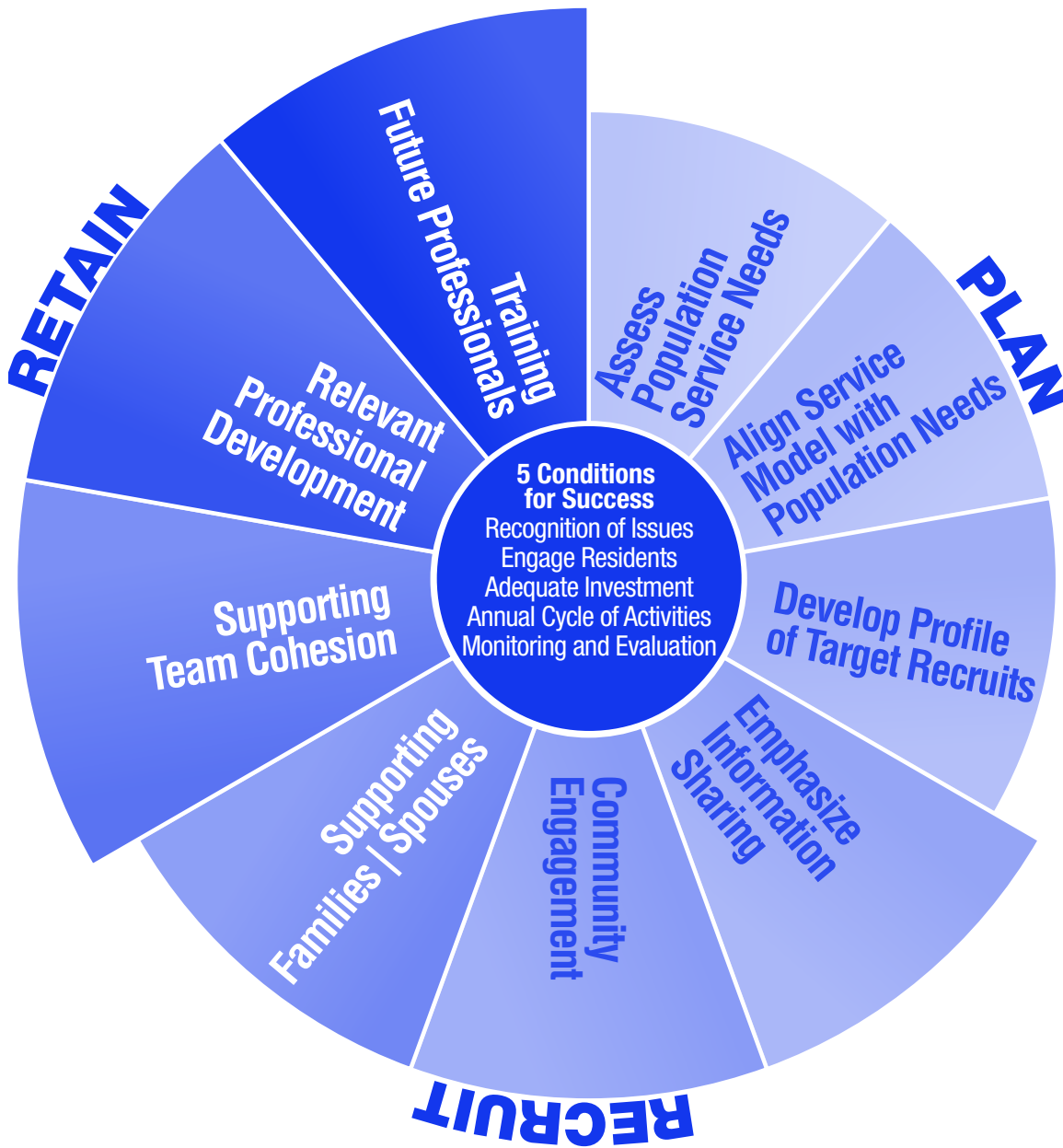




making
it work

The Norwegian Case Study Report

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The Framework consists of nine key strategic elements, grouped into three main tasks (Plan, Recruit, Retain), with five conditions for success.

Executive Summary

The Norwegian case study as part of the Recruit and Retain Making it Work, project aimed at improving the recruitment and stability of regular GPs in three case municipalities, identify successful strategies, and to disseminate these strategies to other areas.

The three case municipalities were Meløy situated in Nordland county, Odda in Hordaland county, and Årdal in Sogn og Fjordane county. They self-recruited to the project. During the last ten years, the population has declined in the case municipalities, and the older population has increased. All case municipalities have had long-lasting difficulties with retention and recruitment of regular GPs.

Each case municipality planned and carried out their own local regular GP recruitment and retention project. They set their own goals and decided their own work methods. The Norwegian Centre of Rural Medicine facilitated the local projects with up to date scientific knowledge on GP recruitment and retention, and arranged workshops to gather representatives from the case municipalities and relevant others for both mutual inspiration and knowledge transfer.

The most important result pointed out in all three case municipalities, was that based on the Making it Work platform, they had been able to establish a local regular GP recruitment and retention project that was anchored, understood, and strongly supported at the top municipal administrative and political level. The second most important result was that the three case municipalities evaluated their service model and ended up extending their number of regular GPs with one extra GP to reduce workloads. During the project period, all case municipalities also succeeded in reducing the number of vacant regular GP positions.

Key lessons learned in the case municipalities for future recruitment and retention projects:

1. The process and the result are equally important.
2. Ensuring that working conditions for regular GPs are flexible, is increasingly important for retention of GPs.
3. It is easier to recruit than to retain regular GPs.

Based on the Making it Work framework for Sustainable Rural Remote Workforce we present recommendation for continued work to stabilize the regular GP workforce in the case municipalities. The sustainability recommendations are also good advice for other municipalities struggling with regular GP recruitment and retention.

Background: The Recruit and Retain Project

From 2007-2019, an international collective of academics, human resources professionals, health services administrators, health professionals, social and cultural development professionals, living and working in Northern rural or remote communities in Sweden, Norway, Iceland, Scotland, Greenland, Ireland, Northern Ireland and Canada, studied factors related to workforce recruitment and stability in rural and remote environments.

Funded by EU's Northern Periphery Programme and based in the project Recruit and Retain (2007-2013) the partnership developed, implemented and evaluated a variety of solutions that supports recruitment and retention in these communities. Funded by EU's Northern Periphery and Arctic Programme and based in the project *Recruit and Retain: Making it Work* the partners from Sweden, Norway, Iceland, Scotland, and Canada, moved the work forward and developed *Making it Work: Framework for Remote Rural Workforce Stability*.

The Making it Work Framework describes the necessary elements of a strategy to ensure the recruitment and retention of the right professionals to provide needed services in rural and remote locations; in other words, to ensure a sustainable fit-for-purpose workforce. The Framework consists of nine key strategic elements that fall into three sections:

1. **Plan:** these elements are activities that may be taken at a local, regional or national level to ensure the population's needs are periodically assessed, that the right service model is in place, and that you are going after the right recruits.
2. **Recruit:** these elements are generally at the local and/or agency level to ensure the right recruits have the information and support they need to make the life decision to relocate to your community and that when they arrive, both they and their families are welcomed and integrated in the community.
3. **Retain:** these elements are part local, part regional and part national and are to ensure the current remote and rural workforce are supported, and developed, and meanwhile, that the future workforce is grown.

The document *Making it Work: Framework for Remote Rural Workforce Stability* provides a thorough description of the different elements of the framework. Figure 1 gives a graphic description of the strategic elements.



Figure 1: Making it Work: Framework for Remote Rural Workforce Stability

As part of the project *Recruit and Retain: Making it Work* each partner has worked on their unique case studies. The partner projects have given important input to the development of the Making It Work Framework. The following parts of this report gives a description of the Norwegian Case Study.

About Our Project

The Norwegian Centre of Rural Medicine (NCRM) is the Norwegian Making it Work Partner. NCRM is situated in Northern Norway, at the Department of Community Medicine, UiT The Arctic University of Norway, Tromsø. NCRM aims to promote research, professional development projects, education and networks. The vision is to bridge praxis, academia and responsible authorities, to contribute to quality improvement, recruitment and retention of health professionals in rural and remote areas. Our project is about recruiting and retaining GPs to Norwegian rural municipalities.

Recruiting and retaining regular GPs

All citizens registered in the National Population Register in Norway are by law entitled to a regular GP. A regular GP is a general practitioner who has entered into an agreement with the local authorities (in Norway: a municipality) to act as a regular GP for citizens registered on a certain patient list.

When we started our case study, rural municipalities in Norway faced increased struggles to recruit regular GPs, and short-term GP-locums were far more common in the scarcely populated municipalities than in the densely populated ones (Abelsen et al 2016). Mass media reported that single municipalities had engaged 20-30 short-term GP-locums during a two-year period. Such discontinuity in the GP services increases the risk of errors and threatens patient safety. Continuity of care has been shown to improve health care in several ways (TOP 2017). When our project commenced, recruitment problems concerning regular GPs were documented as a challenge, in both rural and urban municipalities (KS 2015), however not publicly debated. Today, three years later, recruitment of regular GPs is a challenge that has increased rapidly. This seem to have much to do with 1) increasing workload pressures on regular GPs where the GP numbers have not kept pace with demand, and 2) a generation shift among GPs, especially in urban areas. Since summer 2017 recruitment and retention of regular GPs has been high on the public agenda.

National level policies to attract regular GPs are however still lacking. Every single municipality is thus largely responsible for finding ways to recruit and retain regular GPs within the limits of their budgets and creativity. They are, in other words, limited with few restrictions but equipped with few specific measures or tools.

However, a scarcely populated and rural municipality does not automatically struggle with GP recruitment and retention. On the contrary. Many rural municipalities in Norway have had a stable GP-workforce for a long time.

In order to attract and keep regular GPs, rural municipalities are known to use different incentives. Some offer increased salaries, extra vacation, and paid educational leave of absence (Abelsen and Bæck, 2005). Others have increased the total number of regular GPs to make the workload more livable or invested in temporary, but regular GP-locum arrangements to handle the out-of-hours emergency medical service parts of the year (Brandstorp, 2014). Yet others, have merged small GP practices to create larger professional environments (Gaski and Abelsen 2015). Organizational issues like climate of cooperation between regular GPs and municipality authorities, and incentives (financial and other), are important explanatory factors when seeking to understand the causes of variations in regular GP-stability (Abelsen and Bæck, 2005). In the Norwegian Case Study we wanted to explore whether this knowledge could be useful for municipalities struggling with GP recruitment and retention.

Our partners, and the purpose of our work together

Aims

The main aims of the Norwegian case study was:

- to improve the recruitment and stability of regular GPs in three case municipalities
- to identify successful strategies
- to disseminate these strategies to other places

Choosing the case municipalities

The three case municipalities self-recruited to the project. Through our web-site and use of social media, we invited municipalities (cases) to take part in the Norwegian Case Study in March 2016. Our requirements were: 1) that the case municipalities should have had long-lasting difficulties with retention and recruitment of regular GPs; 2) that the municipality was located in the support area for the Northern Periphery and Arctic Program; and 3) that they were willing to actively engage in systematic improvement work anchored at the top administration level in the municipality. Eleven municipalities applied to participate.

The case municipalities

The three municipalities chosen were: Meløy situated i Nordland county, Odda in Hordaland county, and Årdal in Sogn og Fjordane county (see figure 2). The population size in the three case municipalities varied slightly (see Table 1). They all had a population size above the national municipality median level of 4 672 inhabitants per January 1th 2018. During the last ten years, the population has declined in all case municipalities, and the population older than 67 years (retirement age in Norway) has increased in all of them. The population share above 67 years was above the 14.9 percent national level in all case municipalities in 2018. The population share above 67 years has also increased in all case municipalities during the last 10 years, but only slightly in Odda. The increase on national level in the above 67 years share last 10 years was 2 percent.



Figure 2: The Norwegian Case Municipalities

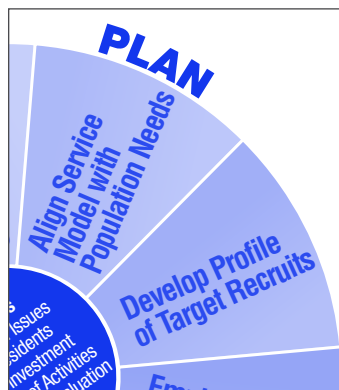
Table 1: Population characteristics in the case municipalities.

	MELØY	ÅRDAL	ODDA
Population 1.1.2018	6 346	5 277	6 835
% pop. change last 10 years	- 4.4 %	- 5.8 %	- 3.1 %
% population > 67 years	18.5 %	20.2 %	19.9 %
% change in pop. > 67 years last 10 years	+2.9 %	+3.1 %	+0.5 %

All case municipalities have industry business based on hydro electricity, and have been through downsizing and readjustments lately. Primary care (e.g. GP practices, community care centres, and home based nursing) is available in all three municipalities, as is the case for all Norwegian municipalities. Odda has a small hospital with limited specialist care. The main transport option in all three municipalities is private cars. All have more than a one hour drive by car to nearest airport.

Our project activities and timeline

Spring 2016

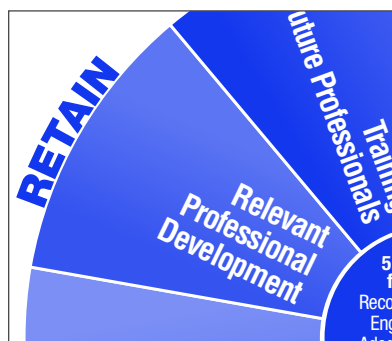


The first activity in each of the case municipalities was a meeting in the case municipalities between the project team from NCRM and representatives from the case municipalities. The NCRM-team familiarized themselves with the local premises and context, and met the case municipality representatives on their home ground. Attendees from the case municipalities included the chief municipal executive, regular GPs, and health managers. In Meløy local politicians were also present. In these meetings the NCRM-team presented research findings and evidence on recruitment and

retention of GPs, as a starting point for discussions on the need to review and adjust the existing service model.

Autumn 2016

Each case municipality agreed to plan and carry out their own local recruitment and retention project. They set their own goals and decided their own work methods. In September 2016, the NCRM-team organized a workshop in the city of Bergen. In addition to participants from the case municipalities, we invited persons from other rural municipalities with considerable practical experience, success, and/or relevant knowledge regarding regular GP recruitment and retention. The aim of the workshop was both mutual inspiration and knowledge transfer between the municipalities and their local projects.



During the project period, the competence requirement on regular GPs increased. From March 1st 2017 a new regular GP has to be a specialist in family medicine, or under such specialization. This entails new requirements on the municipalities to arrange for specialization in family medicine for their regular GPs. This new requirement had implications on the Norwegian Case Study, and members of the NCRM-team contributed to the project description and funding work

to establish the “ALIS-Vest project”. ALIS-Vest is an education and recruitment program where salaried educational positions for GPs to specialize in family medicine were established aiming to improve recruitment of regular GPs.

Spring 2017

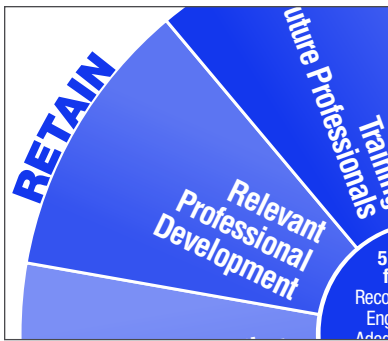
Altogether 10 municipalities in the counties of Hordaland and Sogn og Fjordane were included in the “ALIS-Vest-project”. Among them, two of our case municipalities Odda and Årdal.

Case municipality health managers promoted the local work done and progress achieved in the Making it Work-project in the case municipalities with the audience during a separate section at the 10-year anniversary of NCRM in Oslo in June 2017. Representatives from the Norwegian Health Ministry, the Norwegian Directorate of Health, and Norwegian Medical Association were present.

Autumn 2017

In October, a follow-up workshop with the three case municipalities was held in Bergen. The municipalities presented progress on their local projects, they shared reflections, experiences, and inspired each other. As part of the workshop, NCRM hosted a one day international seminar “Recruit, retain and specialise doctors in the municipalities” with participants from Scotland, Iceland and Sweden. Before lunch, the theme was recruitment and retention of GPs in general. After lunch, specialization/postgraduate training for GPs in rural settings was the main topic. The focus was on what we can learn from each other in Norway, Iceland, Scotland and Sweden. The seminar drew more than 50 participants from all over Norway and from both management, government and municipality level of primary care.

Spring 2018



The NCRM-team initiated and took part in developing a project similar to ALIS-Vest in the three northernmost counties in Norway (ALIS-Nord). Stakeholders from municipalities in the counties of Finnmark, Troms and Nordland were included, as well as county medical officers, the medical associations, federal authorities and others were invited to the first meeting. The NCRM-team drafted the “ALIS-Nord project” description and managed the application process.

Autumn 2018



Close up meetings between the NCRM-team and the case municipalities summed up the results and experiences from the local projects. The Norwegian government decided to fund ALIS-Nord, initially with 15.6 mill NOK for the first two years of the five-year long project.

What resources (funds and in-kind) were required for the project

The resources put into the project by the case municipalities was work hours for planning and implementation of the local projects, expenses for additional regular GP positions, work hours for supervision and counselling between newly recruited and specialist GP, investments in a new GP clinic. Among savings were lower expenses for GP-locums. Additional to this was resources put in by NCRM for facilitation funded by NCRM and the Northern Periphery and Arctic Program on a 50/50 split. The expenses were not estimated in monetary terms.

Key Outcomes and Lessons Learned

In the following, we describe the most important outcomes of the Norwegian case study. First, we outline common results in the three case municipalities, and then we describe some specific outcomes in each of the case municipalities. This outline is based on Skype-meetings in October 2018 with participants from the case municipalities to sum up their experiences. The discussions in the meetings were recorded, transcribed, and analyzed. We present condensed findings and use some quotations in the text originating from the meetings.

1. **The most important result pointed out in all three case municipalities, was that based on the Making it Work platform, they had been able to establish a local regular GP recruitment and retention project that was anchored, understood, and strongly supported at the top municipal administrative and political level.**

The new local projects made it possible to both discuss and decide on new solutions locally, and generate economic resources to implement them. One of the case municipality participants said:

“Participating in the project meant that we got higher up in the system. They were a little more interested, and understood a little more. The mayor, the chief municipal executive, and the municipal health manager are all in the steering group. When you get such anchoring something positive can come out of the project. It’s not just hanging in the air.”

2. **All the three case municipalities evaluated their service model and ended up extending their number of regular GPs with one extra GP to reduce the workload. During the project period, they also succeeded in reducing the number of vacant regular GP positions.**

Table 2 show the results for each case municipality. The numbers from 2015 are per January 1st, while the numbers from 2018 are per August 1st. Meløy and Odda were able to reduce the number of regular GP positions served by a GP-locum. This was not the case in Årdal. The GP-locum numbers from Årdal reflect that three of their regular GPs were serving mandatory time at a hospital in 2018 as part of their specialization in family medicine.

Table 2: Developments in the regular GP situation in the three case municipalities from 2015 to 2018.

	MELØY		ÅRDAL		ODDA	
	2015	2018	2015	2018	2015	2018
Number of regular GP positions	7	8	5	6	7	8
Number of vacant regular GP positions	3	1	3	0	2	0
Number of regular GP positions served by a locum	3	1	2	3	5	0

Table 3 show the changes in gender and age distribution among the regular GPs. The regular GPs are slightly younger while the proportion of females was reduced in 2018 compared to 2015.

Table 3: Regular GPs' gender (*female*) and age distribution in 2015 and 2018.

	MELØY		ÅRDAL		ODDA	
	2015	2018	2015	2018	2015	2018
Under 30 years		1		1		1
30-44 years	1/1	1	1/2	1/4	1	2/2
45-59 years		3			3	2
60+ years	1/1	2			1	1

Case specific outcomes

Meløy

Representatives from Meløy went on a study trip to visit a GP practice (Senjalegen) they were introduced to during the first project workshop. They learned how they could change and improve their own service model. The health administration in Meløy has proposed to merge their several GP practices into one large practice. The motion has not yet been approved by the local politicians, and has created a lot of local opposition. One of the participants said:

“After visiting [Senjalegen] we had a lot of new knowledge. Before we were only thinking about localization, after our visit we realized that we could do a lot of other things to improve our GP services.”

They have organized the regular GP service with more flexibility to meet with the regular GPs' preferences concerning payment system. They also got new ideas on how to organize their GP-locum needs. Instead of thinking separately about each GP absence, they realized that absence among regular GPs is part of everyday life and has to be seen in a broader perspective. They now hire GP-locums for long periods to cover for occasional GP absence. This GP-locum sees all patients whose regular GP is absent. This has reduced the waiting time to get a GP-appointment. This change was mentioned by one of the participants:

“Previously people booked an appointment months ahead without having any particular reason - just to be on the safe side. Now you get an appointment in just a couple of days.”

The participants from Meløy experience that their reputation as a GP employer has improved. They also experience that the new competence requirement on regular GPs has made it easier to recruit regular GPs as they see the need to be specialized in family medicine also if they prefer to practice as GP-locums in the future.

Årdal

During the project period, a new joint chief municipal medical officer position covering Årdal and two neighboring municipalities was established. This is received as good news to the GP service in Årdal. The position might provide new quality standards and a better overview of the needs in the area.

A common GP-committee in the three municipalities has created a larger professional environment and a very good inter municipal cooperation. Traditionally, it has been difficult to get the municipalities to cooperate. The participants from Årdal say it's hard to tell if this cooperation would have happened without Making it Work. After they joined the project, the top leaders in the municipality have been more interested in the defects of their GP service. Before the focus was on just covering up the leaves. Now they are more interested in why regular GPs do not stay. System improvements like the ones mentioned is part of the ambition to do something to improve the situation.

In October 2018 the GP-situation was difficult in Årdal, but not considered a crisis. Three GPs among the regular ones were, as mentioned above, serving their mandatory year at a hospital as part of their specialization in family medicine. It is difficult for regular GPs to get entry at the hospitals to serve this part of their specialization. When they get access they just have to grab that chance. The present situation in Årdal was described as “a coincidence of unfortunate circumstances”. They hope that the GPs will come back to Årdal, but they know that it is a common situation in rural areas that GPs don't come back after their hospital year in specialization. Having to leave creates a break-up atmosphere and one year is a long time. Earlier in the project period they were much better off. One of the participants (a regular GP) said:

“We had six months with full crew - the waiting list went down and the pressure on emergency appointments went down. We were not in a hurry all the time. We got the taste of the good life and hope that it is possible to get there again.”

Årdal engaged a GP as part of the “ALIS-Vest project” in September 2017. In October 2018 this GP had resigned. However, the participant from Årdal still thinks that the “ALIS-Vest project” will improve the recruitment and stabilization of GPs in the area and will apply for a new GP through ALIS-Vest. They doubt that they would have taken part in the “ALIS-Vest project” if they had not heard about it at the first project workshop.

Odda

The participants from Odda experience large synergies as they participate both in Making it Work and the “ALIS-Vest project”. The participant stated that if they had not been part of Making it Work, they would not have participated in the “ALIS-Vest project”. ALIS-Vest is, however, more important for Odda now. They have recruited two GPs as part of that project and two more on similar terms (i.e. to specialize in family medicine in salaried educational positions). During the project period, they have also merged two GP practices into one. They have hired a new chief municipal medical officer who has contributed with establishing new and important routines. They feel things are in place and that everything is very good. The merging of the GP practices means that they have brought together young and elderly GPs. Supervision and counselling of GPs under specialization has improved. They only have one specialist who can counsel and have made sure to provide working hours for this important job. Getting enough resources for this is however a challenge.

One of the participants said that it is very noticeable that all GP positions are filled. Things are stable and it is possible to move on to work more with establishing a professional environment. She said:

“We need to develop a professional environment and have structured meetings for the GPs. It tends to be very lonely inside the GP offices.”

An unexpected challenge associated with filling all the GP positions with doctors who go into specialization in family medicine, is their absence due to accompanying courses and counselling. The local politicians do not understand that with all the new doctors in place there is still a long wait for an appointment. It is also a challenge to get collegial cover for this absence among the GPs. There are some disagreements regarding this between the doctors who are private practitioner and those who are employed by the municipality.

Lessons Learned

The case municipalities have learned for future projects that:

- **The process is just as important as the result.**

To make a good change process it is important to include a wide array of people (i.e. all staff in the GP practices, local politicians, chief employment representatives, and also ordinary people). The strive for change most often creates opposition. A broad based anchoring does not make it easy, but it makes it easier when the ones who promote change suggestions know they have allies at their back.

- **Ensuring that working conditions are flexible is increasingly important.**

Although difficult to achieve when there is under-staffing, it is important to be able to plan and facilitate for the long run, and not just be occupied with day-to-day crisis solving. Even if you are extremely motivated, it is difficult to survive in such situations over time.

- **It is easier to recruit than to retain regular GPs.**

People choose what's right for them. They need to be motivated beyond the job to stay. Those who bring their family are the ones most likely to stay in a certain place.

- **Take good care of GP-locums, especially those you would like to keep.**

Provide good working conditions, good housing, up to date equipment, and make them feel welcome. Think of short-term GP-locums as potential regular GPs.

- **One needs to talk well about general practice.**

Being a regular GP is not busy everywhere. Much of what is said about heavy workloads is true, but much is also laid on thick. It is not the same everywhere. Promotion of the positive sides could have positive gains.

Sustaining a Stable regular GP Workforce

The *Making it Work: Framework for Remote Rural Workforce Stability* provides a set of key areas of activity that, when implemented as a holistic, integrated set of interventions, can provide good conditions to establish a stable and appropriately skilled workforce in rural communities. Based on the framework and the work so far done in the case municipalities in Norway, we present recommendation for continued work to stabilize the regular GP workforce. It might not be possible to implement all of them, and planning to recruit a new GP will happen at the same time as measures is taken to retain other GPs.

Recommended on-going activities

Plan

Assess population service needs

According to the Public Health Act of January 2012, Norwegian municipalities are required to have sufficient overview over health conditions and influencing factors, in order to:

- Contribute to societal development that promotes public health and reduces social inequalities in health.
- Ensure that municipalities, county authorities and national government health authorities implement measures and coordinate their activities in the area of public health in a proper and adequate manner.
- Facilitate long-term, systematic public health work.

The Norwegian Institute of Public Health (NIPH) publish Municipal Health Profiles yearly¹. These profiles can be downloaded from a web-site, and they are according to NIPH used actively by the municipalities. It is important that rural municipalities have the capacity to assess the healthcare needs of the population, and especially bring about significant change initiatives when required. Such assessment and change initiatives does not have to originate from a doctor, but could with advantage be performed by a doctor. A chief municipal medical officer with good social medicine expertise and interest will be particularly suitable for the task.

The resources allocated to chief municipal medical officer functions vary significantly between Norwegian municipalities, and the general impression is that they are under-dimensioned (Agenda Kaupang 2016). Some small municipalities do not have a chief municipal medical officer to ensure this function either because they do not prioritize it, or because they are unable to recruit doctors for this position. Such a position can be created in an inter-municipal cooperation, like Årdal municipality has shown in this case study.

Align service model with population needs

In general, it is difficult to retain regular GPs in rural and remote areas. It is even more difficult, not to say impossible, to retain regular GPs in GP positions with non-attractive working conditions. The Norwegian case study shows how all three case municipalities found reason to add additional regular GPs to their service model after having done a thorough review.

It is important to create a local routine where the local GP service model is reviewed, and questions like “do we need change?” and “how do we make these changes happen?” are raised

¹ <https://www.fhi.no/en/hn/health-in-the-municipalities/hent-folkehelseprofil-for-kommune-fylke-eller-bydel/>

and answered. We would recommend this done as part of the development of the social element of the legislated municipal master plan work done every fourth year (i.e. every election period) in Norwegian municipalities, and also that a review like this is initiated from the chief municipal executive level. A central agreement (ASA 4310) recommend that municipalities make their own plan for the medical service based on necessary management data, but for the time being, few municipalities follow this up.

Develop profiles of target recruits

Many municipalities make a lot of effort in recruiting regular GPs. However, to our knowledge, hardly any effort is put into finding out why some regular GPs continue staying while others quit. We would recommend rural municipalities to keep a systematic overview of regular GPs who quit and be interested in why they quit.

We therefore recommend systematic exit interviews when regular GPs quit. We would also recommend that a periodic survey of the stable doctors is performed to find out why they stay in their jobs. This could be done every four year as part of the Review of service model mentioned above. Overall, this could provide a good starting point for new recruitment rounds. If the municipalities own systematically collected data indicates that it is not the right doctors you recruit with the present approach, you should change the approach.

Recruit

Emphasize information sharing

Every municipality is different and so is every local health care service. In order to promote the good and positive sides of the service, communication work is needed. Such “positive media” could also act as a positive enhancement of what works well and may cause a ripple effect.

In addition, information of the local health service should be shared at the education sites, both face-to-face, and with the use of social media. The leading GP in Odda invited mass media when they started their recruitment work with a social evening during Christmas leave. Later he accepted several interviews about the struggle in Odda to recruit GPs. The same open attitude towards mass media has been continued by the newly recruited GPs.

Community engagement

The case municipalities in the Norwegian Making It Work project have managed to anchor their change processes in their medical services at the top level in the municipalities. The fact that the local top managers and politicians are interested in the GP service, is an example of community engagement that has a great positive effect, and it has been noticed outside the municipalities as well. The trick is to hold on to this engagement, both structurally and more personally. The head of the GP service should ensure that they maintain the relationship with the top municipal level and keep them well-informed about developments. Årdal has established a regular meeting point between the GP's and the top level managers. Another possibility for the GP manger is to identify when the local top managers and politicians gather, and ask for some time to give a short presentation. This should be repeated and thus become a routine, minimum once a year.

Supporting families/spouses

It is often said that doctors marry doctors or have highly educated partners with job preferences that is difficult to meet in rural areas. This is to our experience not always the case and should not be presumed without closer checking.

Easy access to the local kindergarten, safe and easy transportation to school and leisure facilities, safety in the community and family friendliness are likewise aspects that would be important to highlight to GPs with children. In Odda, the health service managers put weight to the young GPs involvement in the local sports clubs.

Retain

Supporting team cohesion

Doctors are in general concerned with their professional development. In order to retain regular GPs, it is of utmost importance to establish an inclusive and educative professional environment for both new and more experienced regular GPs.

A possible professional gathering point that also involves other local health professionals may be to conduct emergency medical team training. Norwegian regulations mandates both the municipalities (responsible for primary care) and the health trusts (responsible for secondary care, including ambulance services) to establish such training. However, a survey has shown there are many municipalities where this does not happen (Abelsen & Brandstorp 2017). Research shows that emergency team training outside hospitals creates a good learning culture locally and improves the ability to interact (Brandstorp et al. 2016). Local training in collaboration also creates professional safety (Brandstorp 2017).

Research done in Alta municipality (ibid) shows that young regular GPs would not have remained in a demanding medical job far from hospital without emergency team training at their own workplace, with their own equipment, own colleagues and local issues (i.e. in situ training). In this way they become acquainted with their own and others' competence and role. Commitment for a shared service is created together by all groups of health professionals. There is a common responsibility for delivering good services, which in turn can cause health professionals to stabilize and relieve each other. Lack of fee/salary to do the training is probably a significant explanation factor for lack of training in many municipalities. This is possible to get in place. The research from Alta municipality shows that the health personnel have personal "professional days" included in their employment contracts. Emergency team training is done on such days. Responsibility for the training is assigned to one specific GP who works with an interdisciplinary facilitator team. The exercises are conducted on the same day every month and participants sign up on professional-specific lists so that there is no doubt about who will exercise when and so that the different professions are represented. The training has very good support and is voluntary. The learning goals are not clearly defined before training, but the teams themselves are challenged during the training by the facilitators and each other to work with different conditions. The exercises thus reflect the complexity of the medical activity locally and provide room for the participants' own accountability. We would strongly recommend rural municipalities to get started with emergency team training.

Relevant professional development

Learning objectives that can only be achieved in hospitals, which form part of the specialization in family medicine, represent a challenge in several ways. This is traditionally referred to as “the hospital year”. The hospital year is experienced by many regular GPs as a major obstacle to completing the specialization in family medicine. In many cases it is difficult to get access to a hospital to take this part of the specialization. Many rural GPs remain in hospital positions after this year and do not return to the municipality they left. It would probably be an advantage if the hospital year could be implemented more flexible than today. The opportunity to split up the year in smaller parts, and to increase the number of services that could host such secondary service training, is currently discussed at the national level. The state owned Regional Health Authorities and the associated local health trusts responsible for the hospitals must however also engage in this issue. They must play a key role in ensuring better access, facilitation and predictability in connection with the implementation of the hospital year (or secondary service training) for regular GPs under specialization to safeguard further retention in their municipalities after having finished their specialization.

Training of future professionals: Rural municipalities should welcome medical students who need an internship as part of their study or who need a summer job. They should also facilitate good specialization courses in general medicine for their regular GPs. This can be done by creating adapted education positions that involve either fixed salary or tailored private practice with municipal economic subsidies in a start-up phase.

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