She holds that it is too complex to be dealt with using traditional methods alone:

> *"It is a Gordian Knot somewhere here. Once, Alexander the Great attempted to break such a knot, but then everything was destroyed."*

In order to tackle the crisis, one must, therefore, in her view, attempt to untangle the knot in other ways in order to find good answers. She believes that Bergen Municipality has good insight and understanding of the issues of recruitment and that both the Directorate and Ministry of Healthcare have various inquiries and knowledge on the issues. Simultaneously, several district municipalities have developed alternative ways of recruiting GPs that have turned out effective, that we possibly could learn from. She also suggests it might be a good idea to gather a sample of 50 young physicians and ask them for their opinions on necessary steps.

#### *6.1.1.1.2. Lacking Supervision*

The lack of supervision was pointed out as a topic of concern by Jakobsen. This is especially related to the problems in basing the FLO upon a sole proprietorship model:

> "*It is clear that we with medical degrees don't have any skills in either economy nor administration, and we do not have prerequisites to run a sole proprietorship. But darn it if we're gonna learn it!*"

Jakobsen expressed that GPs run into the exact same problems as any others running a smaller business, such as accounting, payrolls, judicial twists, and employment contracts. The GP

expressed that these are things that they eventually learn, but they do not receive any supervision from the municipality whatsoever. He did, however, commend the General Practitioners Association for providing judicial assistance.

Brattetaule was aware of this issue but mentioned that it was, from her experience, a lesser occurrence issue in Bergen. Being the largest single municipal administration in the country, since Oslo is divided into city districts, Bergen's GP offices tended to be generally larger. This meant that their ALIS was not put in solo or dual practices.

> "*There shall always be a minimum of 3, and ideally more, before we station an ALIS in an office. Except if they recruit themselves at their own initiative*."

When the municipality gets involved, they aim to terminate solo and dual practices, as she expressed, Bergen Municipality finds it important to promote medical practices with a supportive and collaborative work environment: "Then, there will always be someone to ask."

Sæther also mentioned that the issue of too few ALIS supervisors was a hot topic within the General Practitioners Association and mentioned that they were very satisfied with the Government's decision to increase funding to this area. The Association themselves were also currently working on recruiting more supervisors. It should, however, be mentioned that it also was pointed out in the interview with Brattetaule and Christiansen that all ALIS becomes GPs, but not all GPs will work in the FLO. There are also GPs working in other areas of the healthcare sector, e.g., in hospitals and elderly care homes. As such, students can also have their ALIS specialization in other institutions. However, regardless of where students undergo their ALIS specialization, Brattetaule emphasized that they still needed to have two years of obligatory practice at a GP office in order to become specialists in general medicine and will, therefore, also qualify to work in the FLO.

#### *6.1.1.1.3. Leave and Time Off*

A consequence of the understaffing in the FLO is that it impacts the ability of a GP to take their rightful leave and time off. As a result of the GP Crisis, substitutes are in both high demand and expensive, Jakobsen says:

> "*I can't take time off when I want to because my office would be heavily impacted as we would not get substitutes."*

The GP expressed that his office was heavily impacted by the GP Crisis, they, at times, had been as low as 50 % staffing, and it sometimes had been quite critical. At times, it had been so bad that they had to close their office or had to reduce their opening hours. This problem does, however, appear to vary. Brattetaule mentioned that many young GPs start in well-managed

practices and manage to maintain a sense of a normal workday. Ofte said the municipality knowingly assigned him a very small list of patients. This was due to Hol being a destination for tourism, and, therefore, had to have the capacity to cover tourists. As a result, he was able to take time off in the off-season, such as in May.

A more serious consequence of the understaffing relates to the ability of a GP to take various types of leave, such as maternity, parental, sick, or childcare leave. Ofte said he was lucky not having any children or family to take care of when he was working in Hol:

> "*If I had a family and so on when I worked as a GP, I would have been heavily bound by the school holidays and so on. In that case, it would've likely been far more problematic."*

Christiansen said they were very much aware of this issue in Helse Vest and were actively keeping a dialogue with the Medical Association on finding solutions on this issue with regard to ALIS. She stressed that it was important that the time of specialization fits the individuals' needs:

> *"Well, you can't say you are going to have your specialization if you're having parental leave or managing a research project, etc. We [the hospitals] must also be open!"*

In collaboration with the Medical Association, Helse Vest has, therefore, created an ALIS Application Portal where students can register, and the health trusts can post their available periods. This way, the students not only decide *where* they want to have their specialization, but *when*:

> "*We have created some sort of zipper method! In this way, both interesting periods and fields of expertise in the health trusts are made available."*

Christiansen said they have enough vacancies to meet the needs in the portal. Helse Vest has already had its first evaluation and will have another one this autumn. The first one showed that the health trusts were satisfied and that those who did not get their positions filled instead hired substitutes. She said that this model accommodated the students' needs for rightful leave and stressed that GPs had been actively involved in developing the model. As of her knowledge, Helse Vest was the only regional trust that had employed this model.

Another pilot model was mentioned by Sæther, which took place in the City of Tromsø. There, they were testing municipality-run GP offices, where the doctors were working directly for the municipality:

> "*One of our GP supervisors in a practice course of my fourth year was working there and said he was very satisfied with working for the municipality since he did not have to think about getting substitutes and could take paternal leave without issues.*"

While acknowledging that he had no personal experiences in this area, he had the impression that especially students were more positive about working directly with the municipalities. He did, however, stress that he did not have any data proving that this was the case. This differed from the general stance of the Medical Association, Sæther said, which favors private GP offices.

Julie mentioned that there in connection to the ALIS Vest Project had been a survey of younger GPs in Vestland County in 2017:

> *"[The results showed] that the new generation, such as you, want more free time! Could you imagine?"*

Julie stressed that work-life balance was a recurring theme amongst the new generation and is, perhaps, being valued differently than by previous generations. This opinion was also reflected by Luther, who meant there should be more flexibility for GPs who prefer to work part-time, as there may be valid reasons for this choice. She strongly felt that the best and most favorable conditions should be offered to attract and retain GPs.

#### *6.1.1.1.4. Financing*

In light of the increasing workload and responsibilities for the GPs working in the FLO, several of the respondents were concerned that they were not adequately compensated for these additional responsibilities. Sunde explained that the financing model of the FLO earlier sufficiently covered the costs associated with the GPs' work. Jakobsen explained that the GPs in the FLO were financed through a three-way model. First, a base subsidy, which works as a 'per capita' subsidy, where GPs receives a grant for the number of patients on his/her list. Then, they would also receive funding through each consultation through deductibles and healthcare reimbursements.

Sunde was concerned the 'per capita' subsidy over time had not been adequately increased to cover the increasing costs of operations. The 'per capita' subsidy has steadily increased, but simultaneously, the number of patients on the lists has decreased. As a result, the 'per capita' subsidy has ultimately decreased, whilst the costs associated with working as a GP have increased:

> "*So, as the [monthly balance] before almost always ended in zero, maybe with a gap of about 10 000kr, today's GPs experience gaps of almost 30 000kr. This means that the GPs must earn 30 000kr in order to break even and actually start earning for their salaries.*"

Sunde stresses that this assumes that the GP is of good health, does not have sick children to take care of, etc. This brings a level of financial uncertainty for the GPs. He explains

that the government has not adequately addressed the costs associated with the increased workload and responsibilities that has resulted in GPs having to decrease their lists. His daughter, who recently had graduated and resided in Tromsø, was currently debating whether she would work as a substitute or work as a GP in the FLO. Sunde said she was concerned with the workload not being adequately compensated. Especially with regard to follow-up work such as filling forms, medicine applications, etc., which is work not explicitly compensated.

Jakobsen shared these concerns and felt that the 'per capita' grant was too low and needed to be addressed by the government. He also explained there were other operational costs that needed to be taken into account, e.g., the upkeep of digital systems. Jakobsen here commended his municipality, Bjørnafjorden, who had implemented an action package effectively increasing the 'per capita' by 55 %, providing annual office operations grant at 50 000kr and providing scholarships for continuing education and other things. Sunde and Sæther also mentioned similar packages had been implemented in the municipalities of Tromsø and Sør-Varanger. However, Sunde was disappointed that these programs were funded by the municipalities themselves. In his opinion, they should have been financed by the state, which, by so doing, would signal they were investing in the GPs.

The Progressive MP, Hoksrud, also expressed that the 'per capita' subsidy was a major concern for his party and something that the parliament needed to resolve. One solution, he suggested, would be to add an additional grant for each consultation. From his experience, several GPs can service more patients, but in order to do so, they must be adequately compensated. He stressed that GPs have several responsibilities that require much time and resources, e.g., meetings with NAV (Norwegian Labor and Welfare Administration), patients' employers, etc.

Another concern brought up by several of the informants was the issue relating to how GPs have to "purchase" themselves into the FLO. When entering a contract with the municipalities, GPs need to purchase a contract to provide care for a specific list of patients. This endeavor may cost up to hundreds of thousands of kr, and often require the GP to take up a loan. Sæther explained that the rationale behind this idea was that this ensured the GPs were "bound" to his specific office. This connects with the idea of the FLO, guaranteeing a permanent GP who lives in the area.

Several informants, however, including Sæther himself, explained that this investment might be perceived as a significant financial risk for young GPs. Christiansen was afraid it may have become too challenging to take up loans with today's increased costs of living:

"*I believe the economy is very burdensome when seen in combination with the high housing prices in parts of the country. I believe this brings the GPs into a very unfortunate situation.*"

Both Sæther and Hellesnes stress that GPs tend to accumulate a significant amount of student debt since the medical degree is a long education. This is especially true for the GPs educated privately outside of Norway, who additionally have to pay tuition fees, as Sæther explains:

"*If you take your education in Norway, you will usually end up with about 300-400 000kr in debt, whilst if you study outside of Norway, one will easily end up with over 900 000kr. Medicine is one of the most expensive degrees that we have.*"

It is, for this reason, often both challenging and significant financial risks associated for young GPs who consider signing contracts with the municipalities.

#### *6.1.1.2. LIS1 Reform*

Another topic that was brought up during several of the interviews was the LIS1 Reform that happened alongside the Coordination Reform in 2012. It was set to replace Turnusordningen, which was Norway's equivalent of the UK's Foundation Program, also referred to as Medical Internship. Until the reform, it had been lottery based. Students were given a random number from 1 to 150, where students with lower numbers would get to be the first in deciding where they would like to be stationed. The reform sought to fundamentally change this model by making it applications based. At the time, Julie was concerned about how this would affect the recruitment to the districts:

"*As students finishing their degrees were anticipating being stationed in the districts, as they had no choice – it was a lottery – everyone was prepared for this scenario. Many were anxious. Then, it went better than they expected, and ended up staying a bit after. They got a journey of self-cultivation and a life-long experience. You see, many physicians talk about their medical internship."*

As the applications-based model was rolled out, Julie expressed that she and several others feared students would tend to apply to the cities where they had taken their degrees and opt not to work in the districts.

"*It was a profoundly bad move. Today's director [of Health] was involved in its implementation, whilst I demonstrated against it.*"

Both Sunde and Ofte spoke about their good experiences, having taken their medical internships before the reform. Sunde got number 146 of 148 and had the option of Lofoten or Kirkenes. He opted for the latter and said that choice, in many ways, defined his life thereafter, and he never moved back to Oslo. Ofte said he got a middle-tier number and ended up with

what he described as very enjoyable years at a hospital in Orkdal, close to the city of Trondheim, where he had never been before, as well as half a year in the district municipality of Åfjord.

Julie says she, at the time of the reform, heard a bureaucrat in the Directorate of Health question why doctors should always receive differential treatment with regard to the internships. Julie argued the reason was that the distribution of doctors having internship is an inherently complex task and is something one could see all over the world:

> "*When we reformed the medical internship, we did, to a large extent, copy Sweden, which we knew already had problems in spreading their students. The best rating was in Gällivare [in northern rural Sweden]. The young doctors didn't want to go there.*"

As a result, Julie said one saw a tendency that students would rather wait several years until they eventually got an internship in Stockholm, having to do unsupervised substitute jobs for a living.

Christiansen said that Helse Vest themselves had noticed this trend starting in Western Norway:

> "*We have seen that neither Bergen nor Stavanger [Norway's second and third largest cities] are urban enough for some people. In fact, the accumulation of doctors in other places in the country, such as in central Eastern Norway, is a grave issue."*

Christiansen says this is a result of the medical internship now working within the conventional principles of the free labor market:

> "*For as long as there is a demand centrally, the migration patterns will continue to follow this trend."*

Christiansen herself says Helse Vest would prefer a decentralized model where one instead would apply for an admissions area. This way, one perhaps could balance this issue better.

Another concern raised by Jakobsen with regard to the reform had to do with the learning objectives. While stressing that the medical internship today is about the same as before the reform, he had begun to notice a trend where the participants no longer have as many responsibilities as before, and their tasks now being more routine-oriented. Similar concerns were also raised by Luther with regard to the internship. Having worked with following up internship doctors in a hospital, she expressed a need for better training packages:

> "*It can't be so that interns should be thrown into surgical tasks with almost none or basic knowledge."*

She stressed that a basic condition for interns to have a good working environment and teamwork with other hospital staff is that they have adequate basic knowledge when they enter

their practice. Similar concerns were also raised by Julie when she and a group of doctors from all across the country protested against the reform:

> "*We were afraid that, and are still, that the reform would impact the good supervision. The additional support, right? That you receive an emergency medicine course, you are placed in a group of peers, you get a senior colleague on-call duty, you receive the extra attention*."

Julie says she is concerned that if such things are normalized to a too large extent, the medical internship could easily become very similar to the normal work-life.

#### *6.1.1.3. Dialogue*

Issues with the dialogue amongst the various stakeholders in the FLO were brought up by several of the informants as a major concern having negative consequences for recruitment. Recalling her experiences after the Coordination Reform, Julie observed the way the healthcare sector was organized with regards to who it was that could describe the actual conditions on the ground-level to the government:

> "*It was evident that the Regional Health Trusts had direct access to the ministry. They were heard, understood, and avoided creating a fuss. Or, as I would call it, 'to shoot themselves in the foot.*"'

She said this was not the case for the GPs, who, in her view, were left with no other alternatives to be heard or believed. Julie thought back to a conference in relation to the FLO that she had participated in together with the Medical Association in 2016. There, a couple of young GPs voiced that they could not make their job work with their lives and that the workload was too heavy. She recollected the older GPs and representatives from the Directorate and Medical Association undermining their statements with typical remarks about the young generations always complaining.

Being believed and understood, Julie argues, have come at the expense of the FLO's reputation:

> "*One has always had to resort to causing trouble. We have also seen this in other countries. In Scotland, which I know well, we see the exact same patterns. It's not good for the FLO that we've had to exaggerate a crisis on this matter, as it will negatively affect recruitment. After all, the FLO doesn't become more appealing when all the young physicians hear is that the GPs working there are always complaining."*

The GPs Ofte and Jakobsen also expressed concerns that the persistent negative attention in the media does not contribute to promoting the FLO to young physicians. Both Christiansen and Brattetaule carefully articulated in this regard that not all issues may be appropriate to discuss

openly. Julie expressed sympathy to these concerns, but argued that the GPs did not really have any other alternatives to be heard and understood:

> "It's a reason why we do not see similar situations in the hospitals. They have their regional trusts for that. Short distances for communication, they're heard, receive funding, and constantly receive some new billions from the ministry. You never hear the neurosurgeons taking to the barricades! They don't need that. They have effective structures to voice their needs."

From Julie's understanding, this is not the case for the municipal primary care services and the FLO. They have KS (the Association of Local and Regional Authorities) on the strategic level, the Medical Association, and the directorate. She says their playing field is rigged significantly more unevenly.

In connection to the LIS1 Reform in 2012, was invited to the parliament, where she got the opportunity to talk to MPs from the governing party. When confronting them with her and other opponents' arguments against the reform, their response made a significant impression on her:

> "They told us that they understood our arguments, they made sense, but we had to make a bit of a fuss. Ok? You are health policymakers in position, and you ask us to make noise?"

Julie expressed that they were given a similar response by top-level bureaucrats in the directorate. That was why she and like-minded physicians organized the LIS1 Protest Action. They believed only the hospitals' views were getting addressed and felt that the Medical Association was too heavily influenced by hospital physicians. As a result, she regrets they were not able to prevent the reform.

Julie also brought up another instance that she believed exemplified the GPs' sense of disempowerment. It happened in relation to the protest action she contributed to organizing, dubbed the 'LIS1 Revolt' in 2018. She recalls they were invited to a conference in Iceland:

> "*I sat on a bus together with several frustrated young GPs like me, as well as older ones. I believe that they soon understood that many people with authority sat on the bus. The leader of the General Practitioners Association, professor this and that, the leader of the competence center for such and such. And no one had the power to do anything alone!*"

She explained that when they came to this realization, they understood that they had to start a protest action, recruit spokespersons, and notify the media by writing various cornicles. Then, she explains, things started developing.

With regards to Julie's understanding of the effective channels of communication with the health trusts, throughout my interviews with Sunde and Christiansen, who represented Finnmarkssykehuset HF and Helse Vest RHF, respectively, both expressed that they were very

satisfied with their communication and dialogue with the ministry and directorate. Sunde's experiences fitted well with Julie's remarks:

> "*We have very little direct communication with the national ministry. That goes through Helse Nord [RHF]. That's the way it works, and how it should work. […] I don't believe we're very neglected. I actually believe we receive our fair share.*"

In the interview with Jakobsen, he said he had noticed in recent debates that politicians and public officials often appear to lack insight. When I asked him for suggestions for my interviews with legislators and the national administration, he recommended I check their professional backgrounds:

> *"It's hard to say! You really never know until you're there! Check their backgrounds, or at least ask them about it – if they have a background within medicine. That might be my best tip because then you know how to relay your questions."*

Julie appeared to be very pleasantly surprised to receive this question and commended Jakobsen for pointing it out in relation to the GP Crisis. She thought it was very interesting from a political science point of view that only 6 % of the directorate's employees have a medical degree:

> "*As a doctor, you're trained to think in terms of side effects, right? To think as complexly as possible, especially as a GP. Patients are part of a community, family, jobs… If I issued a sick leave now, what sorts of consequences would that entail? You try to 'really' grasp the complexity.*"

She felt that the perspective on issue-solving worked differently with the economists she was working with in the directorate. They, on the other hand, are, in her view, taught to narrow the scope down. Not thinking in terms of complexity but rather thinking in terms of making the issues manageable so that they could be priced or calculated. Having a medical background, Julie says she is taught to bring in culture and history and bring about the complexities of the issues:

> "*When people come with their doctoral degrees, they come with a quantitative point of view. They're used to handling statistics and data and are fascinated by this – more data, then we better know the reality!"*

Julie argues that an important part of the qualitative tradition is the importance of talking to people. Data alone is not enough to find patterns that we can trust.

> "*So that has been a weakness, I think, with public healthcare administration on various levels. The quantitative paradigm is actually dominating all over.*"

Sæther also pointed out that, in his view, viewing the GP Crisis solely as an issue of funding was a misinterpretation. Instead, he believed it had more to do with the capacity of the GPs:

"*There are several reasons […]. I don't believe it has so much to do with low salaries and such. It has to do with working hours, and that several GPs feel they do not have enough capacity, simple as that.*"

In the interview with Luther, she mentioned that the directorate had experienced significant budgetary cuts. She thought this might be one of several explanations of why LO does not have an as close dialogue with them now as before, as the employees now are experiencing busy days with limited staff. Julie acknowledged that this was the case and that the most significant cut happened in 2018 under the rationale of less bureaucracy:

"*We did not see the same budgetary cuts in the RHFs because they're not viewed as bureaucracy in the same way."*

Julie found this interesting in relation to the GP crisis because, as a result, there have not been enough resources to address the FLO to the extent that one may have wished for. Another problem in this regard was a trend where resourceful and knowledgeable personnel with insights into the area had not been adequately replaced when they quit or retired.

"*To secure one's rights, one needs the bureaucracy. And it isn't easy for everyone to understand its importance. We need the bureaucracy to make things easier as well.*"

Julie thinks that an unfortunate result of the cuts is the directorate's capacity to catch signals centrally in an orderly way. She said KS delivered the first report in 2015, providing national data showing that all sorts of municipalities experienced problems recruiting GPs in the FLO, both in the cities and the districts, and believes this is an example of the issue with capacity in the national administration. However, Julie also stressed that she believes the current Director of Health is aware of the issue:

"*I feel that he listens, and not the least, to the stories. The qualitative. So, I believe that the directorate's understanding of the GP crisis has changed, and we now are actively looking at how we can address it with our resources. The climate is different now than when the crisis was in full swing. However, it has been a long time coming, and the signals were clear in 2015 [KS], in the conference in 2016 where they made excuses, or the campaign in [the major news agency] VG in 2017, and with the Turnus Revolt [in 2018] where I personally contributed to kicking it off.*

#### *6.1.1.4. Public Discourse*

Talking from her own experience and what Luther had been told through her encounters with former GPs when she worked at a hospital, she had started to notice a trend where the threshold for exercising violence against GPs appeared to be decreasing:

"*I know a couple that instead decided to become pathologists, who initially were GPs. Due to the risk of violence and threats in their work, they opted out of the FLO.*"

Luther stressed that this inherently differed but that she had heard similar stories from GPs operating in especially susceptible locations or had patients affected by substance abuse on their lists. Luther emphasized that GPs always had dealt with such areas but that she could see a general trend with rising violence within the healthcare sector, including in the GP offices.

"*We see that one might not have the same respect that we once had for the doctors. In many ways, this is a good thing. But simultaneously, we see that some individuals who earlier had a filter refraining them from exercising violence on public servants have deteriorated. And one should count the GPs as public servants.*"

Luther was unsure of the cause but suggested that it could be perceived in association with general demographical developments in various groups of age. That Norwegians no longer may have the same respect for authority figures. She also suggested it could be connected to recent developments in the public discourse in social media:

"*The GPs are sitting with the last word and will often get the blame if something goes wrong. Therefore, I believe their conditions and terms of employment should be better accommodated.*"

Julie also brought to attention that recent developments in the public discourse suggest that one has attempted to bring the doctors down from "their pedestal":

"*... and for good reasons! They're arrogant and dominating and not good at collaboration. Of course! But to what price?*"

The GP, Ofte, was also concerned with how the negative public discourse and media attention had affected the FLO's reputation. He feared it might leave young physicians with an impression that the FLO had significantly deteriorated, and consequently, they are discouraged from becoming GPs.

### 6.1.2. Implications

Having now presented what I, throughout the interviews, perceive as the main causes for the problems with recruitment in the FLO, it is now time to delve into the implications of this issue. I have chosen to divide this code into three sub-codes: Implications for the districts, Specialized Health Services, Urgent Care, and for the patients. Here, as well, one could argue that the two former sub-codes ultimately involve implications for the patients. Just as with the earlier discussed sub-code of recruitment, however, I decided to differentiate these sub-codes as I find it most informative to discuss them individually.

#### *6.1.2.1. Districts*

Sunde, who worked as the Medical Director of Finnmarkssykehuset HF, operates, as the name suggests, in the most peripheral and sparsely populated region, Finnmark. The region is in the north-eastern part of Norway, bordering Finland and Russia. Sunde proudly states that GPs working in the region matter more, which he also says is the slogan of Finnmarkssykehuset HF. As a result of the region's lack of people with higher education, he says it is much easier for young graduates to get into a position with authority. Furthermore, he says GPs working in the region experience far more variety in their workdays:

> "*In other places of the country, there are lots of private services. This makes the patients shop a bit of gynecology here and perhaps a bit of dermatology there. As a result, the GPs are left with the most demanding and tedious work that no private profiteers want to take part in. In Finnmark, such services aren't available. In other words, GPs here get far more comprehensiveness in their work.*"

Jakobsen, who spent some years working as a GP in one of the most remote coastal municipalities, Stokmarknes, was left with a similar impression. His experience appeared to match that of Sunde's. Jakobsen felt he was presented with challenges that went a bit beyond the normal responsibilities of a GP working more centrally. He described his work as far more varied and that he also cooperated more closely and felt a sense of closeness with the local hospital. Sunde agreed with this description and said that he perceived that Urgent Care in places like Oslo and Eastern Norway had been outsourced. In Finnmark, Sunde explained, the GPs played an integral part in Urgent Care and were often left with the main responsibility together with the air ambulance:

> "*You are a part of the picture, you are involved, and you matter more.*"

With this understanding in mind, about the importance of the GPs in the districts, I asked the informants about the implications of the GP Crisis. Jakobsen expressed that he already, in 2006, when he got his GP authorization and started working in Stokmarknes, observed that the districts struggled with recruitment. He said most municipalities solved the issue by employing substitutes to cover the vacancies but that this was quite an expensive service that put a strain on their budgets. When I asked Jakobsen about his view on the recent news articles showing some municipalities paying over 200 000 kr monthly to secure substitutes, he said it was nothing new:

> "*I have seen that for all the years that I've worked and all places. I saw it in Hardanger (in Western Norway) when I worked there and even in the neighboring municipality where I am*

*working now! We see it all over. You don't need to go too far into the districts before you see it, and it's not news. It's actually terribly old news.*"

Jakobsen claimed he had seen similar figures as long as 14 years back in time. Sunde was also familiar with the issue. Although he had not been working as a GP in 12 years, he still had contact with his old colleagues at the GP office in Kirkenes. He said he had heard one temporary employment agency demand up to 15 000 kr daily for their services:

"*How can they not feel ashamed? That is at least my opinion. But they're fishing in a market, right? And what can the market give? And if some GPs are tired and exhausted, the municipalities need substitutes in order not to exhaust the ones remaining. It places the municipalities in a difficult situation.*"

Sunde says the current situation is unacceptable and wants the state to take responsibility for the financing. Furthermore, he believes it is necessary to start an inquiry into the possibility of shorter lists in peripheral regions. However, the medical director did not express much optimism about the prospects of change anytime soon:

"*Then, one will often examine this for a year or two, right? One will evaluate. Then, one will gradually begin with implementing measures, right? But one tends to be a bit tentative, and the measures too weak, I'm afraid. One needs drastic measures in order to get a hold of this issue.*"

When speaking on the implications of the LIS1 reform, Julie brought to attention the concept of the 'Salmon Steam Effect,' which held that medical graduates tend to go back to the same location (or the equivalent) where they had their medical internship upon finishing their specialization. Neither Jakobsen nor Sunde thought the reform had made any significant negative impact on recruitment in the districts. Sunde did not think that was the case, as the graduates still need to be stationed in both the hospitals and the municipalities. He acknowledged that the applications-based system worked differently but did not think it had any significant impact on recruitment in the districts. Also, Jakobsen provided a similar response:

"*I believe so because everyone must have that last semester [GP Practice in the municipalities], also under the new system. So, I don't believe it has had any impact.*"

Jakobsen did, however, acknowledge that he had perceived that many graduates tended not to move and instead opted to stay and take various jobs until they managed to get a position where they lived. He did, on the contrary, underline that he did not have any data to support this statement.

In an effort to attract people with backgrounds from higher education to Finnmark, Sunde said the Norwegian government had put in place various incentivizing programs. One

such concern is cutting student debt, and the other is tax relief. Sunde experienced that these efforts, to a certain degree, have had an effect:

> "*The tax breaks are progressive. So, the higher group of income you belong to, the more you will experience its effect. One could, of course, ask whether it is socially just. But it has at least had some effect in stimulating to attract professionals.*"

He also believed that student debt forgiveness is a targeted and effective measure. Furthermore, he says, Finnmark will provide free kindergarten spots from August, which he describes as an incredibly good offer:

> "*These sorts of financial incentives from the state are helping.*"

Sæther mentioned that some district municipalities had sorted into creative measures to attract GPs. The first measure, which he told was piloted Porsanger, was what he described as a "North Sea rotation." This refers to a working schedule commonly used in Norway's oil industry, where offshore workers are stationed for a set period of time continuously, e.g., for two weeks. Then, the workers are relieved by another group of workers who take over the duties for the same period. This system is meant to, on the one hand, ensure continuous operations to the offshore facilities and simultaneously provide the operators with rest and time with their families (Rønold 2019, 5). Sæther believes this measure attempts to address some of the concerns that have prevented GPs from working in the districts:

> "*The GPs work two weeks consequently. Then they get three weeks off. Then two more weeks. It effectively becomes North Sea rotation for GPs. First off, it's very economically advantageous. Secondly, it gives physicians the freedom to travel while simultaneously providing them with a quite comfortable lifestyle. So, we see that's a solution that has emerged in some places.*"

The leader of LO/Fagforbundet's Professional Section of Health and Social, Luther, brought up an interesting personal reflection in this regard. She argued that patient rights have been steadily increasing over the years. As a result, some GPs and nurses (which she was) alike felt they were always at risk of being blamed when things went wrong due to the increasing patient rights:

> "*We're no longer talking in terms of collective rights, but, rather, patient rights.*"

Luther personally believed that Norway had to think differently to ensure health personnel staying and that one should evaluate the current emphasis on patient rights. While emphasizing the importance of providing patients with high-quality care, she also emphasized the need to acknowledge that it may not always be possible to fulfill all patient rights due to resource constraints. Therefore, one may instead go back to talking in terms of collective rights:

> "*It shouldn't be so that all health personnel should be left with the blame. I think it's necessary to look at this issue more closely.*"

Another measure that was piloted in the City of Tromsø dubbed the "Tromsø Model," was mentioned by also Sæther. In this model, the municipality increased the funding to the per capita subsidy so that the GPs would get higher compensation for the first 1000 patients on their lists. After surpassing 1000, they would still get increased compensation, but not to the same extent as the first 1000. From Sæther's experience, this measure had proven to be effective:

> "*Before its implementation, almost no one wished to work as a GP in Tromsø, whilst after, we saw that as good as everyone wished to continue*."

He cited an article made by the independent news agency for healthcare, Dagensmedisin, which had surveyed Tromsø's 69 FLO GPs before and after the implementation (Figenschou & Midtbu 2022). He expressed that these examples proved that there did exist good solutions for the GP crisis but that the government, unfortunately, had not been willing to listen.

However, not all piloting projects appeared to show the same level of success. In Alta, Sunde said the municipality had attempted to run a GP center where everything was set up, and the physicians would just come to practice. Even so, they were still struggling with recruitment, despite Alta being one of the more densely populated city formations in Finnmark. He argued that the municipalities and government must find solutions in cooperation with the General Practitioner's Association.

Hoksrud also commended the idea of North Sea rotation and said he had seen the municipality of Fyresdal in Telemark had experienced similar success. The progressive MP also said he was aware of the Tromsø Model, which he found exciting. However, he also stressed that if some municipalities managed to attract GPs, it would, in reality, mean that one moves the problem from another place where there is a lack of GPs. In other words, he believed there was a shortage in the totality:

> "*This is a fight for everyone, cannibalism. Everyone needs GPs, so then they need to pay for it.*"

#### *6.1.2.2. Specialized Health Services and Urgent Care*

##### *6.1.2.2.1. Specialized Health Services*

As part of the Coordination Reform, the GPs are responsible for following up on hospitalized patients when they are written out. The GPs are then tasked with forwarding them to the rehabilitating institutions within the municipal healthcare or following up on them if they are rehabilitating at home. The justification of this reform was to, on the one hand, relieve the resources in the hospitals that had to coordinate rehabilitation and maintain patient contact. Furthermore, it was believed to be in the best interest of the patients, who now only needed to

interact with their GP. However, with the GPs now playing such an integral part in the patient pathways, several of the informants expressed deep concerns regarding patients who had not been assigned a general physician.

Jakobsen brought to attention an alarming example from his own work in Bjørnafjorden Municipality:

> "*I have one alarming example where a discovery was made on a patient. I don't know, in the end, how it was eventually detected, but no information was sent to a GP to follow up on that serious revelation. Possibly a tumor or something like that.*"

The GP says he did not believe anything serious unfolded from that case but stressed that something seriously bad could have happened:

> "*We see that the hospitals make discoveries. This should be forwarded to a GP, but the information does not get to a GP. The patients may, for some reason, not be capable of understanding this and can't move forward*."

From Jakobsen's understanding, the responsibility in such situations tends, in reality, to end up with the physicians working for the rehabilitating institutions, whilst rehabilitation at home tends to be followed up by staff in the municipalities. However, where the formal responsibility lies, he was unsure:

> "*That's a really good question! We have actually asked that amongst ourselves – who's responsible? But we've never received an answer*."

When interviewing Sunde, I asked him if he and his colleagues at Finnmarkssykehuset shared similar experiences. He said he had received feedback from hospital specialists that they found it especially difficult to end patient contact when they knew there was no GP to take over the responsibility. This, in turn, severely impacted the hospitals, as these patients are ready for discharge:

> "*[This] results in increased queues for us, which brings queues to the outpatient clinics, and increases wait lists and deadlines.*"

Sunde stresses that a functioning primary care is a prerequisite for a functioning specialized care. He argues it is possible to calculate this by looking at the numbers for the discharge of patients. Municipalities struggling with their municipal care and FLO, such as Alta, are profoundly bad at accommodating such patients:

> "*Alta Clinic and Hammerfest Hospital are plagued with an excess of patients who should've been discharged.*"

Christiansen argues that the importance of the functioning of the FLO came to light throughout the pandemic. The GPs' role in accommodating the patients in the municipalities, in

coordination with various parts of the health care services, including but not limited to the hospitals, ensured the patients' rights in a time of crisis. However, she was in this regard also concerned with the implications for the patients who had no assigned GPs:

"*If we don't get a stable FLO, more people, instead, get referred to the health trusts.*"

As a result, Christiansen believes one in the process may undermine the clear priorities on the health trust's part, in line with the national priority guidelines set in the Coordination Reform. As a result, she is concerned that several patients may not get access to medical examinations or treatment in the health trusts:

"*And then, the patients to a large extent accept this, but it does lead to a spiral of sorts – I call it a 'spiral of death' – where the issues for the GPs are amplified in the hospitals, which again amplifies for the GPs, we get this runaround.*"

However, as far as Sunde's remarks on whether municipalities struggling with their FLO results in prolonged hospitalizations, she would be careful in drawing any conclusions as she lacked data. However, she said his logic was clear and that there should be held an inquiry that could provide evidence indicating whether one could see prolonged hospitalizations for regions experiencing a lacking presence of GPs. Regardless of whether the situation described by Sunde was true, that clinics and hospitals displayed such levels of compassion with their patients and did not discharge patients if they did not deem it justifiable, she thought this was a well-founded approach.

#### *6.1.2.2.2. Urgent Care*

When I asked Jakobsen how his doctor's office responded when they were contacted by patients without an assigned GP when they needed medical attention or needed a prescription, he said they were often told to contact other parts of the healthcare system, like Urgent Care. In Bergen, Brattetaule said they recently had established two municipal offices where patients experiencing hardship reaching GPs could get access to urgent medical attention. This was partly done to alleviate the burden on the city's Urgent Care, which the Deloitte audit found was struggling to keep up with demand. This service did, however, not cover more than critical health needs or needs considered too high-risk:

"*This is something that we feel deeply every day – that there are needs that we cannot cover. And these are needs by law.*"

#### *6.1.2.3. Patients*

Considering the essential role played by the GPs, I talked with the informants about the implications of their absence, such as in Finnmark, where 1 in 10 residents lack a designated general physician (Allmennlegeforeningen 2022). Jakobsen responded:

> "*That means 1 out of 10 lacks quite many services. Many citizens will not have the same services as everyone else, right? They can't use digital services; essential documentation is not registered. Crises may erupt, [disruptions in the] correspondences between [service providers] in their journal.*"

From his experience, he believes several patients feel a sense of significant uncertainty in their situations. Furthermore, he thinks that a significant number of patients postpone medical controls when they lack a GP. He says he especially notices this pattern with patients that have no assigned GP. Furthermore, it is the emotional aspect:

> "*We've been called several times by patients at the office that expressed anxiety when they noticed they no longer were assigned a GP. What can I do? […] Sometimes, we get a substitute. But in other cases, we can't really do anything more than try to comfort them by saying someone surely will come, eventually. We're at that level!*"

Hoksrud expressed similar concerns and argued this could negatively impact patient safety. He feared that one could end up in situations where early signs of serious illnesses are not detected soon enough.

Jakobsen misses a degree of continuity for non-listed patients, which was also expressed by Sunde. The latter said that he could see considerable differences between the listed patients. He described those things worked quite orderly for these them, and one could easily find the responsible GP. For the non-listed, he said it was important to get a system in place that could aid and meet the patients' needs.

When I asked Brattetaule if there was any additional topic of importance to her that she wished to discuss, she wanted to provide insights into some of the difficulties Bergen was facing in connection to the municipality's long waitlist for getting assigned a GP:

> "*Right now, there are 16 800 citizens on a waitlist. How many of these there are that actually have no assigned GP, we don't know. We can't get this information due to privacy concerns. Therefore, there is no way we can get statistics on who they are. It is very interesting. Most citizens on the waitlist have a GP, but they may not have the one that they desire.*"

Brattetaule expressed understanding in that it for some citizens was hard to be followed up on, for instance, their diabetes by their GP in Alta if they lived in Bergen. However, it would still be unfair for these to categorize themselves as non-listed since they could ask for e-

consultations when things get tough. Simultaneously, the municipality offers all additional resources for necessary healthcare and urgent care.

## 6.2. Bottlenecks

A topic that was discussed throughout several of the interviews was bottlenecks that restricted the provision of fresh physicians to the labor market. Mainly three such bottlenecks were identified by the informants. The first concerns the lack of study spaces at Norwegian universities, the second is the scarcity of medical internships (LIS1), and the third are the current practices of granting medical authorization for physicians and medical graduates from the EU/EEA. In this section, I will present the informants' views on the bottlenecks in the universities and LIS1. As the latter appeared to be the most contentious and multifaceted, I decided to dedicate this to a section of its own.

### 6.2.1. Universities

As of December 2022, 40 % of Norwegian medical graduates have degrees outside of Norway (Studentum 2022). Luther was puzzled with why the country could not arrange more study spaces, and she could not see any reason why Norway could not educate most of their own physicians:

> "*We have almost thought that there must be some sort of unwillingness to establish more study spaces.*"

She held that LO and Fagforbundet had been clear in their dialogue with the government in both the Health Personnel Commission and with ministers of health that they needed to influence the Ministry of Higher Education to increase the national capacity of medical studies.

> "*I believe there's room to increase the national capacity. It has to do with the will. And, in time, this affects others, so we need to see the bigger picture*."

Luther also expressed concern over the variation in Norwegian medical university's academic contents and that the way this system works today is regrettable.

Sæther believes the shortage in the national capacity to educate medical students, in part, has to do with it being one of the most expensive university degrees in Norway:

> "*It's incredibly long, requires a tremendous amount of organizing, and demands expensive medical resources. It's physicians who lecture, which entail higher compensation than other professors at the universities.*"

Furthermore, he believes it also has to do with Norway being an elongated and sparsely populated country. In comparison to Denmark, Sæther believes it is easier for students in, for

instance, Copenhagen to commute between their practice at local hospitals and their lectures. In Norway, he argues, this is not possible due to the significant distances. Therefore, one could easily assume that universities are "full" despite having the necessary resources. The actual reason for their limited capacity is the considerable distance to the next hospital. Sæther did, however, stress that this was his personal speculation.

Julie also believed that the universities found it challenging to receive more students, especially in Tromsø:

> "*Suddenly, they received many more students on very short notice. They didn't have the capacity to provide them with a good education. You know, large plenary lectures are one thing, but there should also be group assignments, and they are supposed to be followed up.*"

Due to such factors, she believed the government had purchased its way out of a problematic situation as it had been proved too difficult to build a national capacity.

However, the extent to which there was a lack of capacity in Norwegian universities was not agreed by some of the informants. Brattetaule acknowledged that she was not too familiar with how the situation was on a national basis. However, she said that the head of the medical degree at the University of Bergen, Steinar Hunskår, had said that they are educating enough students, at least in Bergen. Brattetaule did recognize that the situation may be different in Northern Norway. Sunde also appeared to share the understanding that Norway educated enough physicians. He held that the capacity at the Norwegian universities had significantly increased since he took his degree in Dublin 40 years ago. At that time, he said medical students were encouraged to study medicine abroad, as there was a significant lack of physicians in the country. Sæther, however, argued the reality was quite different and that even when taking the intake of international students into account, Norway did not educate enough physicians:

> "*That does indeed include the medical graduates from abroad. If we only look at those educated in Norway alone, we aren't even close to meeting the demand!*"

Hoksrud recognized Julie's concerns on the issues revolving around the short-notice increase in study spaces in Tromsø. However, from his understanding, medical universities in both Bergen, Oslo, and Stavanger have expressed available capacity to increase their number of medical students. Furthermore, he said that the Progressive Party wished to look at what he described as more decentralized approaches:

> "*We have Haugesund, Florø, and Stavanger, who have expressed a desire to offer medical degrees.*"

Both Haugesund, Florø, and Stavanger are located in close proximity to potential candidates for university hospitals. It is important to note, as context, that Stavanger's proposal was turned

down in 2021. The government argued in favor of maintaining the current monopoly on medical studies for the time being and was instead inquiring about the possibility of what was vaguely described as a 'national dimensioning' of the existing medical education (Norheim 2021).

In connection to the intense competition for the limited domestic study spaces, Sæther shared his personal take on how this may unintentionally affect the recruitment of GPs. He speculates that as the admission requirements are set so high, only a few select people that may have high ambitions gets through:

> "*The people at the medical studies may be quite "nerdy." Personally, I want to become a specialist – in other words, very good at 'something.' […] I believe that more and more of us who start with medical degrees aspire to become experts in something.*"

With the general practitioner's specialization being considered too generalist, which is how he believes it is currently advertised, he fears it simply does not appeal to today's medical graduates. Furthermore, he fears there is a lack of opportunity for further career advancement as compared to other LIS3 specialties. Sæther did, however, stress that these were his personal speculation based on his own experiences and encounters with fellow students.

Hoksrud was also concerned with the high level of admission requirements. He stressed that it should be hard to get admission, as the healthcare sector needs the best minds for these professions. However, he did not believe a slight decrease in grade requirement as a result of an increase in study spaces overall would affect the quality of the students:

> "*It will still be hard to get admission into the medical universities of Norway, regardless*."

### 6.2.2. LIS1

The bottleneck in recruitment posed by a struggling capacity in the mandatory medical internship, LIS1, was presented as a major concern by several of the informants. LIS1 is the first level of a three-part pathway that medical students must complete in order to become specialists. LIS1 consists of a year working in specialist healthcare, such as hospitals, and half a year in municipal healthcare. Upon finishing the second level, LIS2, students can decide what sort of specialty they would like to focus on. The LIS3 with a specialty of general medicine, where one qualifies to become a GP, is commonly referred to as ALIS. As of November 2022, Chief Medical Officer of Oslo University Hospital and UiO professor Ketil Størdal estimates that 400 medical graduates currently are waiting for a LIS1-position (Størdal 2022). In the same year, the Medical Association reported that Norway only had made 575 LIS1 positions available (Johansson 2022, 1001). This poses a significant problem, Størdal argues, as the Directorate of

Health estimates that Norway will need 1150 physicians to complete LIS1 annually to meet future demand (Størdal 2022).

Drawing upon her experiences managing the FLO in the City of Bergen, Brattetaule provided insights on how this problem manifests itself in practice:

> "*We would appreciate having more LIS1, as it would contribute to a larger pool of recruitment. As of today, we have 12 ALIS vacancies that we don't get filled.*"

Brattetaule said the County Governor had implemented minor temporary improvements between 2020 and 2022 by 6, 5, and 4 additional LIS1 positions, respectively, but that the municipality this year was back down to its 10 fixed positions. On the other hand, the city had been delegated an increased number of ALIS positions:

> "*Today, you must have completed LIS1 in order to become ALIS. Fair enough. But then, you should not tighten LIS1 and increase ALIS. That doesn't work.*"

Brattetaule expressed a need for the national administration to understand ALIS in relation to LIS1. She had personally asked both the County Governor, the Minister of Healthcare, and others about this issue without receiving any good answers.

When speaking with the employees from the health trusts, who are responsible for the specialized healthcare services, their capacity to increase the number of LIS1 positions appeared to vary. The medical director of Finnmarkssykehuset HF said they received an offer to increase the number of internships. However, the health trust had to turn down the offer since they did not have the capacity to accommodate them:

> "*There are learning objectives, and a small clinic, such as Kirkenes Hospital, does not have the capacity to handle all these interns. We can't just keep adding. They get nothing to do, they overlap, and don't get to learn anything.*"

Sunde did, however, say that Finnmarkssykehuset managed to provide one additional internship in Hammerfest by involving the psychiatric department. However, they had not been able to meet the ministerial request in Eastern Finnmark.

In contrast, when I discussed the LIS1 capacity with the director from Helse Vest Regional Thrust, Christiansen mentioned that their health trusts were highly receptive to increasing their number of LIS1 positions. They had even proposed that the LIS1 positions turned down by Helse Nord RHF, which Finnmarkssykehuset HF is part of, could be transferred to Helse Vest instead. She stressed that the health trusts in Vestlandet had been very clear to the government that they wanted to contribute to increasing the national capacity for LIS1. Furthermore, she added that Helse Vest had various proposals to improve the current system.

First, the regional health trust proposed to make all LIS1 interns go through a three-part internship that included surgery, internal medicine, mental healthcare, and substance abuse. Helse Vest thinks this will provide potential GPs with essential widths in knowledge, as well as encourage more physicians to choose specializations within areas of mental healthcare and substance abuse. Second, Christiansen says Helse Vest has proposed to look closer into the recruitment process of LIS1, which she finds somewhat outdated. In dialogue with the Medical Association, Helse Vest proposes to increase the number of periods of recruitment from two to three. She believed this measure would be much more practical, both for the students, as well as for the health trusts:

> "I think it is something odd about the starting dates of the internships – that the interns start when people have barely returned from vacations. And I find the deadlines to be too short for the health trusts to ensure serious recruitment processes. They often receive 100 applications with some weeks deadline to make a decision. Additionally, these processes often happen in periods where the final year students are having their finals and are already up to their necks with work."

Christiansen said the Medical Association appeared to be positive to the proposal and would like to seek approval for a pilot project in her region. She believed this could help make the recruitment process for LIS1 would give graduates more professional and positive experiences.

When I presented these proposals, Sæther, who led the Norwegian Medical Students Association, held a more balanced view. He could see that it could contribute to mobility for the provision of internships. He did not find the idea problematic as long as it involved freeing up more internships:

> "*If one still would keep the same number of LIS1 positions, we would still meet the same problems, just adding the additional hurdle of more rounds of recruitment.*"

On the other hand, he acknowledged that the government's aim with the LIS1 Reform was to introduce an applications-based system, making it more similar to a standard job application process. On the other hand, as normal jobs were not as strict with their application periods, he believed Christiansen had a good point.

Julie was in favor of keeping the application system for LIS special and different from conventional job applications. She argued this was to maintain the understanding of LIS1 internships being a very special period. This had been a major concern for her and the participants in the Turnus Revolt in 2012 and remains a concern to this day. If this system was normalized to a too large extent, it could potentially impact what she described as a safe and good introduction to the specialty training of medical graduates.

As far as the lacking capacity of LIS1 was concerned, she held that this partially could be blamed on the LIS1 Reform. Another aspect introduced in the applications-based system was that GPs could now turn down offers, similar to normal recruitment processes. A candidate who, for instance, received an offer in the districts could withdraw their offer if they later received an opportunity elsewhere. In the former lottery-based system, the districts were guaranteed interns since the applicants could only choose one of the offers remaining on their lists, which was binding. Julie believed this put the districts in a tough position, as their municipal healthcare was structured around the assumption that there would come an intern. This increased level of uncertainty may, as a result, lead some municipalities to instead drop their LIS1 positions altogether. So, in spite of the health trusts having the capacity to increase their number of internships, these interns would still need the municipal part of their periods. Julie, therefore, believes there is a problem with capacity and resources:

> "*If they no longer had the options not come or change for the cities, the municipalities would have a stable, reliable resource they could depend and plan for.*"

In 2015, the Chief Municipal Doctor for the district municipality of Masfjorden in Vestland described the consequences of the reform from first-hand experience to Julie:

> "*He experienced that the interns, after the reform, never came. They signed their offers, but they weren't binding. It didn't have any consequences if they breached their contracts. So, they simply decided not to come.*"

However, the districts rely on access to interns, as their already few GPs needed colleagues in Urgent Care. Julie said this was the prerequisite for the establishment of the ALIS specialization, where they instead would invest in training positions for those who had finished their LIS1.

> "*An ALIS (General Medicine) Specialization! And it was a major success! Today, ALIS has become a national program, and it is very interesting that it derived from the Chief Municipal Doctor in Masfjorden.*"

Luther from LO/Fagforbundet's Professional Section of Health and Social believed it was necessary to revert to the old lottery-based model. Based upon conversations with GPs working in the districts, she argued the current system had resulted in several graduates queuing up for internships in the cities while the districts felt neglected. This was something she brought up in her work in the government-appointed Health Personnel Commission:

> "*I was very serious with this when I spoke against this in the Health Personnel Commission. Kristin Utne [the leader of the Young Doctors Association] got angry at me. But I believe we*

*need to take a political stance. Most doctors will manage to work one year away from where they're currently living.*"

Luther proposed that the government instead should look at alternative approaches to enable the hospitals to increase their capacity. One way, she reflected, would be to look at LIS1 more in terms of dual tracking, where the hospitals instead would be responsible for distributing interns to the municipalities upon finishing the hospital part.

## 6.3. EU/EEA Medical Authorization

### 6.3.1. Proposals

#### *6.3.1.1. Liberalizing LIS1 Authorization*

For most professions in the Norwegian labor market, international students must get their degrees approved by NOKUT (Norwegian Agency for Quality Assurance in Education) in order to work in their respective fields. However, certain specialized professions may require additional authorization from relevant regulatory bodies (NOKUT 2023). For health professions, the competent authority for recognition is the Directorate of Health.

The framework of authorization experienced a significant change alongside the LIS1 and Coordination reform in 2012. Graduates studying at international universities without integrated practice would no longer receive authorization. At that time, this meant that students graduating from 17 EU/EEA countries suddenly found themselves without authorization (Brandstorp 2013, 157). By 2021, this change in policy also impacted Danish graduates, which is a popular destination for Norwegian medical students (Helsedirektoratet 2021b).

The NMF leader, Sæther, said the government's rationale was that a student at least needs medical authorization in the host EU/EEA country in order to qualify for authorization in Norway. In countries without integrated practice, medical students do not receive full authorization before they have completed the requisite coursework. However, some of the international practice programs are quite extensive. In Denmark, for instance, NMF, together with ANSA, holds that the Danish program, Klinisk Basisutdannelse (KBU), covers several of the LIS1 learning objectives. The ANSA president, Hellesnes, finds it problematic that students finishing KBU still must finish the LIS1 internship in full and says they, in practice, receive "double internships:"

"*KBU and LIS1 are relatively equivalent. Therefore, it would've made more sense if one could have approved the LIS1 learning objectives that KBU covers. Then, one could simultaneously provide relief for the LIS1 bottleneck and let students move on with their specialist training.*"

The student associations, therefore, together with Hoksrud in the Progressive Party and the Christian Democratic Party, presented a couple of parliamentary proposals to the Committee of Healthcare in May 2022. In the first proposal, Document 8:98 S (2021-2022), the Progressive Party advised the government to approve learning objectives in LIS1 that are met by KBU (Stortinget 2022a). Furthermore, the proposal advises that these students should apply directly to LIS2/3 and will finish the remaining courses throughout their specialist training. In the second proposal, Document 8:128 S (2021-2022), the Christian Democratic Party sought to change the Specialty Regulation § 18, first paragraph, to give the Directorate authority to evaluate LIS1 learning objectives from medical practice programs throughout the EU/EEA (Stortinget 2022b).

Hoksrud expressed gratitude for the student associations' involvement with the parliamentary committee:

"*We received valuable input. They know the students and their needs. Ways to solve these issues, and how to do it in a good manner. We've also worked with the Medical Association and received great input. So, it's important that we cooperate with both students and associations. We appreciate this collaboration.*"

Neither Sæther nor Hellesnes held leadership roles during the period their respective organizations worked on these parliamentary proposals. However, both say they still are working actively on these issues and bringing awareness to politicians on how dire the situation is, often in collaboration with each other.

Following the parliamentary vote on these proposals on May 19th, 2022, the parliament voted, through Resolution 561, in favor of urging the government to inquire about the proposal by the Christian Democratic Party and advised the government to return to the parliament in an adequate manner by the end of the year (Stortinget 2022c). However, as of the time of my interview with Hellesnes in February 2023, the government had yet to get back to the parliament:

"*The Government was instructed to get back to the Parliament at the end of 2022. They haven't done this, as we're now sitting here in February 2023 and are still waiting.*"

She did, however, say that she had been made aware that Hoksrud, on the day of the interview, had forwarded a formal request to the government about the status of the inquiry.

Hoksrud found the delay both disappointing and frustrating but said this was commonplace in the Norwegian political system:

> "*It's a parliamentary motion. And one will often experience that the party in position will be less inclined to get involved. It's possible to create a majority in opposition to override the government. However, then, we will often find ourselves in situations like the one at hand.*"

Hoksrud said the rationale for often delaying such inquiries is that the government would instead like to present these notions as its own. If one really needs something to be done with an issue, he said, it would, to a large extent, depend on the motivation and engagement of the minister. He did not find this was the case with the current Minister of Health from the Labor Party, Ingvild Kjerkol:

> "*We're very dissatisfied with the government's handling [of the GP crisis]. Especially when Kjerkol sits on election night and promises that this is their most important issue.*"

Hoksrud, furthermore, believed that certain systemic barriers restrained the government and sought to exert control over the situation.

Julie stressed that she had not personally been working with these proposals but that she was familiar with the situation. She described the rationale behind the heavy regulations on the framework of foreign medical authorization as well-founded and intended to ensure quality, as international students would not have received the tight LIS1 supervision provided by the regional health trusts:

> "*In the absence of the RHF's supervision and control, this is the legal framework we have to depend on.*"

However, Julie did experience there had been a shift in attitude lately, as there no longer were doubts within the directorate of the crisis. As a result, she experienced that the organization now acknowledged the need to lighten and provide more flexibility to such hinders. Furthermore, as the current Secretary of State, Ole H. Bjørkholt, himself had his education in Denmark, he also believed it necessary to soften up.

Sæther said the Directorate formerly had provided summer courses for international graduates with an introduction to the Norwegian healthcare system. This was offered so that they could get covered the missing learning objectives from their medical internships:

> "*There are several physicians here at Legenes Hus [the headquarters of the Medical Association] that have studied abroad. I did, for example, talk to one who had studied in Germany, who, upon graduation, was given the opportunity to participate in a summer course introducing her to the Norwegian healthcare system.*"

Sæther argued such resources could once more be made available for international graduates. Julie was familiar with these former courses. She believed they were terminated due to issues with resources and capacity:

> "*I believe there in the 60s and 70s were provided quite extensive courses. Then, they became shorter and shorter and eventually terminated. So, this is a resource-capacity issue.*"

#### *6.3.1.2. Need for Pre-Authorization*

An article on the Directorate's webpage justifies the practice of refusing pre-authorization in that all medical authorization preconditions require a specific compositional organization of the degree and that specific learning objectives are met (Helsedirektoratet 2023a). As these factors may change throughout the course of students' education, the directorate does not have judicial grounds to provide pre-authorization.

The lack of pre-authorization was brought up as a major concern by the student organization leaders, Sæther and Hellesnes, as well as by the GP, Jakobsen, who had his medical degree in the Netherlands. The GP said this provided him and his classmates with a large degree of uncertainty, and their universities could only provide limited information. It would not be resolved until by the end of their degrees, and he expressed that they were missing reassurance:

> "*There was no one who told us that 'everything will be all right' and 'this will work out, we'll fix this for you.'"*

Both Sæther and Hellesnes experienced that the issue of pre-authorization was frequently brought up by their members. Sæther meant this practice posed unnecessary uncertainty to students and said that he received such inquiries daily:

> "*Just today, I got received an email from a student who asked, "If I study here and here, will it be approved?" And then, of course, I must answer that "All signs point to it, it is an EEA country, and the Directorate has a long history of approving these degrees. So, you will probably receive authorization."*

However, he was aware that there had been cases, such as for psychology students, where things suddenly changed. As a result, there is a high level of uncertainty involved when medical students take up significant student debt to study abroad, while at the same time do not know whether they, in the end, will receive authorization:

> "*I understand that it's tough. And, in a way, it makes them feel a bit scrutinized when studying abroad.*"

Hellesnes sought an approach where the practice of medical authorization could be more aligned with other professions or degrees in order to overcome the current issues with retroactivity:

> "*When students start with their educations, they should have the same premises for that degree the whole way. We're very serious about the need for certainty for the students.*"

In the summer of 2022, ANSA's general assembly delegates debated this issue. They voted in favor of a policy of non-retroactivity, which entails that students should be authorized based on the legal framework present at the start of their degrees, provided that this is to the student's advantage. She referred to their political program, which states: "Healthcare students must be guaranteed authorization at the start of their degree in the EU/EEA if there are changes in the regulatory framework concerning the approval of authorization throughout their course of study" (ANSA 2022, 10). Sæther said NMF shared ANSA's stance on this issue. While he could understand the directorate's argument about the risk of changes in the composition of medical degrees, he could not see for himself any hypothetical scenario where a host institution would change their medical degrees to such an extent that graduates no longer would be authorized to practice medicine in their host countries. After all, he argues, the criteria for EU/EEA Authorization only required graduates to have authorization in their host country and joked:

> "*So, I can see the argument of the directorate. Everything can happen, and all that. But that could also happen with the Norwegian medical degree. Who knows?"*

### 6.3.2. Sentiments

When discussing the informants on their views on the prospects of liberalization in the practice of EU/EEA authorization, it became apparent that the informants held notably diverse opinions and appeared to be divided into their perspectives. When discussing the issue of pre-authorization, the Medical Director of Finnmarkssykehuset HF, Sunde, held the view that students having their education abroad had made a conscious decision. They should, therefore, anticipate finishing their degrees in their host countries rather than relying on Norwegian educational institutions:

> "*We do receive some applications for internships from international students, and we can only say "no, we don't have the capacity for you." So, they run a partial risk in that they must also finish their education where they are. They can't expect to come and get all their clinical training here in Norway. We're already troubled following up with the students from the University of Tromsø! That's our number one priority.*"

The medical director expressed that they did not have enough capacity for external graduates and pointed out that these students should have been aware of this risk upon choosing to study medicine abroad.

When discussing Sunde's arguments with the NMF leader, Sæther, he acknowledged that this also had been a topic of contention between some domestic and international students. However, he held that this argument did not hold up, as the Norwegian healthcare sector would not have functioned without the international students:

> "*When the state, on its side, compels students to study abroad, and that one then says they, in a way, should "thank themselves" for having studied abroad, that doesn't sit well with me. These are people we desperately need.*"

The next concern on liberalizing the practice of authorization was raised by the leader of LO/Fagforbundet's Professional Section of Health and Social, Luther. Speaking from her own experiences when working as a lead nurse at a hospital, she had been working and supervising LIS1 interns. She expressed that she encountered knowledge gaps with foreign-trained physicians and that she did not meet with those educated in Norway:

> "*We often have to make them unlearn parts of the hierarchy that they were familiarized with in, e.g., Eastern Europe. We have another structure and organizing of our healthcare system.*"

Furthermore, Luther was puzzled that the educational compositions in some countries were too different from Norway, especially in some Asian countries and Russia:

> "*There, one becomes a specialist almost immediately. They take half of their education on a general basis, then become either a surgeon or a physician.*"

This posed a major concern, she argued, as Russian physicians do not receive a proper primary education:

> "*As a result, if a complication arises during surgery, they may not understand the procedures, or understand patterns, in the same way as a surgeon educated in Norway, as they lack the primary education before having their specialization."*

Luther, therefore, held the view that the national administration had to be very careful before meddling with the current requirements of authorization. In her opinion, Norway should educate most students domestically. To provide context, it made national headlines in 2021 when the police discovered a Kazakhstani head doctor at Flekkefjord Hospital had performed orthopedics without the necessary education. As a result, eight patients were discovered to have been subjected to serious surgical errors, leaving several permanently impaired and one patient dying due to neglect (Arntzen & Cantero 2021).

Brattetaule also said she was familiar with instances where there had been issues with interpreting foreign general physicians' authorization. She stressed that the Directorate's strict criteria of authorization, in combination with her department's requirements of satisfactory employment references, was a prerequisite for employing foreign GPs. However, as far as Norwegians studying medicine abroad were concerned, her personal reflection was that one should reconsider today's strict approach to medical authorization:

> "*You see, the LIS1 Service is a very nice way of introducing them into the Norwegian healthcare system, both to the specialized and municipal healthcare. Regardless, the supervisors will, through the course, have 18 months to evaluate whether the candidates are fit for duty.*"

Another problem raised by Luther concerned the professional linguistical skills of international physicians. She says the current practice of teaching and evaluating their professional language was not satisfactory. She was referring to "Bergenstesten," which was an advanced-level Norwegian test that, for context, was discontinued in 2022 (Utenriksdepartementet 2022). Luther argued that Bergenstesten and other tests for health personnel were inadequate:

> "*You can cram for these tests! It's simply not good enough. I'm very serious in my view that the linguistical education must be reformed.*"

The grounds for her concern were that it lacked an emphasis on communication. In Luther's view, cramming folders and not learning to communicate in Norwegian, to a large degree, led to misunderstandings. She emphasized that for the country to fully utilize the best labor force, it would be in its favor to provide migrants with the opportunity to learn the language properly. Luther also believed that, in a medical sense, it would be well-founded to incorporate a module for all foreign health personnel that introduced the working environment in Norway. This would include an introduction to the country's working culture, the organization and structure of the healthcare sector, and what they may expect:

> "*They aren't taught this, and, additionally, they lack the necessary linguistical skills.*"

Luther did, however, acknowledge that several of the Norwegians who study medicine abroad are really talented and eventually become good physicians.

The GP, Jakobsen, who himself had his degree in Amsterdam, had a very positive impression of the inclusion of foreign medical personnel in Norway's healthcare sector. As far as the recruitment of Norwegians studying medicine in the EU/EEA was concerned, he did not believe there was much risk associated. His impression was that the current practice of authorization of these groups was very convoluting and difficult, as compared to the former practice before the LIS1 reform, which he described as quite automatic. He believed this process

still worked in this way for the EU/EEA universities that had practice incorporated in the medical studies, but that the situation was vastly different for those requiring medical practice post-graduation in order to receive medical authorization.

Jakobsen also believed one should consider having a more open approach for those studying outside of the EU/EEA. Not only in terms of the possibility of authorization but also in assisting them with resources throughout the applicational process:

> "*We have several physicians from countries outside of the EU and EEA, and the processes they have to go through are totally insane! I know one from Venezuela that said he had to cover all associated costs. It's understandable that they need to test them for professional quality assurance, but they have to cover the costs themselves! That's very expensive – over 100 000kr out of their own pockets to even be considered! That's crazy!*"

Another concern raised by Hoksrud was the problem of expiring medical authorizations for foreign GPs. He said that he had been aware of a practice where Danish GPs who worked as GPs had their authorizations automatically withdrawn after a year. They then had to move back to Denmark. As a result, he was afraid they would be discouraged from re-applying and would opt to work elsewhere. The progressive MP was puzzled by why Norway maintained such special provisions. In his view, the government tended to blame various EU Directives. However, he argued several European countries still managed to fix this problem and that Norway earlier also had a more liberal practice in spite of being an EEA Member.

## 6.4. Temporary Employment Agencies and Private Actors

The presence of private actors in the FLO, and in healthcare more generally, appeared to be a significantly contentious issue amongst several of the respondents. As was mentioned in the section on the implications for the districts, the high demand for substitutes made national headlines in September of 2022 when it was discovered that Danish substitutes were offered monthly salaries of 200 000kr to work in the district municipality of Sykkylven in Møre and Romsdal County (Henriksen & Nyhus 2022). In this section, I begin by presenting the informants' perspectives on this issue and then share the experiences of the former FLO GP, Ofte, who ultimately transitioned to working privately.

### 6.4.1. Stakeholder Sentiments

The NMF leader, Sæther, expressed understanding for Sykkylven's decision, acknowledging that such measures were necessary during acute situations. It was better to have a substitute

than no GP at all. However, he was concerned that this undermined the FLO's underlying intention of citizens being assigned a fixed GP:

> "*Our first thought is that, when one turns towards temporary employment agencies, one also turns away from the thought of having a fixed GP, right?*"

Sæther would, rather, encourage the municipality to instead invest long-term in ways to make it more attractive to work as a GP there, which he argues is their responsibility.

This view was also shared by the leader of LO/Fagforbundet's Professional Section of Health and Social, Luther:

> "*I understand their need for substitutes. However, I wish they could've used all these resources on their existing GPs instead and make sure that they're well taken care of and that they recruit more.*"

She argued that, irrespective of their outward appearance, temporary employment agencies ultimately function as commercial enterprises primarily focused on profits. Luther stressed that commercial enterprises *should* exist in several areas, but within the healthcare sector, she found it "utterly reprehensible." She was also afraid that some GPs are not fully aware of what they are signing themselves into:

> "*If a privately working GP needs sick leave, they don't cover your salary. They reduce your shifts; they don't receive compensation. So, salary and working conditions are significantly worse.*"

Additionally, Luther argued they did not accrue any state pension, which they had to sort out by themselves. She expressed concerns about the challenging situation that GPs working in the private sector may face upon retirement, as they may not have adequately prepared for their pensions savings, resulting in a drastic reduction in their annual income from 2 000 000kr to only 450 000kr:

> "*I believe that first and foremost, they see that they can work for three days a week and earn lots of money. That's it.*"

The Director of Employee Organization and Technology from Helse Vest RHF, Christiansen, also expressed deep concerns with the growing number of private business concepts in the healthcare sector. She was afraid of their impact on the patients:

> "*I'm afraid that we no longer will have patient pathways, but, rather, fragmented pathways.*"

Consequently, she said that patients instead would need to consult multiple parties for simple clarifications and that patients that may have serious conditions will have to meet several doctors to be diagnosed and get treatment. This, she argued, could happen if the healthcare system came into a situation where the private sector would build up a private capacity, which

eventually could become the only professional capacity within a specific area. From her experience, this may be especially prone to happen within areas that do not require significant investments in technology, as she argues one has seen in the field of mental healthcare.

Christiansen shared Luther's concerns about the working conditions for substitutes. From her own experiences, several of those working as substitutes were also working full-time elsewhere:

> "*We see that they are often only available one week at a time in the municipalities – limited periods. This implies that they have other places to be. They aren't only substitutes.*"

This, Christiansen argued, she had been very vocal about with the labor associations, as they also represented members who worked for the private sector. She did, however, recognize that it was an unfortunate development that they, on the one hand, saw an increasingly demanding workload and, on the other, saw an increasing presence of substitutes in the hospitals and municipal healthcare. She emphasized that Norwegian society has invested considerable resources in the education and specialization of physicians and should focus on improving the sectors rather than relying on substitute contracts and risking the disintegration of the system.

Julie expressed deep concern over the potential pitfalls associated with students waiting for LIS1 internships opting for unsupervised positions for private actors, such as "Dr. Dropin," in the meantime:

> "*They're in the fully private market, right? They're not really qualified for it, and it makes me wonder about the quality of their supervision. We don't know! In LIS1, as it's currently structured, they receive resources and attention, and we hope they will continue if they're well taken care of. Especially for the districts and the FLO more generally. It's very important.*"

Julie was aware that this had developed to be an issue in Stockholm, where several students awaiting medical internships instead turned towards private actors.

The municipal leader of general medicine in Bergen, Brattetaule, offered a different perspective on the presence of temporary employment agencies. She experienced that these actors offered an easier alternative for Danish and Swedish GPs to enter the Norwegian labor market. At the time of the interview, Bergen had appointed two Danish substitutes. Brattetaule was not aware of how high the percentage of Norwegians in these agencies was. She could, however, see that it could offer a larger flexibility for GPs:

> "*It gives them the opportunity to work a bit here and there, to move around, and I also believe it's a good way for them to earn a lot of money. They can still be good GPs, regardless!*"

The GP, Jakobsen, said for his part that his initial placement as a substitute in the remote municipality of Stokmarknes eventually led to his full-time career there. It may, therefore,

appear that the presence of temporary employment agencies could provide some district municipalities with an alternative way of recruitment. The Progressive MP, Hoksrud, whose party generally favors private involvement in healthcare, rejects the view held by his political opponents that private actors solely benefit from the public sector without contributing to its improvement:

> "*I believe that one also should look at why we can't include private actors such as Aleris in relation to the GP Crisis. They've proved willing, and my experience is that Aleris wants to be involved in improving the FLO.*"

### 6.4.2. Ofte's Journey: From FLO GP to Private Practice

Given the strong and diverse opinions expressed by the informants regarding private actors and temporary employment agencies in relation to the GP Crisis, I found it necessary to also include the experiences of a former FLO GP who, after a long career within the public system, ultimately transitioned to the private sector. I, therefore, got in touch with Ståle Christian Ofte, who presently is working as a GP for the private business concept, Dr. Dropin, in Bergen.

Upon finishing his medical internship in 2004, Ofte ended up working as a GP in the district municipality of Hol in central Norway, halfway between Bergen and Oslo. He described it as rather coincidental that he ended up in Hol, as he had applied for several positions by the end of his internship. Having positive experiences with general medicine during his internship, and since none of his close friends were in Bergen either way, he accepted the offer, as he wanted to try working as a GP and see how well he would thrive in the role.

As Hol mainly focused on tourism, Ofte described his patient list as relatively small, as Ofte also needed to accommodate the influx of tourists during peak seasons. At the same time, he found it engaging to serve a diverse range of patients rather than being limited to a fixed patient base. He really appreciated this variation, which he described as his best experience. Conversely, he was not fond of the tasks associated with the mandatory urgent care service, especially working in the districts:

> "*That was, in a way, one of the things I was happy to leave behind when I moved*."

Ofte felt that it's not always ideal for a GP to be the sole responsible for the municipal provision of urgent care in the districts, especially when there is a long way to the closest hospital. He did, however, say that there was an air ambulance station nearby, which made him feel a bit more secure in handling severe medical situations.

Upon starting his position in Hol, Ofte chose to reside in the neighboring municipality of Geilo, which was approximately a 15-minute drive away. Due to the intimacy of living in

the districts, where everyone knows who you are, this was a conscious decision on his part. Ofte raised this as a major concern for GPs who are considering working in the districts:

> "*I felt relatively anonymous in Geilo, as the residents there mostly had their assigned GP there. It is a disadvantage to live and work in the same place. It can become exhausting. So, if you have the possibility to live and work in separate places, that's something I would recommend. Be aware of this!*"

As time went by, Ofte found working as an FLO GP to become increasingly tedious. As he also was not keen on the urgent care part, and his friends eventually moved back to Bergen and his family being there, he ultimately decided to move back in 2009. Since then, he never returned to the FLO. Instead, he worked for a period as a head physician for an elder care home and as an FLO GP substitute until he ultimately transitioned to the private business concept, Dr. Dropin, in 2019. He currently serves as a clinic manager for their location in Bergen city center.

When asked to compare his current working conditions, as compared with working as a GP in Hol, Ofte did not think there was much difference. As he operated with a short list in Hol, he felt that he managed to complete his paperwork within a reasonable amount of time, just as he does with Dr. Dropin. The only difference was mandatory urgent care. However, this was not the case when he worked as an FLO GP substitute in the district municipality of Osterøy, a 45-minutes-drive away from Bergen:

> "*There, I had a very long list that I substituted. I often needed to work two-to-three hours in the evenings to finish the paperwork alone. My alternative would be to use the Friday that was dedicated to paperwork and use that whole day for paperwork. However, for me, it was more efficient to work in the evenings to finish the paperwork, allowing me to have free time on that Friday rather than commuting to the office.*"

Ofte emphasized that the mere amount of paperwork that he experienced in Osterøy was reason enough for him not to work in the FLO. In addition, if he signed a contract with the municipality, he would additionally have to work with urgent care.

> "*I thought that would simply be too much.*"

Compared to his current work with Dr. Dropin, he felt that his current workload was much more manageable.

Ofte said his working conditions at Dr. Dropin were significantly better in other aspects as well. In Hol, he would mostly be restricted to taking time off during the off-season for tourism, such as in May. As he also did not have children to take care of at the time, he felt fortunate that he did not have a family to take care of:

"*If one has a family to take care of, one will be very bound up to school holidays and such. In that case, my situation would have become more problematic.*"

He described the situation as different working for Dr. Dropin. As they have no fixed lists of patients to take care of, it is more convenient for him to take time off:

"*I am not responsible for any patients, so it's not critical to hire substitutes to take care of them. In the worst case, we must close down the office when I'm on vacation.*"

When about if he saw a difference in the aspect of patient contact between working in the FLO and his current workplace, he believed that the FLO GPs received enough patient contact but that the real issue was the mounting paperwork in addition to patient care. Additionally, FLO GPs also receive inquiries from the welfare administration, home care nursing, and insurance companies. Dr. Dropin did, at times, receive inquiries from insurance companies but not from the former two.

When asked to respond to some of the concerns raised by the other respondents, he stressed that Dr. Dopin had never intended to become a full-fledged alternative to the FLO or Urgent Care. Rather, he argued, they aimed to provide patients with the opportunity to access care promptly rather than enduring prolonged wait times. Patients were followed up through the Patient Sky messaging service, and stressed that they encouraged patients to contact their FLO GP when that was appropriate. As far as Dr. Dropin's provision of substitute services was concerned, he was not able to provide any comment, as he had not worked closely with that part of the enterprise. In terms of the argument that GPs should feel a responsibility to work in the FLO, he disagreed:

"*No, I believe that is a bit ideological and a too simplistic view of the situation. That one, in a way, "owes" the society because one has a certain education.*"

In that case, due to the current situation in the FLO, Ofte argued he would have instead taken a new specialization or different education. For him, the only alternative would have been to quit as a GP or work for Dr. Dropin. If the state established a hard-line policy where GPs were forced to work for the FLO, he thought they would quickly experience a dropout:

"*Similar to the experiences of the nurses, right? Where 1 out of 5 drops out in a short number of years simply because they've had enough. I believe it's necessary to provide flexibility in working opportunities.*"

When it came to the arguments that GPs working as substitutes did it for economic purposes, he acknowledged that he knew some physicians that speculated on quitting their regular positions in order to do so. He could, however, not see for himself how this would work out in practice:

"*I don't think it would be very popular when they eventually would return to their former positions. To put it one way, I don't believe that it would be good PR for that doctor. I think one would consider them greedy and bad. It would have created a negative atmosphere in their office, both with the patients and other health personnel. I would not recommend going for such an approach.*"

Instead, Ofte argued it would be ideal for empty nesters who may want to travel a bit across the country and experience new places, get new impulses, and not get stuck in one place.

## 6.5. Summary

On the following page, Figure 2 represents an overview of the themes, codes, and sub-codes of the analysis, as well as the relationship between them. It is not surprising that the most extensive theme of the analysis is "Recruitment." Ultimately, the main cause of the crisis is a lack of general physicians in the National GP Service. The other themes, "Bottlenecks," "EU/EEA Authorization," and "Temporary Employment Agencies," could also be argued to represent various codes concerning recruitment. However, as I find them of special interest to the analysis, I chose to include them as separate themes.

The figure effectively displays the inherent complexity of the Norwegian GP crisis. I would argue that this is a simplified version of the various facets brought up by the informants. In reality, several of the codes across the themes are directly or indirectly interlinked. However, in the end, they are all contributing parts of the GP crisis that are worth examining independently. With these new insights in mind, we shall now turn to the discussion chapter of the thesis.

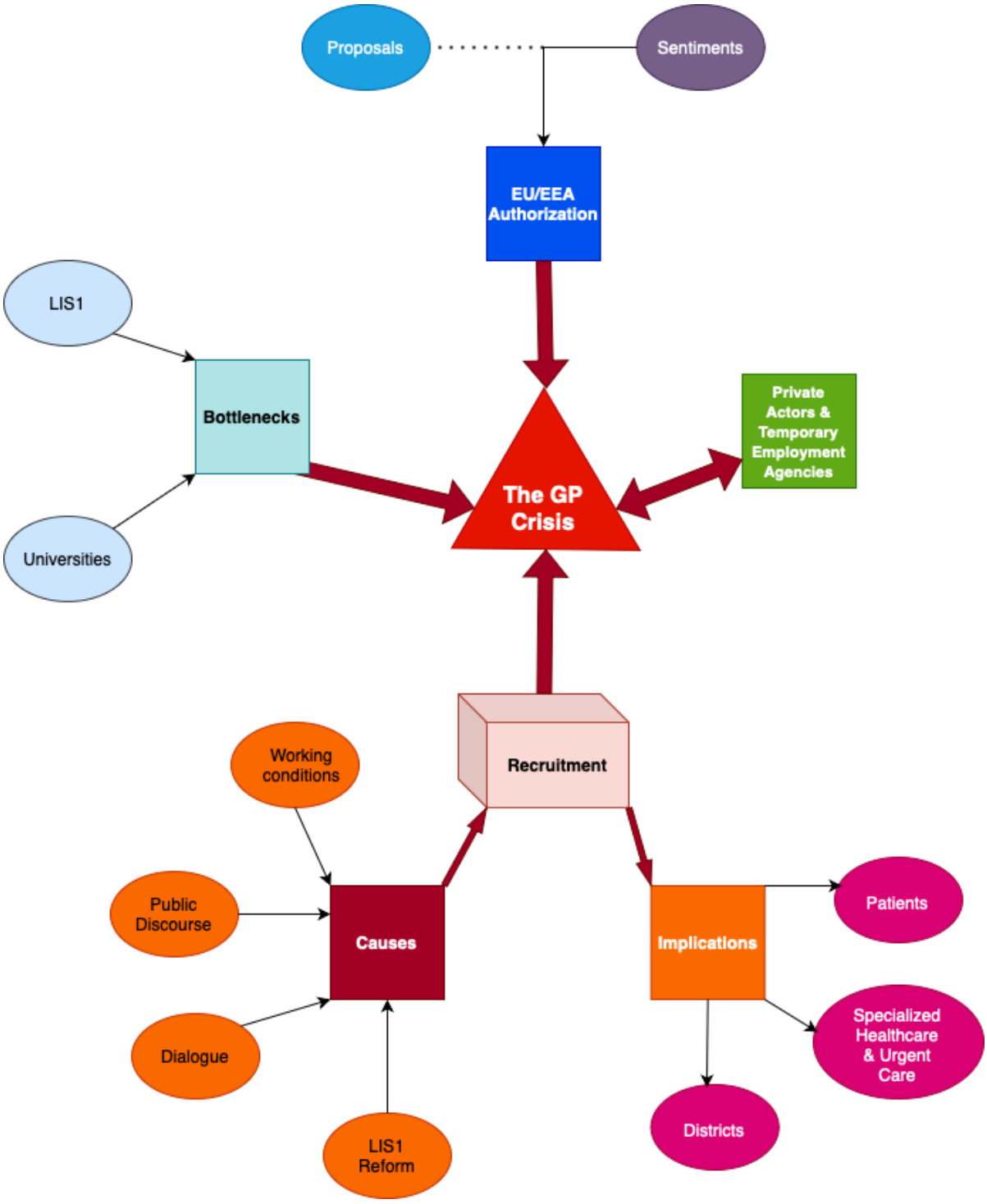


**Figure 2**: Overview of Themes, Codes, and Sub-Codes of the Analysis.

# 7. Discussion

## 7.1. Implications of the Findings

This study provides new insight into the underlying causes of the Norwegian GP Crisis and intricately unravels the long-term repercussions of new public management reforms within the public sector. The discoveries uncovered in section 6.1.1.3 about the underlying issues of dialogue between various operative levels of Norway's healthcare sector suggest that, after a decade of re-organizing in the Directorate of Health, the professional focus has gradually shifted towards one favoring economy and efficiency over medical expertise. This, in turn, has precipitated a shift in organizational mindset, where problem-solving is approached from the perspective of allocating increased funding to specific areas rather than acknowledging the complexities and need for structural reform. In turn, this can result in public administration misinterpreting the issues faced by the GPs, reducing their concerns to merely a reoccurring demand for increased financial compensation.

This study's implications highlight the need for a fundamental reassessment of the Norwegian healthcare sector's approach to problem-solving, particularly in relation to GPs' concerns. However, before moving forward, we will revisit the initial research question. We will then discuss the findings in light of existing research and theories before moving on to the conclusion.

## 7.2. Answering the Research Question:

In this section, I will address the research question of this thesis, as stated in section 1.2. We will now delve into the perceptions of various stakeholders regarding the Norwegian GP Crisis. Their insights, drawn from various levels and areas within the healthcare system, illuminate the complexities of the crisis and provide an array of perspectives that underlines the crisis' far-reaching implications. Furthermore, we will discuss their views on the potential of liberalizing the practice of EU/EEA medical authorization, as well as explore the short-term solutions they propose to address the crisis. Let us begin by discussing the multitude of issues faced by FLO GPs, as conveyed by the respondents.

### 7.2.1. Stakeholder Perceptions on the GP Crisis

#### *7.2.1.1. Causes for Issues with Recruitment*

In an ironic twist, the President of the Medical Students Association, Sæther, lucidly explained that the roots of the GP crisis could be traced back to the very success of the program itself. The idea of all citizens being assigned a fixed GP, they got to know their physician, and it improved the user experience. Due to its success, the authorities had another well-intended idea to transfer responsibilities from other areas of the healthcare system to the GPs, as they know their patients the best. This has led to a steadily increased workload, where the authorities, as was described by several informants in section 6.1.1.1.4, have not adequately understood nor addressed the increased costs involved. As the FLO GP, Jakobsen, discussed in the same section, he sought the government to acknowledge that there today are new costs associated with running a GP office, especially concerning the upkeep of digital systems. These increased costs have, as the Medical Director of Finnmarkssykehuset HF, Sunde, said, forced the GPs to increase the number of patients on their lists to break even economically. The Coordination reform was cited by several of the informants as a catalyst in this development, as it largely enabled the transfer of responsibilities from the specialized health services to FLO GPs, as discussed in section 6.1.1.1.1.

The second major issue relates to the difficulties FLO GPs are facing when applying for rightful leave, such as sick days, sick child, paternal/maternal, as well as annual leave. As was described by several of the informants in section 6.4.1, municipalities do not only hire substitutes to cover GPs on leave, but they also hire these services to periodically substitute for unfilled lists. This has resulted in a significantly high demand for these agencies, significantly driving up the costs. This puts municipalities, and perhaps especially economically weaker district municipalities, which, as we have seen in section 6.1.2.1, puts them in a tough situation.

A third major issue is the lack of training on the practical operations of self-employment. As discussed in section 6.1.1.1.2, the lack of practical supervision beyond the training in general medicine was highlighted as a potentially major factor deterring the recruitment of young physicians. As Jakobsen described, GPs receive limited training in how to run a private business, including handling judicial twists, writing employment contracts, accounting, and payroll management. Sæther did, however, mention that the government appeared to become aware of this issue and had directed significant funds to improve the capacity of ALIS supervisors.

The fourth major issue was the organizing of Urgent Care, where FLO GPs, by law, must dedicate 1-2 days a month on top of their full-time employment as general physicians. Some GPs, like Jakobsen described in section 6.1.2.1, appreciated this variation. Especially in the districts, as this could provide GPs with a sense of closeness with the local hospitals. Other GPs, like in the case of Ofte in section 6.4.2, did not enjoy this part of the job. Especially working in the districts, as one could often end up being the only one in charge, which could be scary when there is a long distance to the closest hospital. As was discussed in section 6.1.1.1.1, Bergen Municipality had come aware of this issue in its 2022 Deloitte Audit, where several of the city's GPs expressed dissatisfaction in balancing urgent care duty with their normal working hours. The municipal FLO Head, Brattetaule, mentioned that they, to an extent, had attempted to address this issue by covering about half of its urgent care capacity with external doctors on permanent contracts. This was mainly an effort to relieve, e.g., senior and pregnant doctors, as well as those with specific social needs. Bergen is, however, as Norway's second largest municipality, in a favorable position with regards to resources. As was mentioned by Julie in section 6.2.2, district municipalities tend to depend solely on FLO GPs for the functioning of urgent care.

#### *7.2.1.2. Bottlenecks in Universities and LIS1*

The bottlenecks in universities and LIS1 were pointed out as major concerns by several of the informants in section 6.2. With regards to the universities, it was argued by Sæther and Julie that this was due to the medical degree being one of the most expensive degrees. They also argued it was due to capacity, as Norway has a challenging geography and a sparsely distributed population. As there are often significant distances between the hospitals, it is difficult to coordinate medical students' education concerning obligatory practice. However, as Hoksrud argued, several other universities have signaled interest in providing medical degrees without the government seeming to provide any serious attention.

With the LIS1 bottleneck, Julie argued a major reason was the reform of 2012. With the introduction of the applications-based system, LIS1 contracts were no longer binding, which she argued had left district municipalities in a tough spot. As the latter is dependent on a reliable provision of LIS1 interns for the functioning of their urgent care, several municipalities have opted out, negatively impacting the national capacity. So, despite some health trusts, like Helse Vest, having the capacity to increase their LIS1 positions, this is not possible as students also need to do their obligatory municipal training. Helse Vest did, however, propose ideas on how to address this issue, such as making students apply for health regions rather than specific

hospitals and municipalities. This, however, does not appear to have attracted any national attention, and the anonymous respondent from the Directorate was not aware of this proposal.

#### *7.2.1.3. Implications for Recruitment*

The dysfunctional vertical dialogue between the FLO GPs and municipalities towards the public administration, as uncovered in section 6.1.1.3, appears to be one of the most significant underlying issues for the Norwegian GP crisis. The national administration's lacking professional ability to deal with the challenges facing the FLO GPs is, as was argued by the anonymous employee of the Directorate, a consequence of a long-term neglect of its medical professional capacity in favor of economic managerialism. As a result, the GPs are left with no choice but to voice their frustrations through alternative channels, being the media. As was mentioned by several informants, such as the FLO Head of Bergen Municipality and the director from Helse Vest, several of those challenges should not ideally be discussed openly. However, as the anonymous respondent argued, the GPs are really left with no other realistic channels to voice their opinions, and powerless government MPs and top bureaucrats alike are urging them to go public as well. However, it comes at a cost. As mentioned by the GP, Ofte, and the NMF Leader, Sæther, it has contributed to undermining the FLO's outward reputation and has made the specialization less appealing for young medical students.

Christiansen and Luther also talked about what they perceived to be a generational shift, where the new generation of GPs held a certain standard of expectations for working conditions, as discussed in section 6.1.1.1.1. Work-life balance appears to be a major concern for young physicians. Furthermore, as discussed by Sæther and Christiansen, the idea of having to "purchase" lists is considered a high-risk investment for several GPs, and many physicians appear to not want to settle down such a short time after receiving their specialization. Sæther and Hoksrud pointed out the success of alternative pilot projects in several municipalities. In Tromsø, for instance, a model where FLO GPs worked directly from a municipal office and received increased subsidies has been very well-received. Additionally, the North Sea Rotation initiative is gaining traction among especially young GPs. This initiative allows these doctors to experience working in the districts before making commitments.

#### *7.2.1.4. Liberalizing EU/EEA Authorization*

The prospects of liberalizing the practice of authorization of physicians educated in EU/EEA were discussed with several of the informants in section 6.3, who appeared to have various views. Sunde, for instance, argued that today's practice should be maintained, and Norwegian

students who have their degrees make a conscious decision, should be aware of these challenges and should, therefore, expect to complete their education in their host nations. With regards to foreign GPs, Luther was concerned about today's methods of linguistical testing and coursing and maintained that they did not sufficiently prepare students for a professional working environment. Brattetaule believed today's criteria for authorization for EU/EEA medical graduates was too strict but maintained that she trusted the Directorate's judgment. Speaking on behalf of Norwegians studying medicine abroad, Sæther, Jakobsen, Hoksrud, and Hellesnes were in favor of liberalizing today's practice in relation to approving EU/EEA medical internships as LIS1 and the necessity of pre-authorization. Julie believed that the current practice was due to fragmentation in the professional capacity. In the absence of the RHFs' control, sufficient capacity, and resources, the Directorate is left with no options but to strictly enforce existing laws with no flexibility.

#### *7.2.1.5. Private Actors and Temporary Employment Agencies*

Voicing his dissatisfaction against such actors, Sunde maintained that it was important to recognize that these actors have found a very lucrative market that they are exploiting (6.1.2.1). I argue that these actors' apparent success is grounded on the weaknesses of today's FLO. First, as Brattetaule and Hoksrud argued, these actors have also provided Scandinavian GPs access to the Norwegian labor market. Second, provides the GPs with the flexibility they are seeking, a way of avoiding urgent care duty, a way to travel across the country without being bound, and lastly, a way of earning good money fast. Furthermore, private non-FLO affiliated GP offices, such as Dr. Dropin, provide citizens with a quick and practical alternative for fast medical attention without having to wait for weeks for a doctor's appointment with an overworked (or non-existent) FLO GP (6.4).

#### *7.2.1.6. Implications for the Specialized Healthcare and Urgent Care*

The Medical Director of Finnmarkssykehuset HF, Sunde, said he had become aware that several of their hospitals and clinics expressed unease over ending patient contact when they knew there was no GP on the other end and the municipality was struggling with their capacity (6.1.2.2). This resulted in patients ready for discharge being left waiting in their hospital beds, which negatively impacted the institutions' waitlists. The director from Helse Vest, Christiansen, believed in Sunde's logic but said they lacked the data to officially establish that this was the case.

With regards to Urgent Care, both Brattetaule and Jakobsen said patients without an assigned GP who needed medical attention often found themselves with no other alternative than getting in touch with the municipal Urgent Care. However, as the Urgent Care services themselves are struggling with their capacity, several patients are denied attention, as these services by law are operated by the FLO GPs (which there is a lack of).

#### *7.2.1.7. Implications for Patients*

As was discussed in section 6.1.2.3, given the importance and reliance of the FLO for the functioning of the Norwegian healthcare system, citizens without a designated GP present a serious problem. In the region of Finnmark, as of September 2022, 1 out of 10 lacks a designated GP (Allmennlegeforeningen 2022). When describing what this would entail in practice, the GP, Jakobsen, said these do not have access to digital services, essential documentation may not be registered in their journals, crises may erupt, and coordination between various service providers may experience disruptions. He described that patients whose GPs have retired express anxiety and are left with few options. Hoksrud argued it impacts the safety of the patients, as early signs of serious illnesses may be discovered too late due to the lack of routine check-ups. The head of the FLO in Bergen Municipality, Brattetaule, also mentioned an important problem relating to user privacy, where the municipality only could see who was on a waitlist but not who *actually* was not assigned a GP.

### 7.2.2. Short-Term Solutions

Answering the first half of the thesis' research question, we have now seen the multifaceted nature of the Norwegian GP Crisis from the perspectives of various stakeholders. We have uncovered a myriad of issues and experiences and have clearly underscored their collective insights. In the following section, we will now turn our attention to the short-term solutions proposed by these stakeholders. We will explore how they envision addressing the immediate impacts of the GP crisis, mitigating its most pressing consequences, and establishing a foundation for long-term systemic improvements.

In relation to the national administration, it appears, from Jakobsen and Julie's view, that the government should inquire and reconsider its lines of communication with the municipal health services and FLO GPs. Steps should also be taken to heighten the recognition of the necessity for incorporating medical professionals within the directorate and ministry decision-making. As was proposed by Christiansen, there should also be considered establishing groups

or distributing questionnaires with open-ended questions, where medical students, LIS physicians, or current GPs can voice their opinions.

Regarding the government's district policy, more attention should be made to the various piloting projects, as mentioned by Sæther, Hoksrud, and Sunde. Various subsidy schemes, municipally run GP offices, and North Sea Rotation have, for some previously struggling districts, helped in recruiting physicians. Christiansen's proposal of restructuring the application process of LIS towards admissions regions, rather than applying to hospitals and municipalities directly, should also be inquired. As Julie said, the current system has proved difficult for districts to recruit the LIS1 that their health services heavily rely on. Luther proposes an intriguing dual-track solution where LIS1 candidates apply directly to hospitals, which are then entrusted with the responsibility of ensuring a balanced distribution of these interns to municipal healthcare services. This cooperative solution could provide districts with greater predictability and stability.

Luther also raised an important point on the government's heavy emphasis on patient rights. Instead, she argued, the government should acknowledge that it does not always have the capacity to ensure every right. Instead, Luther proposed that one should focus on citizens' collective rights. This is a thought-provoking suggestion that arguably should be examined. It also plays well with the principle of North Sea Rotation: The municipality does not have the capacity to cover your *patient* right for a fixed GP, but you will provide your *collective* right to medical attention by a rotational GP.

In the context of the bottlenecks at the universities, the government should inquire about the possibility of lifting the current monopoly in medical education and open for including other candidates, as proposed by Hoksrud.

When it comes to Urgent Care, the government should inquire whether Bergen's model of partial staffing by permanent GPs, aimed at relieving the burden of the FLO GPs, could be implemented as a nationwide norm, including providing district municipalities with the necessary funding to realize this. This could provide them with a more flexible approach toward GPs who do not wish to take part in urgent care.

As was mentioned by Christiansen, Sæther, and Brattetaule, the process of purchasing patient lists is considered a risky investment for young GPs. It should be inquired whether this approach is appropriate for the districts and evaluate whether there could be established piloting projects where some of the lists could be managed on the basis of North Sea Rotation.

With regards to EU/EEA Medical Authorization, the government should, as soon as possible, evaluate whether it is appropriate that Scandinavian GPs have an expiry date on their Norwegian authorization, as was pointed out by Hoksrud. The government should also report back to parliament with regard to the adopted resolutions on liberalizing the laws regulating the authorization of EU/EEA medical graduates who have undergone internships in their host countries. The government should also inquire whether today's policy of not providing pre-authorization for Norwegian students studying within the EU/EEA is appropriate, as expressed by Sæther and Hellesnes.

Concerning working conditions, Hoksrud, Jakobsen, Sunde, and Ofte argued that the government should inquire about the possibility of compensating FLO GPs for their additional work, such as paperwork, filling of forms and applications, but also meetings and other communications on behalf of their patients with the welfare administration, employers, insurance companies, etc. This could also make shorter patient lists more economically viable.

In relation to the right to leave, the municipal health services must be able to guarantee FLO GP's rights to sickness, sick child, maternal and paternal, as well as annual leave. In the worst case, GP offices should be able to close periodically in cases where the municipalities are not able to find a substitute. Ofte brought this forward as a significant strength for working privately at Dr. Dropin. As he argues, it also makes it easier for GPs who have children to take care of. Closely linked to this issue, it was described by Brattetaule, Christiansen, and Luther that several GPs might have good reasons for periodically wanting to work at a lower percentage. The national government should, therefore, also inquire about this option, as it may prevent those GPs from turning to the private sector.

Finally, the effectiveness of the government's financial incentive schemes, such as forgiving student debt for academics residing in Finnmark and the northern parts of Troms, in addition to providing progressive tax relief for high-income earners, was argued by Sunde to be effective measures to attract professionals to the most remote districts (6.1.2.1.). There should, therefore, be inquired whether such programs could be expanded to district municipalities that are experiencing issues with the recruitment of FLO GPs.

## 7.3. Alignment with Previous Research

Having now discussed the perceptions of various stakeholders on the Norwegian GP crisis, we have painted a comprehensive picture of the multifaceted issue at hand. As we move forward, we will now examine how these findings align with, challenge, or potentially improve upon

existing research. In this section, I will discuss the findings in light of the literature review in section 2.

### 7.3.1. Research on the GP Crisis

Drawing upon the reviewed literature in section 2.2, it becomes evident that my research findings not only align with existing research but also contribute in additional depth and nuance to our understanding.

The finding on the national healthcare administration lacking the professional capacity to interpret and respond to the FLO GP's concerns fits well with the discoveries made in Sørensen & Berg-Olsen's (2021) study. Considering some digitalization reforms, the GPs interviewed in the study criticized the authorities for not being included in the designing process and stressed that dialogue was essential for such reform's success. While the physicians really were critiquing the additional workload associated with these reforms, they experienced that it was misinterpreted as resistance to change (Sørensen & Berg-Olsen 2021, 45). A similar understanding was shared by several of my informants, where problems concerning deeper structural issues on working conditions, as discussed in section 6.1.1.1, are inaccurately being interpreted as never-ending demands for increased funding due to the professional lack of medical expertise in public administration, as seen in section 6.1.1.3.

My findings on the issue with the current practice of authorizing physicians who had their medical degrees abroad also fit well with the experiences of the two informants with medical backgrounds in Westad (2020). Both described the authorization process as a hopeless fight and process and emotionally draining. The lack of flexibility in providing foreign physicians with the necessary courses to meet the requirements of authorization often left them with the only option to restart their degrees, having to compete in the regular admission for medical studies (Westad 2020, 57-58). In addition to confirming these experiences, my interview data also provide further insights into the multifaceted underlying causes of the current practice. As discussed in sections 6.2.1 and 6.1.1.3, the reason for the lack of flexibility appears to come as a result of lacking capacity and resources in both universities and the directorate. As became apparent, this has not always been the case, as the availability of state-sanctioned courses for foreign GPs that introduced them to the Norwegian healthcare system and filled the gaps of learning objectives was widely available in the 70s and 80s. However, due to resource and capacity constraints, these courses were gradually phased out and eventually terminated by the turn of the millennium.

This study's findings in section also correspond well with the findings of Kristoffersen, who already in 2013 described an FLO beset with multifaceted issues, including an aging workforce and medical graduates refraining from specializing in general medicine. Kristoffersen held, on the one hand, that the 2001 reform that introduced the FLO was successful in terms of cost control. On the other hand, its micromanagement-styled incentives systems had, in Kristoffersen's view, impacted the state's will for innovation and professional development (2013, 125-126). As of the findings in my analysis, these problems appear to remain as of today and have been even further exacerbated.

With regards to the remarks by Brandstorp (2013, 151) concerning the "salmon steam effect" in connection to the LIS1 reform of 2012, most of the respondents did not appear to believe the reform had made any significant impact on the recruitment for the districts. The medical director of Finnmarkssykehuset HF, Sunde, as well as Julie, did, however, acknowledge that it had an impact on the recruitment of LIS1 in the district municipalities. Today, the districts experienced a pattern where graduates signing contracts tended to terminate their contracts if they got an offer on a more desirable location. Jakobsen, the Director from Helse Vest, Christiansen, as well as Julie, also perceived a trend where medical graduates tended to flock to the cities and would queue up for a LIS1 position rather than going to the districts. Jakobsen also pointed out that this could be a result of medical students no longer expecting or planning to move to the districts, as it was no longer compulsory. This stood in contrast to the old lottery-based system, where contracts were binding.

Lastly, with regards to the 2021 Deloitte audit for Bergen Municipality, the findings of this thesis confirms that the issues that were described also are experienced nationwide and were described by several stakeholders in section 6.1.1.1.

### 7.3.2. Research on Migration in Norway, Scandinavia, and Beyond

In section **Error! Reference source not found.** of the literature review, where existing research on migration to Norway, Scandinavia, and beyond was presented, I believe my research findings can contribute to providing both depth and clarity to many of the topics that were discussed, at least for the healthcare sector's part.

The 2014 OECD report on the current state of recruitment of immigrants in Norway was presented, which found that high-skilled migrants who come to work in the country tend to leave (2014, 15-16). Researchers suggested that this group faces obstacles not encountered by the local labor force, and ineffective and time-consuming hurdles in education and skill recognition were pointed out as examples (Sonniks 2014, 3; Søholt 2016, 25; Westad 2020, 4).

I believe my analysis not only appears to confirm this pattern but, furthermore, describes how these hurdles work in practice for the country's healthcare sector. My interview data also provides explanations on the origins of this issue, which, in part, could be blamed on cuts and efficiency reforms within public administration, resulting in decreased professional capacity and resources to efficiently address these issues, as discussed in section 6.1.1.3.

However, my analysis' findings appear not to contribute to any further knowledge of Häusermann, Kurer & Schwander's (2014) study on how labor market vulnerability is spreading into the highly educated segments of the European labor market. This may primarily be due to there being a critical lack of GPs and other medical specializations in the Norwegian healthcare sector, where physicians do not meet the same problems of employment vulnerability. However, as for Peterson, Pandya & Leblang's (2014) study, several of the stakeholders interviewed had a differing view on the prospects of liberalizing the practice of authorization and access to LIS1 for foreign graduates, as discussed in section 6.3.2. The leader of the Medical Student's Association, Sæther, also expressed in his interview that this had been a contentious issue between domestic and foreign Norwegian medical students. Especially in relation to whom should be prioritized in the provision of LIS1 internships.

As of Olsen's 2009 SSB report, he had identified what appeared to be a pattern where high-skilled migrants in Norway tended to favor the private sector over the public sector. The report concluded that this was the case as this group generally tended to have professional backgrounds that are less relevant to the public sector and hypothesized that migration generally does not center around the public sector (Olsen 2009, 3-4). Despite it being fair to claim these data are outdated, I believe that my research findings nonetheless provide a different perspective on this pattern, focusing on the difficulties migrants are facing in the healthcare sector. The obstacles to recruitment and skill recognition, and the practice of only providing temporary authorization of EU/EEA physicians, were discussed in sections 6.3.2 and 6.4.1 as reasons why Scandinavian physicians opted to work as substitutes on temporary contracts for private-sector agencies

## 7.4. Theoretical Implications of the Findings

In this section, we turn our attention to the theoretical implications of the research findings. Given the grounded theory approach adopted in this study, the process of data analysis was fundamentally inductive. This means that the existing theories did not directly influence the progression of the analysis. Rather, the data was collected and analyzed to generate a theory

grounded in the data itself. However, now that the findings have been established, it is both enlightening and essential to examine how these findings relate to existing theories within the field, such as the ones discussed in section 1.4 in the theoretical framework. By so doing, we can gain a deeper understanding of the GP Crisis as a phenomenon, as well as discuss the extent to which my research supports or challenges the existing theoretical landscape. In the following part, I will discuss my findings in light of the thesis' theoretical framework: 'Insider-Outsider Theory,' 'Historical Institutionalism' and 'Critical Juncture' theory, and, finally, 'Wicked Problems Theory.'

### 7.4.1. Insider-Outsider Theory

As discussed in section 3.1, it could, from this theoretical point of view, be argued that the Norwegian state's reluctance to liberalize the practice of authorizing foreign-educated physicians is grounded in Norwegian physicians' ("insiders") fear of compromising their working conditions, security and protecting their salaries from being underbid by an influx of cheap foreign labor ("outsiders"), as suggested by Lindbeck & Snower (1989, 119). This theory has, as Boräng, Kalm & Lindvall claim, led to a common belief that labor unions tend to resist immigration as it may threaten the native workforce (2020, 558). However, the results of their statistical analysis of historical data suggest an alternative answer, where the relationship between unions and the social and economic rights of migrants is inherently dynamic and context-bound. In other words, neither inherently exclusionary nor inclusionary toward immigration (Boräng, Kalm & Lindvall 2020, 558). This argument fits well with my research findings, as none of the unions that I interviewed appeared to understand the need for recruiting foreign GPs.

As discussed in section 6.3, both Sæther and Luther, who represented NMF and Fellesforbundet, respectively, appeared to understand the need for recruiting GPs who are educated in the EU/EEA. They also emphasized that the ideal situation would be that Norway educated the majority of its own medical students. Of the two, Sæther appeared to be the most positively centered toward liberalizing the practice of authorization for EU/EEA-educated physicians. This may well be a result of the fact that 40 % of Norwegian medical graduates study abroad (Studentum 2022), many of whom are also NMF members. Sæther appeared to be more reserved towards migration but was not inherently against it. Rather, she raised concerns over foreign physicians' professional linguistical skills and sought better quality assurance and provision of courses for the healthcare sector to better utilize what she described as talented foreign expertise.

This fits well with Boräng, Kalm & Lindvall's statistical argument that unions' relationships with the social and economic rights of migrants are both dynamic and context-bound. However, my analysis provides an alternative perspective to the theorists' arguments that unions will prioritize securing basic social and economic rights for the native workers before drawing their attention to promoting migrants' rights. As was discussed in section 6.1.1.1, the pressing need for GPs negatively impacts the working conditions of the remaining physicians. The larger pool of recruitment consisting of foreign GPs would, therefore, provide relief to an already strained system. This situation thus presents a whole new dimension to the Insider-Outsider Theory, where the native workforce would actually benefit from an increased presence of foreign physicians. The emergent dynamic described in this thesis could therefore provide an evolution of the Insider-Outsider Theory, where the welfare of the native workforce is intricately linked to the integration and acceptance of foreign professionals. In the case of the Norwegian GP crisis, an increase in foreign physicians would not necessarily undermine the insiders' position. Instead, it could enhance the overall resilience and capacity of the healthcare system. This reaffirms the need for a nuanced understanding of labor dynamics in specific contexts, as suggested by Boräng, Kalm & Lindvall (2020).

### 7.4.2. Historical Institutionalism and Critical Juncture Theory

Although the theoretical insights of historical institutionalism and critical junctures, reviewed in section 3.2, well could have proved interesting in relation to the GP Crisis, my interviews, and analysis have a limited ability to provide any further insights in that regard. This is predominantly due to the inductive approach, where such themes were not explicitly investigated. It should, however, be mentioned that earlier research on the development of Norwegian migration policy, such as the OECD report discussed in section **Error! Reference source not found.**, did suggest that a major shift in policy took place in the aftermath of the Oil Price Shocks in the 70s (2014, 66). As was suggested in the literature on the historical development of the Norwegian healthcare sector in section 5.1.2, the GP practice was loosely regulated before the introduction of the Municipal Services Act in 1983-84 (Schøyen 2021, 250; Kristoffersen 2013, 115). At the end of section 6.3.1.1, it was also discussed by several of the informants that in the 60s and 70s was provided quite extensive courses to help foreign GPs fill knowledge gaps in order to reach authorization. These courses were then, however, gradually shortened and eventually terminated. The extent to which it could be argued that this shift partially could be blamed on a shift in public policy due to a "critical juncture" occurring

in relation to the Oil Price Shocks of the 70s remains an open question and could be a topic for future research.

### 7.4.3. Is the Norwegian GP Crisis a 'Wicked Problem?'

As we now turn our attention to Rittel & Webber's (1973) concept of 'Wicked Problems,' as discussed in section 3.3, it is intriguing to discuss this theory in light of the findings from the analysis. Especially considering Head & Alford's (2013) proposed solutions to such phenomena. So, is the Norwegian GP Crisis an example of a 'Wicked Problem?'

Rittel & Webber (1973) holds that some of the problems that the public administration encounters are of such an inherently complex nature that they may be deemed incomprehensible and resistant to a solution (in Head & Alford 2013, 716). Multiple stakeholders are often involved, having differing biases, and neither is necessarily "right" or "wrong." As modern societies have evolved to become more pluralistic rather than homogenous, this has also become true for the problems that public administrations encounter. As economic and social problems can no longer be understood and addressed in isolation, traditional top-down approaches are less amendable today (Head & Alford 2013, 713). Due to managerialism and contractualism, which aims to cut cost and promote fiscal discipline, Head & Alford argues that NPM processes of public administration are unable to sufficiently deal with wicked problems (2013, 719). Furthermore, wicked problems often involve areas that are characterized by fragmentation and gaps in reliable knowledge (Head & Alford 2013, 716). This is argued to be especially prevalent in NPM systems, as they tend to foster "cultural fortresses" of professional expertise (Head & Alford 2013, 719).

The description provided by the informants, as discussed in section 6.1.1.3, could provide insight into what this looks like in practice. As the Directorate of Health has gradually shifted towards a professional mindset of managerialism, and its medical expertise appears to have been neglected over time. As the Coordination Reform created asymmetrical lines of communication between the municipal and specialized health services towards the public administration, this has contributed to what Head & Alford (2013, 716) rightly describe as fragmentation and gaps in reliable knowledge. Furthermore, the neglect of the medical expertise in the Directorate of Health has resulted in a situation where the public administration lacks both the capacity and resources to effectively acknowledge and respond to signals. Instead, less effective traditional top-down approaches, as described by Head & Alford (2013, 716), are implemented, where economists attempt to solve problems based on traditional economic principles. These principles tend to simplify reality to identify economic focus areas for funding

rather than acknowledging the fundamental complexity of the problems, which necessitates deeper systemic change.

Considering Rittel & Webber's (1973, 161-167) 10-point list of features characterizing wicked problems, as discussed in section 3.3.1.1, I argue that the Norwegian GP Crisis fits with several of the descriptions. As for point 1, we know that the GP Crisis ultimately involves a problem with recruitment. However, just as with climate change, there is no definitive formulation of the problem. As described in Figure 2 and 6, the GP Crisis is inherently multifaceted, and it is hard, if not impossible, to point to one specific code and claim this is *the* fundamental cause. Furthermore, there may be several facets of the GP Crisis that my research has not entirely or sufficiently touched. This argument also holds for points 2, 3, and 4, as there cannot be a definitive solution to a problem that cannot be defined. It also holds for point 5, as we cannot be truly certain of the implications of any attempted solution in the same way as the results cannot be readily undone.

As for point 10, like with so many dilemmas facing the healthcare sector, there is very little public tolerance for experiments that fail. Especially for the FLO, due to the important role of the GPs. As of point 7, as was mentioned by Julie in section 6.1.1.3, Norway is not the only country currently experiencing a GP shortage as she mentioned both Scotland and Sweden were experiencing the same issues. However, as discussed in relation to point 1, the specific historical context, circumstances, and contributing factors make the Norwegian GP Crisis unique. Especially in relation to its demography and geography, educational system, structuring of the healthcare system, and social/cultural factors, making the Norwegian case essentially unique. As for point 8, the Norwegian GP Crisis could, as seen in section 6.1.1.3, be considered a symptom of another problem, being the professionalization and managerialism of the Norwegian public sector. This has, in turn, resulted in a fracturing of knowledge and expertise amongst various stakeholders, leading to discrepancies in various parts of the healthcare sector's understanding of the GP Crisis, as suggested in point 9. This also appeared to be the case amongst the informants as some argued this was an issue in the financing, whilst other stakeholders argued this was a systemic problem that required re-organizing.

#### *7.4.3.1. A 'Wicked Problem' Approach to Solving the GP Crisis*

As discussed in section 3.3.2.1, Head & Alford argues that an important first step a government must take to solve a wicked problem is acknowledging the realities that they pose (2013, 722). This requires attention to their complexities, uncertainty, as well as disagreements among various stakeholders. Rather than the traditional top-down mentality in solving such issues, the

theorists argue in favor of a horizontal approach where solutions should be rooted in negotiation between the involved actors' concerns in order to reach a common understanding of both the problem and possible solutions (Head & Alford 2013, 723).

What may this look like in practice? Head & Alford (2013, 731) brought to attention an initiative modeled in the Dutch civil service, where two program ministries were established in 2007 with the hope of achieving "horizontally and vertically coordinated thinking and action." These ministries were granted significant responsibilities and authority that spanned across various stakeholders within the public administration. To fulfill these responsibilities, the program ministries were granted generous, flexible "pool budgets," as well as the authority to draw on the capacity and human resources across ministries (Head & Alford 2013, 731-732).

Translating these learnings into the Norwegian context could prove to be an intriguing feat to explore the feasibility of implementing such an approach. Creating an FLO program ministry, like the Dutch model, with extended authority and flexible budgets might present a dynamic strategy to address the GP Crisis. It would allow for greater cross-sectional collaboration and a more inclusive process of problem-solving, aligning with Head & Alford's (2013) advocacy for more horizontal approaches. However, this also would also necessitate a willingness from the Norwegian government to take a significant risk and embrace potentially fundamental changes in the FLO. The real question, then, is whether its healthcare sector is ready to venture into such uncharted territory, considering the complexities and uncertainties that characterize the GP Crisis as a wicked problem. It could potentially lead to innovative solutions, but it also requires a fundamental shift in mindset toward acknowledging and embracing the inherent complexity of the GP Crisis. Therefore, a more thorough examination of the experiences and outcomes of other countries that have experimented with program ministries would be valuable next steps in considering this approach for the Norwegian case.

## 7.5. Reflections on Research Limitations

In the context of this thesis, it is essential to acknowledge the scope and limitations of the findings. In this section, I will address and critically evaluate such concerns and outline how various factors and potential biases can impact the interpretation and generalizability of the research findings.

### 7.5.1. Scope of Stakeholder Perspectives

Although I have sought to cover a broad range of stakeholder perspectives in my analysis, it is crucial to remember that the informants spoke on their own behalf and drew on their personal experiences. This essentially means that their responses do not represent their respective organizations, nor the totality of the stakeholders involved in the Norwegian GP Crisis. Their personal views provide valuable and intimate insights, but there are undoubtedly other perspectives and areas not covered in this study.

### 7.5.2. Depth of Exploration

As became evidently clear, the Norwegian GP Crisis is inherently complex and impacts multiple areas, also beyond the healthcare sector itself. I have chosen to focus on certain key aspects, which may have limited the scope of exploration to other factors or solutions to the crisis. There has been an active debate on the GP Crisis in Norwegian media throughout the course of the research. Additionally, a government-sanctioned expert panel, "Fastlegeutvalget," released their report findings and recommendations in April[2]. However, due to the timing of this publication coinciding with the later stages of my thesis preparation, I deemed it not practically feasible to address these new findings.

### 7.5.3. Generalizability

The conclusions drawn from this study are specific to the Norwegian context. While some insights may be useful and relevant for countries dealing with similar issues, one should be careful in directly extrapolating the findings to different contexts or health systems. Furthermore, as several of the informants also stressed, several of their points were based on their own experiences and reflections and not necessarily grounded in statistical data. However, this was never the intention of the analysis, as it primarily was aimed at mapping the crisis and contributing to theoretical generalization, which could be delved into deeper in future research.

### 7.5.4. Validity and Reliability

As we revisit the concepts of validity and reliability discussed in section 4.5, it is important to emphasize that qualitative research tends to prioritize complexity over generalizability and replicability, which is especially true for my Grounded Theory approach.

[2] See https://www.regjeringen.no/no/dokumenter/gjennomgang-av-allmennlegetjenesten/id2971896/

As my study examines highly dynamic and ongoing political issue, my informants' perspectives and narratives may evolve over time. The findings are highly context-specific and are anchored on the time of data collection, which severely limits the reliability over time.

Conversely, the study has the potential for a high level of internal validity, as the study includes a variety of informants, offering a wide range of perspectives on the GP Crisis. Their diverse professional backgrounds and experiences may help to reduce bias and enhance the validity of the findings.

Further measures were taken to improve internal validity, as all informants were sent a copy of their transcriptions and a draft of the final analysis with marked quotes for approval. This not only gave them an opportunity to revise their statements but also provided a chance to offer feedback. This approach not only safeguards the academic integrity of the thesis but also improves its internal validity.

### 7.5.5. Limitations in Data Collection and Analysis

Potential biases can occur in my interpretation of the open-ended interviews, which could lead me to draw ill-founded conclusions. As discussed in section 4.5.2, specific steps were taken to mitigate the risk of such potential biases. This included carefully structuring the interview guide, as well as the abovementioned close cooperation with the informants on both transcriptions and analysis. However, despite my best efforts and critical reflection, the inherent limitations of qualitative data collection and analysis processes are an unavoidable aspect of this type of research.

## 7.6. Suggestions for Future Research

Having now discussed the inherent limitations in the processes of data collection and analysis in my research, it becomes evident that this thesis is part of a broader, ongoing discussion. As this study provides the reader with an in-depth exploration of stakeholder perceptions of the Norwegian GP crisis, it could also serve as a launching pad for a wide range of future studies.

First, I hope that the research findings in the Norwegian context could provide inspiration for similar single-case or comparative studies with other countries experiencing issues with the recruitment of GPs. As was mentioned in section 6.1.1.3, Scotland and Sweden could be good candidates.

Other intriguing avenues for exploration could derive from a more comprehensive investigation of Norway's healthcare sector's challenges of vertical communication. It could,

for instance, be studied deductively in light of Political Mobilization Theory or in light of Hirschman's (1970) *Exit, Voice, and Loyalty*. It could also be fruitful to investigate whether the challenge of vertical communication is unique to this sector or if it is apparent in other areas within Norwegian public administration as well. The education sector, currently struggling with the recruitment of teachers in primary and secondary schools, presents a particularly compelling case for investigation (Utdanningsforbundet 2023).

It could also prove fruitful to use my research findings as a foundation for quantitative research. My analysis provides a rich and in-depth understanding of stakeholder perceptions, and future research could potentially benefit from a quantitative approach. Surveys with larger samples could provide us with a more comprehensive understanding of the various stakeholders' perceptions and suggestions, as well as help us investigate, in economic and social terms, the long-term consequences of the GP crisis, as well as predicting the impact of the proposed solutions.

# 8. Conclusion

In this comprehensive case study on stakeholder perspectives of the Norwegian GP Crisis, I have successfully displayed its inherent complexity, as well as shed light on both underlying causes and possible short-term solutions. My research indicates that a continuous tendency of cost-cutting, economic professionalization, and managerialism within the national health administration is part of the reason why the country has gotten itself into the current situation. This NPM focus has, in turn, led to long-term neglect of its medical professional capacity, depriving the state's ability and resources to effectively detect and respond to the issues facing the FLO, as well as fragmentation of knowledge amongst various stakeholders. This has, in turn, been further exacerbated by what appears to be dysfunctional vertical lines of communication between the ground-level GPs, the municipal health services, and national administrative levels, which is not experienced by the specialized healthcare sector.

However, by moving beyond a strictly economic framework and adopting a more open-ended, inductive approach, which emphasizes engaging with the individuals within the healthcare system, we can gain more nuanced insights. It is these practitioners and stakeholders 'who knows where the shoe pinches,' as is a popular Norwegian saying. These individuals can offer a deeper understanding of the challenges and potential solutions inherent to the system. By utilizing a grounded approach, I have effectively mapped out various facets of the Norwegian GP Crisis, as well as how they relate to each other, as illustrated in Figure 2.

Furthermore, based upon both the GPs themselves, as well as other stakeholder informants across the healthcare sector who, to some extent, are involved with the GP Crisis, I have provided a list of short-term solutions that could address the immediate impacts of the crisis, which can be found in section 7.2.2.

The prevailing organizational approach, which prioritizes budgetary increases for specific areas as solutions, is noted as an obstacle to comprehending the intricate nature of the situation and the necessity for structural reform. This tendency has, as noted by several of the informants, led to a misinterpretation of the challenges facing the GPs by public administration, simplifying their concerns to being primarily about repeated demands for increased financial compensation. The anonymous informant from the Directorate also thought the fragmentation of knowledge could help us better understand the nature of the current practice of EU/EEA medical authorization at the Directorate of Health, as this professional capacity now is now centered within the regional health trusts. In the absence of the RHFs' control, sufficient professional medical capacity, and financial resources, she argued, the Directorate found itself in a position where it could only rely on and enforce the existing laws without any room for flexibility. In the end, it should be acknowledged that the informants had highly varied views on whether a liberalization of medical authorization would be appropriate or beneficial.

Having explored these nuanced insights, it should, however, be emphasized that such qualitative approaches involve important limitations. My informants spoke strictly on their own behalf and experiences and should not be understood as representing their respective organizations. The findings are inherently context specific to the Norwegian healthcare sector and cannot be said to represent cases beyond this scope. Furthermore, the thesis describes an ongoing phenomenon where the conditions discussed in the interviews are prone to change. On the other hand, I hope the findings may provide a foundation to research for other countries experiencing similar issues.

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# Appendix 1: Information Letter & Consent Form Example

## Are you interested in taking part in the research project

## *"In Search of Solutions: Stakeholder Perspectives on the Norwegian GP Crisis"*?

**Purpose of the project**
You are invited to participate in a research project where the main purpose is to *map and assess various stakeholder perspectives and perceptions on the Norwegian GP crisis, and possible short term solutions, incl. liberalizing EU medical authorization.*

*As of August 2022, 235.000 (or 1 of 24) Norwegian citizens had not been assigned a general practitioner (Allmennlegeforeningen). This number drastically increases in the more peripherical regions, where, for instance, 1 out of 10 citizens of Finnmark is not designated a GP. Considering the increased tasks and importance of GPs in the country's healthcare system, serving as "door keepers" for the specialised health services, this presents a serious problem. Recent research suggests that various reforms aiming at modernizing the GP service has led to already overworked practitioners receiving even more responsibilities (Sørensen & Olesen 2021). Adding this up with the strict admission requirements for the Medical studies, marked by heavy competition for few spaces, Norway is currently facing a significant problem with recruitment of GPs. The current situation was recognized by the Norwegian government, where significant funds were earmarked to the recruitment of GPs and research on the GP service in the 2023 annual budget.*

*In this master's thesis, I will investigate the causes of the current problems with recruitment, and how these can be addressed. I will also discuss the current authorization practices of medical students from the EU and EEA (including Norwegians).*

**Which institution is responsible for the research project?**
*This project is registered and approved by RETTE ('Risk and Compliance of Research Projects'), and the University of Bergen* is responsible for the project (data controller).

**Why are you being asked to participate?**
*I aim to make a comparative approach between the perspectives of employers, labour/student associations and political parties.*

*You, as an employee of Dr. Dropin, which is one of the major temporary employment agencies, will therefore provide an important perspective of field experience, giving me as a researcher a more holistic perspective for my analysis.*

**What does participation involve for you?**
*If you chose to take part in the project, this will involve that you will participate in a semi-structured interview of approx. 45 minutes. The questions asked during the interview concerns your experiences with the current practices and legislations concerning the recruitment of GPs. The interview will be divided in 3 main themes:*

- *1: The GP Crisis*
  - *Your general understanding of its causes and implications*
  - *Your experience working as a GP in a district municipality*
- *2: Temporary Employment Agencies and private initiatives in the GP Service*
  - *Your personal view on the presence of such actors*
  - *Your comparison on the working conditions in Dr. Dropin vs. the GP Service*
  - *Aspects from Dr. Dropin's model that could be adopted in the GP Service*
  - *Your response to general critiques on the presence of Dr. Dropin*

**Participation is voluntary**
Participation in the project is voluntary. If you chose to participate, you can withdraw your consent at any time without giving a reason. If you wish, all information about you can be made anonymous. There will be no negative consequences for you if you chose not to participate or later decide to withdraw.

**Your personal privacy – how we will store and use your personal data**
We will only use your personal data for the purpose(s) specified here and we will process your personal data in accordance with data protection legislation (the GDPR).

- *The student (Jørgen Dysvik Bjørke) and supervisor (Georg J. Picot) will have access to the personal data*
- *The transcripts will be stored on my UiB OneDrive account*
- *If you consent, your name will be published in the work along with your occupation.*

**What will happen to your personal data at the end of the research project?**
The planned end date of the project is *June 1st, 2023. Your personal data, including the digital recordings and transcriptions, will then be stored until completion of the project. If you agree to, the recordings may also be made accessible for further research during this time span. By August 1st, 2023, all the data will be deleted.*

**Your rights**
So long as you can be identified in the collected data, you have the right to:

- access the personal data that is being processed about you
- request that your personal data is deleted
- request that incorrect personal data about you is corrected/rectified
- receive a copy of your personal data (data portability), and
- send a complaint to the Norwegian Data Protection Authority regarding the processing of your personal data

**What gives us the right to process your personal data?**
We will process your personal data based on your consent.

Based on an agreement with RETTE, and its host, the University of Bergen, Data Protection Services has assessed that the processing of personal data in this project meets requirements in data protection legislation.

**Where can I find out more?**
If you have questions about the project, or want to exercise your rights, contact:

- *The University of Bergen* via *Georg Johannes Picot, who is supervising this project*
  - *Georg.Picot@uib.no*
- Jørgen Dysvik Bjørke, who is the student conducting this master's thesis
  - Jbj017@uib.no +47 902 04 399
- Our Data Protection Officers at RETTE:
  - Charlotte Lillefjære-Tertnæs – charlotte.lillefjaere@uib.no
  - Thomas Marius Hugøy – thomas.hugoy@uib.no

If you have questions about how data protection has been assessed in this project, contact:

- Data Protection Services, by email: (personverntjenester@sikt.no) or by telephone: +47 53 21 15 00.

Yours sincerely,

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| Georg J. Picot<br>Project Leader<br>(Researcher/supervisor) | Jørgen Dysvik Bjørke<br>Student |

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## Consent form

I have received and understood information about the project " ***In Search of Solutions: Stakeholder Perspectives on the Norwegian GP Crisis*** " and have been given the opportunity to ask questions. I give consent:

- ☐ to participate in *an interview*
- ☐ *for information about me to be published in a way that I can be recognised*
  - *Full name (unless expressed wish to conduct an anonymised response)*
  - *Affiliation and position*
- ☐ *for my personal data to be stored after the end of the project (August 1st, 2023) to secure verifiability*
- ☐ *I consent for a digital recording to be made of my response*

I give consent for my personal data to be processed until the end of the project.

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(Signed by participant, date)

# Appendix 2: Interview Guide Example (Translated)

## Interview Guide to Harald G. Sunde, Finnmarkssykehuset HF

### Medical Director

### Formalities

- Name, employer, where he had his medical education, when he finished his specialization.
- Confirm on-tape that he has received the information letter and given informed consent

### Theme 1: Introduction

- I must admit that I have tried to read up on you beforehand! So if I understood it correctly, you had your internship in Kirkenes, where you decided to stay?
- Say I was a newly graduated medical student who's not yet decided. What would you say are the greatest benefits of having your internship in Finnmark?
- What made you decide to stay after your internship was over?
- Did political tools have an impact on your decision to stay?
    - Tax relief, student debt forgiveness…
- I see that you also have engaged with the Sami culture in your free time, learning the language and writing a book about the wartime history here. Is this also one of the reasons why you stayed?

### Theme 2: The GP Crisis in the Districts

- I thought I'd start with a pretty open question. What is your understanding of the GP crisis? What do you think is the reason for the current situation?
- What do you think is the reason for the issues of recruiting GPs?
- It is particularly in the districts that the consequences of the GP crisis are felt. According to the September statistics from the General Practitioners Association, about 11 %, or about 1 in 10 residents of Finnmark, lack a GP. What does this look like in practice? And what impact does this have on specialized healths services in Finnmark?
- What does life look like for a Finnmark resident without a designated GP?
- What opportunities does a person without a designated GP in the districts have for medical attention?
    - Prescriptions
    - Who coordinates and follows up on rehabilitation after a hospital stay?

- A GP that I interviewed who had worked in Stokkmarknes in Nordland experienced that many people postpone their controls because they are not on al ist, and there are a lot of patients who become anxious and afraid. Especially when their doctor moves or retires. He also expressed concern for situations where the specialized health services have sent information to the GP to follow up on a serious finding, often a malignant tumor, where it could have become really bad. Is this something you recognize? Could you perhaps recall similar situations from your own experiences?
- Do you think the restructuring of the medical internship service ten years ago may have had an impact on the further development of the GP crisis?
- There were some news reports in September about some Danish doctors who were employed via temporary employment agencies, who were offered up to 200,000 in $monthly salary in Sykkylven. Is this also something you see in Finnmark?
- There has been some news coverage this winter about the use of Dr. Dropin, which also became a big debate not too long ago, which is used in several municipalities struggling with a low presence of GPs. What do you think is the reason why GPs choose to work for Dr. Dropin and temporary employment agencies rather than ordinary GP contracts with the municipalities?

### Theme 3: Short-term solutions

- How do you feel the communication is between Finnmarkssykehuset HF and the Ministry and Directorate? Do you feel they take the region's challenges and concerns seriously?
- I was wondering if you are aware of the focus on the GP crisis in this year's state budget, and if you have any thoughts about it?
- Do you feel the measures will effectively solve the recruitment problems in the GP scheme?
- There is often talk about bottlenecks, especially in LIS1. Senior Physician Ketil Størdal at Oslo University Hospital mentioned in a debate post for NRK that as many as 400 newly graduated medical students are in line for internships. What are your reflections here?

### Theme 4: EU/EEA Authorization

- So, a pretty open question. What is your stance or perception of foreign doctors' participation in the Norwegian health sector more generally?
- And what about Norwegian medical graduates educated in the EU/EEA
- What risks or concerns do you believe are associated with the recruitment of these groups in Norway?
- What do you think about the current practice of authorization for these groups?
- Another thing related to this is that it says on the Directorate of Health's pages that authorization is something that can only be considered after completion of the study program, and that no pre-approval can be given for foreign studies. What reflections do you have about that? Was this a concern you experienced when you studied in Dublin?
    - 40 % of Norwegian medical graduates studies at EU/EEA Universities…
    - KBU, double authorization…

### Recommendations for further interviews

- I'm also aiming at interviewing other stakeholders, such as regional health trusts, ministry, directorate, etc. Do any recommendations come to mind that I may inquire them about?
- Finally, is there anything at your heart that you think we should discuss?