Paper I

Introduction of the patient-list system in general practice: Changes in Norwegian physicians' perception of their gatekeeper role

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Introduction of the patient-list system in general practice

Changes in Norwegian physicians' perception of their gatekeeper role

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Objective **– To explore whether the patient-list system, recently introduced in general practice, has influenced general practitioners' (GPs') self-perception as gatekeepers.**
Design **– Structured focus group interviews with GPs and a short self-administered questionnaire.**
Setting **– Primary care within the public health care system in Norway. Group interviews were conducted 6 months to 1 year after the patient-list system was introduced in June, 2001.**
Subjects **– 81 GPs attending tutorial groups or specialists' continuous education groups.**
Outcome measures **– GPs' experience with the reform as stated in 11 group discussions, recorded, transcribed and systematically analysed through coding and extracting of the informants' statements. The questionnaire provided background information about each participant.**
Results **– The doctors generally perceived themselves as less concerned with the gatekeeper role under the new system. They felt it more important to provide better services and keep patients satisfied. The practitioners explained this shift using three contextual factors: increased and more visible competition, higher expectations from the patients and more responsibility assigned to the GP.**
Conclusion **– GPs in Norway have experienced a shift in power in the physician–patient relationship favouring the patient. The GP's consciousness of the gatekeeper role has diminished. We question whether the new system lessens the incentive to consider resource use in decision-making.**

Key words: **cost control, gatekeepers, health care reform, health services, physician-patient relations.**

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The patient-list system was introduced nationwide in Norway in June 2001. According to the White Paper introducing this reform, the main purpose of the system was to improve the quality of the service by ensuring that every inhabitant has the right to register with a regular general practitioner. One important aim was to strengthen primary care and thus to reduce "unnecessary" use of higher levels of the health care system (1,2). In the new system, the GP's role as gatekeeper is, in some respects, more central. For example, the opportunity for patients to "shop" between GPs is reduced and patients need a referral from their GP to see a specialist the first time, and subsequently once per year.

The patient-list system consists of both a new remuneration system and a new organisational scheme. Physicians receive 30% of their income in the form of a per-capita-based fee from the municipality, while 70% is activity-based from the consultation fee and a fee-for-service reimbursement from the National Insurance Service. Prior to this reform, about two-thirds of GPs received a practice allowance component amounting to approximately 40% of their income, with the rest of their income activity-based (3). Each physician is responsible for providing general medical services to patients on his or her list and of giving priority to these patients. When the system was introduced, each physician indicated a maximum limit to his or her list. Patients have the right to change GP twice each year (1,2) and every doctor receives a monthly update from the National Insurance Service listing of which patients have joined or left the list.

Studies show that, when making decisions, doctors are influenced by both economic and social incentives (e.g. patient expectations, the reimbursement system and relations with colleagues) (4–9). The new system implies a change in the organisation of the health services, favouring continuity and closer links between doctor and patient, and an altered remuneration system, which makes part of the payment directly dependent on the number of list patients.

The patient-list system introduced in Norway ensures a better service for patients and encourages rational use of resources.

- Since the reform, Norwegian GPs find it more important that their patients are satisfied.
- The gatekeeper role of GPs is weaker in the new system.

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Coulter noted that health systems in which patients have direct access to specialist care are more expensive than systems where patients are filtered through the primary care system (10). The underlying rationale of a referral system is not to cut costs, but to secure a more efficient use of resources. In Norway, the gatekeeper role of the GP also includes issuing sickness certificates and prescriptions covered by the National Insurance Service. Traditionally, many Norwegian GPs have perceived themselves as gatekeepers for the health care system (11), but there have been indications that this role is perceived by GPs as becoming less important (12). A recent survey shows that more than half of all GPs sometimes or often consider patients' wishes as more important than their own medical judgement when making decisions about activities, and that their willingness to act as gatekeepers was already declining prior to the reform (13). The aim of this study was to explore whether the patient-list system influences GPs' self-perception as gatekeepers.

MATERIAL AND METHODS

A strategic sample was recruited from tutorial groups and specialists' continuous education groups. Nine group interviews were conducted in Hordaland, a statistically typical county within the new system. Two group interviews were also conducted in Oslo, which has some special characteristics, such as more competition in primary care and a higher density of specialists. In Hordaland, 52% of the doctors had fewer patients on their list than they wished and in Oslo this was so in the case of 75.4% of the doctors. Both rural and urban municipalities are represented. The sample was chosen as representative of the well-known differences and typical practices. We invited 23 groups to participate and followed up the invitations with telephone calls. Groups from more sparsely populated rural areas were not included. Of the 23 groups, 13 wished to participate, 2 declined and 8 did not respond. Among the 13 positive answers, 11 groups were interviewed. The groups were homogeneous with respect to age and work experience and, with the exception of one group, balanced with respect to gender.

The data were collected qualitatively and quantitatively through semi-structured focus group interviews and a short questionnaire given to all participants at the start of each interview. The interviews were conducted by the authors; a GP and professor in medical ethics and a social scientist trained in social anthropology. We conducted 11 group interviews of 81 informants from January to June 2002. The interviews lasted between 1 and 2 hours, and the discussion was audio-taped and transcribed for subsequent analysis. Each interview began with an introduction by one of the researchers who clarified the focus and central concepts of the study (e.g. gatekeeper role and discretionary choices) and after which discussion between the participants was encouraged. We used an interview-guide of 12 questions focusing on the informants' experienced changes in relationship with patients and private economic issues and whether these or other changes implied by the new system affected how they perceived their gatekeeper role.

ANALYSIS

The interviews were analysed by combining a strategy of coding and categorisation (14) with condensation as described by Giorgi (15). The authors read the transcripts and decided upon a set of codes that represented the dominating themes as formulated by the participants and interpreted by the authors. The coded text was then condensed, reorganised and analysed according to the research questions. Background variables from the questionnaire are reported in Table I.

RESULTS

The respondents indicated to varying degrees their perceptions that the reform had affected their role as gatekeepers. A few of both the most experienced and those with very little experience as GPs did not believe that their attitude to gatekeeping had changed. Some of these doctors had no experience with the old system, while the older doctors said that they felt well established in the market and in terms of practice style. Doctors in Oslo, especially those who struggled to fill their lists, said that they now take less time and exert less effort convincing patients of their opinion (with the aim of restricting unnecessary use of resources) when this is "in conflict" with the patient's view. They felt more inclined to bend the rules to accommodate the patient. Most doctors perceived themselves as less concerned with the gatekeeper role under the new system. The physicians' explanations for the change in attitude fell within three main categories, as described below.

1. Accentuated competition

Generally, interviewees expressed a view that the patients have more power in the new system, which they explained had arisen from a growing feeling of competition between physicians. Although most respondents were satisfied with their current list size (see Table I), they were concerned about the potential lack of patients and future competition. The GPs practising in Oslo were especially worried about the risk of

Table I. Background information: sample profile and characteristics of the GP population in Hordaland, Oslo, and on the national level in Norway.

Variable	Sample[1]	GPs in Hordaland[2]	GPs in Oslo[2]	GPs in Norway[2]
Number of GPs	81	369	447	3692
Male GPs	58%			70.9%
Age (mean)	42.7			46.2[3]
Years of experience as GP (mean)	11			
Maximum list size (mean)	1273	1291	1347	1301
Current list size (mean)	1215	1132	1139	1152
GPs with open list	38.7%	52%	75.4%	52.5%
Satisfied with current list size	67.6%			
Specialist	44.4%	53.1%	56.6%	59%
Urban	67.5%			

[1]Our data from the questionnaire. The given proportions are calculated on the basis of the total number of answers to each question.
[2]Data from the National Insurance Administration (Rikstrygdeverket): Aktuell informasjon. Available at: http://www.trygdeetaten.no/aktuelt/2001-05-10.html. Accessed 30 April 2002. Styringsdata fra Fastlegeordningen. 1. kvartal 2002. Available at: http://www.trygdeetaten.no/default.asp?strTema = trygdeetaten&path = tall_mrog_mrfakta&path_sub = styringsdata. Accessed 5 November 2002.
[3]Statistics from the Norwegian Medical Association (Legeforeningen): Mean age for GPs in practice in Norway. Available at: http://www.legeforeningen.no/index.db2?id = 1469. Accessed 20 May 2003.

losing patients. Many said that the patient-list system makes competition more visible. Even doctors with sufficient patients on their lists noted their feeling of continuous evaluation of their professional qualities by patients because of the system's emphasis on the patients' choice of doctor through the monthly update. Besides the potential for economic loss, doctors felt their professional pride was at risk. Some reported that patients who found their doctor's practice lacking in terms of accessibility and service sometimes accused them of poor job performance or of keeping too long a patient list.

The informants generally claimed that it has become more important to satisfy patient demands and that they would rather adjust their medical judgement to avoid conflict with patients. Many said that they often prescribe reimbursed drugs, even if the patient did not fully satisfy the indications for such medication; for example when patients claim that other doctors do so. Many also said that they more readily refer patients to specialist care when patients insist. Informants explained this in terms of increased discomfort with patient disagreement and a feeling of not living up to patients' expectations. Fear of losing patients and an unwillingness to lose time in discussion with stubborn patients were mentioned. These factors apparently overshadow their annoyance at losing the discussions and compromising their professional opinion. When GPs sometimes refuse to comply with patients' wishes, it seems to be because of professional and not resource management motives. The informants mentioned patients' requests for addiction-inducing drugs, such as opioids and anxiolytics, as examples.

In addition, the doctors said they have changed their practice style by being more accessible and offering better services. Examples mentioned are better accessibility by telephone, shorter waiting times and provision of sick leave certification over the telephone.

When you receive the next update on disc you would like to see that they're still on your list. So, you want to make sure that you give good service, because it's kind of discreditable if they disappear from the list. It implies that you haven't done your job properly or that they've been dissatisfied. (Male doctor, 53 years old.)

2. Patients' expectations

The informants almost unanimously expressed a sense of increased expectations and sometimes demands from patients. This was described as an abrupt change that appeared with the introduction of the new system. To begin with, some patients visited their doctors only as an opportunity to meet their GP, and introduced the meeting with the words "How do you do! You are my regular GP!" Many informants felt that patients expected their GP to solve their medical problem and give them what they ask for without delay. Words like "servant" and "waiter", rather than gatekeeper, were mentioned in the discussions to describe how they reacted to these expectations.

One notices people's expectations in a different way. They talk about "my car" and "my house" and "my doctor", and they expect you to sort things out almost as soon as they snap their fingers. Some people, whom you've never even seen, expect a referral to an eye doctor

because they've phoned in an ''order'' with the secretary here. (Male doctor, 33 years old.)

3. The doctor's responsibility and continuity

The informants were particularly concerned with the increased responsibility implied by the new system. Because the GP is now the only doctor that most patients see, he or she has more control and a better overview of a patient's health. This also means that, if an error is made or if a malign condition is overlooked, the responsibility is easy to place. Some commonly expressed thoughts about this are illustrated in the following extracts from one of the discussion groups:

Informant 1: *Would it be worse to overlook a cancer diagnosis now than in the old system when patients mainly came to you but also consulted other physicians from time to time?*

Informant 2: *You would feel more stupid, to put it that way.*

Informant 3: *I think so.*

Informant 1: *Yes, you would expect to get it back, that ''that was a mistake'', right?*

Informant 4: *Right, and if they quite consciously change GP afterwards, it's so noticeable...*

Informant 1: *It won't exactly make you think as a gatekeeper, more of the opposite, because as a professional you would like them to come back. It didn't used to be like that, but now the responsibility lies with you*. (Various informants of a group in Hordaland.)

The doctors did not claim to have acquired a better knowledge of their patients, because they had been practising in the new system for less than a year. However, many still felt that links to the patients had become closer. There seems to be a mutual feeling of ownership between the GP and the patient. The doctors claimed that this sense of responsibility induced them to work with long-term preventive strategies (e.g. profiling new patients and more frequent and thorough examination of patients). Some seem to have become more risk-averse in the sense that they would be more likely to follow patients' wishes for referrals and tests.

DISCUSSION

Our results suggest that it has become more important for GPs to keep patients satisfied and to meet their demands. When discussing other topics and on the direct question of the gatekeeper role, the informants expressed the notion that they have become less restrictive as gatekeepers. Our study indicates that GPs seldom think and act as gatekeepers; for example, 330 pages of interviews gave us only a handful of anecdotes referring to incidents where the gatekeeper role was practised when there was disagreement between doctor and patient. It seems that GPs act as gatekeepers if they succeed in convincing the patient of their view, but seldom in the opposite case.

The motivation for the change in attitude lies in a combination of professional, private economic and social incentives in the patient-list system. Firstly, the informants were clearly concerned with what they saw as a new situation of accentuated competition for patients and the patients' favour. Secondly, the patients have higher expectations and more power in the new system; and, thirdly, the GPs feel more responsibility for their patients. This seems to encourage certain changes in attitudes towards practice style, such as better access and service, compliance with patients' expectations, and more thorough and long-term strategies in the provision of care. This can be interpreted as an increasing general trend towards more patient influence on medical decision-making (16), which runs parallel with a decreasingly restrictive practice of the GP's gatekeeper role. It is perhaps time to ask whether there is an inherent tension between increased patient autonomy and the doctor's role as gatekeeper.

It is difficult to comment on how substantial the influence of the reform has been on the general trend in primary care. It was not possible to collect comparable data before the introduction of the reform and, in any case, the gatekeeper role did not seem to play an important part in decision-making by GPs prior to the reform. It is interesting to note, however, that a newly published quantitative study of the patient-list system measures a distinct decline in GP interest in acting as gatekeepers for secondary care (17).

This study has some weaknesses. Although the sample is not random, it does represent the majority of GPs when compared with the profile of the total GP population (as indicated in Table I). However, our sample deviates slightly from the total GP population in two ways that might influence the results in opposite directions. On the one hand, the participants are all members of professional educational groups for acquiring or maintaining a speciality as GPs, which implies that they are, on average, more conscious of issues such as the physician's role and the patient-list system. Our respondents possibly assess changes as greater than does the average GP. On the other hand, in our sample, the proportion of GPs with open lists is smaller than in the overall GP population, which might cause them to be less concerned with competition than the average GP.

A general challenge with focus groups is that some informants may dominate speech time and/or disproportionately influence the opinions of the others. In

this study, there seemed to be fairly lively discussion in all of the interviews. Often informants challenged each other's opinions. It is always difficult to guess at what is left unspoken, however. We registered each interviewee's proportion of the conversation and it was evident that the quantity of the different informants' statements varied widely. The informants who most strongly expressed either positive or negative attitudes to the new system generally spoke more than the participants with moderate opinions.

CONCLUSIONS

The patient-list system gives GPs an increased gatekeeper function compared to the old system. At the same time, the patient is granted more negotiating power, for example, through inherent accentuated competition between GPs in the new system. Our study suggests that the gatekeeper role of primary care physicians, despite its new prominence, is weaker in the sense that GPs are less concerned with reducing unnecessary use of public resources. GPs find themselves in an increasingly strained position in that they are competing for patients and, at the same time, serving as gatekeepers and managers of limited public resources. The twin aims of the reform were to secure better service for patients and a more rational use of resources. The health authorities have to be aware that an unforeseen effect of the success of the first aim might be undermining the second. However, better use of scarce resources might be achieved if GPs were made more conscious of their gatekeeper role through continuous education.

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REFERENCES

1. Odelstingsproposisjon 99, 1998–99. Om lov om endringer i lov 19. november 1982 nr 66 om helsetjensten i kommunnne og i visse andre lover (fastlegeordningen) (Amendments of bill concerning the health services of the municipalities and certain other bills (patient-list system)). Oslo: Royal Ministry of Health and Social Affairs, 1999.
2. Forskrift av 14. april 2000 i medhold av lov av 19. november 1982 nr. 66 om helsetjenesten i kommunene. Fastlegeordningen i kommunene (Regulation laid down by the Ministry of Health and Social Affairs 14 April 2000 pursuant to Act No. 66 of 19 November 1982 relating to he Municipal Health Services). Oslo: Royal Ministry of Health and Social Affairs, 2000.
3. Statistics Norway, SSB. Kommunehelsetjenesten – lege, fysioterapeut og forebyggende tjenester (Health Services in the municipalities – general practitioners, physiotherapists and preventive care). 2001. Available at: http://www.ssb.no/emner/03/02/helsetjko/arkiv/tab-2001-10-12-11.html. Accessed November 10, 2002.
4. Fidler H, Lockyer JM, Toews J, Violato C. Changing physicians' practices: the effect of individual feedback. Acad Med 1999;74:702–14.
5. Iversen T, Lurås H. The effect of capitation on GP's referral decisions. Health Econ 2000;9:199–210.
6. Virji A, Britten N. A study of the relationship between patients' attitudes and doctors' prescribing. Fam Pract 1991;8:314–9.
7. Bradley CP. Factors which influence the decision whether or not to prescribe: the dilemma facing general practitioners. Br J Gen Pract 1992;42:454–8.
8. Webb S, Lloyd M. Prescribing and referral in general practice: a study of patients' expectations and doctors' actions. Br J Gen Pract 1994;44:165–9.
9. O'Donnell CA. Variation in GP referral rates: what can we learn from the literature? Fam Pract 2000;17:462–71.
10. Coulter A. Managing demand at the interface between primary and secondary care. Br Med J 1998;316:1974–6.
11. Getz L, Westin S, Paulsen B. Lege og sakkyndig – mellom barken og veden? Allmennpraktikerens arbeid med uførepensjonssaker i en innstrammingstid (Physician and expert – a conflict situation? General practitioners work with disability pension errands in a time of restraint policy). English summary. Tidsskr Nor Lægeforen 1994;114:1435–40.
12. Arnesen T, Fredriksen S. Coping with obligations towards patient and society: an empirical study of attitudes and practice among Norwegian physicians. J Med Ethics 1995;21:158–61.
13. Gulbrandsen P, Førde R, Aasland OG. Hvordan har legen det som portvakt? (What does it feel like to be a gatekeeper?) English summary. Tidsskr Nor Lægeforen 2002;122:1874–9.
14. Kvale S. Interviews. An introduction to qualitative research interviewing. Thousand Oaks: Sage Publications, 1996.
15. Giorgi A. Phenomenology and psychological research. Pittsburgh: Duquesne University Press, 1985.
16. Falkum E, Forde R. Paternalism, patient autonomy, and moral deliberation in the physician–patient relationship. Attitudes among Norwegian physicians. Soc Sci Med 2001;52:239–48.
17. Sandvik H. Fastlegeordningen – forventninger og erfaringer (Introducing the list patient system in Norway: a survey of general practitioners' expectations and experience). Tidsskr Nor Lægeforen 2003;123:1319–21.