Minutes of the Nordic GP seminar 25-26.8.2018, Helsinki

Pekka Honkanen opened the meeting and wished all warmly welcome and passed the chairmanship of the first session (Session about recent developments in each country) to Tuomas Koskela. An introduction round followed. We were sorry to find out that there was only one representative from Denmark. Half of us were in the last meeting 2 years ago in Reykjavik. It was agreed that Arto Virtanen will make a memorandum of this meeting

25.8.2016 Actualities in each Nordic Country

Finland, Arto Virtanen (Suomen yleislääkärit), **the great Healthcare-reform is on the way**

There are 313 municipalities; the smallest (Kuhmoinen) having 1285 inhabitants and the larges (Helsinki) 628.208 (statistics 31.12.2015). Secondary care is provided by hospitals districts (There are now 21 of them). Social and health-care are organized in different silos so the coordination is sometime sometimes poor. Primary care is provided by the municipalities, each by its own, or together with neighbouring municipalities. The result is Wide variation in quality, costs, methods used, availability of care….

The major issue in Finland is the planned social- and healthcare reform. Finland will be divided into 18 provinces and all social and healthcare is planned to be provided by these 18 provinces and not by the municipalities as is happening now. Many of these functions now provided by the municipalities or the state will be arranged by the provinces. All finances will come from the state. However a taxation reform is planned and the province are planned to have taxation of their own in the future. On social/health-matters each province has to work together, coordinated by the 5 provinces having a university-hospital. There will be 12 emergency hospitals with a broad clinical field and 6 limited-field emergency hospitals. Other emergency units are not allowed; at least they may be not called emergency units. It is however certain that out of hours primary care work will not come to an end. There are two reasons: One is the remoteness of some parts of the country and the other reason is that many patients need medical attention out of hours but are considered to be not “sick enough” to be accepted into some emergency units

Provinces (with an executive, politically chosen board) are responsible for the healthcare but production must be provided by a non-political office led by professionals. Primary care shall be delivered by companies and the health centres existing now shall become independent companies owned by the provinces. The market will be open for other companies too. The patients are planned to be allowed to choose their own primary care provider among these companies. The size of these companies is yet to be decided (minimum GP and nurse and maximum: many GP´s nurses, physiotherapist, midwives…).

The legislation is no finished and the discussions are still going and the final result should be known in 2017 and the new system is planned to be established 1.1.2019. We will see what happens.

In the following discussion arose the worry and wondering about the way out of hours services are planned to be provided and that work will be reimbursed. Also was discussed the worry that multinational corporations will get their foot into Finnish primary care. So we all hoped that the size of the primary care companies would be small enough so that local companies will get their chance. Sweden is planning to cut their number of provinces providing healthcare from 21 to 6. The size of these areas would be proportional to the 5 Finnish university hospital–areas.

Finland, Pekka Honkanen (Suomen yleislääketieteen yhdistys)**: Funding the specialty training in health centres**

Now he employer gets about 1000€/month/trainee. In order to be accepted as a training health centre, the health centre must share that sum of money (75 % - 25 %) with the Primary Care Unit (PCU) of the local university hospital. The goals of training and the methods/content of training are set by university but the university is not funded for this work. Only public, and not all health, centres are accepted.

After the health care reform specialty training is still funded, but in a different way. The Primary Care Unit (PCU) of the local university hospital will make a deal with the university and the primary care providers (public or private). Each partner will get their fair share of the funding in a way to be legislated. The trainee, so to say, then brings the funding with him/her.

In the following discussion Sweden told that their solution is that 2/3 from the trainees wages are paid by the province

Sweden, Ove Andersson (Svenska Distriktsläkareföreningen)

On 2013 the government appointed a national coordinator to analyse how professional resources in Swedish healthcare could be used more efficient and appropriate. The commission should, in dialogue with politicians and professionals develop proposals of measures that could be carried out. The staring points were that the efficiency of health care is generated in the consultation and that the involvement and participation of the patient is crucial. There is a neglect of its structural problem in Swedish health care and will have more problem to streamline the health care and adapt to the needs of the future. On problem is age-profile of GP´s with a lot of retirement coming in the near future. Some other problems:

- The political governing and the structure of Swedish health care guided by provinces, every province looking just for its own interest
- All more clear that primary care has more and more difficulties to sustain its mission as ”first line healthcare” and is considered to be in a worse position to meet future demographic changes and needs in an aging population
- Organisation and way of working. There are enough physicians but they are in the wrong places.
- Hospital beds and overuse (even they already are in the lower part in the OECD-statistics)
- Lack of maintenance of competence
- Operation support (IT, knowledge-support like guidelines)

There were measures to be taken and recommendations

- Stronger guidance concerning structural problems
- National order for consultation
- A law concerning the mission for primary care
- A responsibility for emergency care for primary care
- New requirements concerning how to organise primary care (for example primary care could be segmented into general, elderly care. psychiatric care…)
- Redistribution of resources
- A standing committee for national collaboration concerning providing competence to Swedish health care
- To increase continuity

Some specific goals and measures have arisen:

- More specialists in family medicine
- Segmentation of patient needs
- Redistribution of resources from secondary care
- Increase the attractivity of primary care as workplace
- Primary care based guidelines and other operational support-systems

The central office of Provinces (SKL, Sveriges kommuner och landsting) is on these days seeing things more from the whole Sweden’s view but is more or less a discussion forum with only little effective power. A well-functioning primary care is agreed to be probably the most important instrument in the future healthcare to achieve equal health. The Swedish Medical Association is taking part in this reform, with this kind of a list:

- National definition of the mission of primary care
- National principles of remuneration
- Enlist to a doctor (and not just to a health-center)
- More doctors as directors of health care units
- A strengthened responsibility for providing competence
- A primary care with increased diversity, that is: primary care units must not uniformly alike

Iceland, Þórarinn Ingólfsson (Icelandic College of General Practice) **Icelandic health care structure**

There is one national hospital serving the whole country. The redundancy of private specialists is imminent (with exceptions) and many of those work part time at the hospital. There is no referral system or referral obligation. There are now two new subspecialties in General Practice/Family medicine: geriatry and rural medicine.

As primary care physicians are only 16% of the physician work force, it is a weak minority within the profession. Primary care is centrally organised by state and GP´s work on fixed salary with little influence on management. There are recruitment problems to get GP:s

The Icelandic College of GP:s has been fighting for doctor wages and terms. There was recently a strike in 2014-15 campaigning for reforms in primary care with the agenda to have the Norwegian model in Iceland. Also on the agenda was fighting for a chance to manage their own primary care units The politicians have been ambivalent and there is a definite conflict of interest with private specialist taking care of many patients who would not need a specialist care. For example 30% of cardiologists patients don't have a heart problem.

The college is arranging the Nordic congress next year

A primary care reform in 2016-2017 more a less towards the Swedish model is on its way. The funding for the primary care units come is as following: capitation 46%, disease-burden 46%, and quality indicators 8%.

There were 3 PCU´s on public auction. The bidding process complicated and hurried with only 3 weeks the make an offer. The funding was impaired or even unacceptable? The price was fixed and the offerors where supposed to tell how they manage with the fixed resource of the financing model. A service requirement document was also included. In this document where demands upon transport, parking, architecture, accessibility, co-working with other professionals etc..) The interest among GP´s somewhat low and there were only 3 bidders, one of the was rejected instantly there will probably too be rejected so there will be just one candidate left.

Norway, Petter Breilin (Norwegian college of general practise) **Healthcare-model in Norway**

In Norway there are 428 municipalities, they are mostly small communities and some are larger cities. Health care is provided by the government in 3 levels of health care: Primary health care for which the municipalities are responsible, specialist care in hospitals is state financed as are the national centres. In recent years the cost for primary care has been stable as in the same time the cost for specialist care and community-delivered care has risen markedly.

The primary care sector is large and strong. The municipality is responsible for all services and all medical services provided by GPs. Beside of this there is a large community care sector with home based services, institutions for elderly sick people and psychiatric patients and developmentally challenged people. So is the preventive care for children and midwives doing parts of maternity care. This is a poorly organized sector.

Every GP has a personal responsibility in a list system and companies/organizations cannot take responsibility for the list. GP:s are predominantly self-employed and make contracts with municipalities. General practitioners are coordinators of care. Remuneration comes from 3 sources:

- The municipality pays fixed sum / person on the list.
- The patient pays fixed sum per consultation (about 20€)
- The state has a fee for service system

Norway has 4600 General practitioners and every one of them has on average approximately 1100 patients on his/her list. There are 1600 offices – distributed where people live, where approximately 2,35 GPs per office. The average GP has 0,8 personnel employed, mostly of secretarial nature.

The system promotes relations between doctor and patient, the relation promotes continuity and vice versa. The GP workforce has been relatively stable. A patient has known her doctor for 7 years – on average. Continuity of care and relation are important for patients, and for GP:s too. It´s a win-win situation. Comment in the discussion: Continuity of care is essential for the quality of care given. There is evidence for this in Sweden (The use antibiotics and resistance to drugs). This also diminishes referrals to specialist care.

The structure of the Norwegian medical association was explained. There are 44 speciality-colleges (Fagmedicinske foreninger), 7 Unions (Yrkesforeninger), 19 geographic organisations (Lokalforeningar). Every member of the association must be a member of one speciality collage of their own choice. 97% of physicians are members of the association.

Tom Ole Oeren (Norske förening för Almenmedicin**) what the union is doing**

The board of the union has 8 members. The union arranges workshops about healthpolitical and other issues to build their work-plan. Work is being done in the following sectors with the main issues being the improvement

of the conditions for the general practitioner, wages (payment) and working conditions and health policy matters on local and national level.

- Cooperation with the health care in our 428 municipalities (primary health care)
- Cooperation with the specialist health care in the hospitals
- Specialist training/education in general practice
- Cooperation with the politicians in the local and national level. Importance of good relations with the authorities.
- General practitioners in management and administration (Master program in the university) How to lead an office with employees and other colleagues
- Electronic medical record systems in the future
- Further development of the Norwegian list-patient system. This is not only about the size of patient list but about developing financing and bringing the quality-issues into the field and taskshifting within healthcare.

Petter Breilin (Norwegian college of general practise) **What the college is doing**

In the matter of overdiagnosis and overtreatment the college established a special interest group 3 years ago. The group and the board of the college has produced a white paper. The medical association is working on a similar document. The issue has broad support in the Norwegian medical community

Specialist training / educating doctors has been done by the medical association. The authorities proposed to move all education to hospitals – including training of GPs. The proposal was refused by the college. The authorities are now accepting the role of primary care in specialist training. Formal approval of a specialist is made by the directorate.

The college is working to ban tobacco altogether. They have proposed to forbid sale of all tobacco products to people born after 1 of January 2000. Government has implemented plain packaging. The work with other organisations to ban tobacco will go on.

Pakkeforløp (predetermined guarantied care) for cancer has been a success. The government wishes to implement pakkeforløp in psychiatry. The college is not sure whether this is would be a good thing to and asked now for thoughts. There were negative and positive aspects but no conclusion was reached.

A new line of medical education has been opened: GP:s as managers, 230 applied and 30 where accepted. This is a preparation for the growing size of some primary care units.

The collage works actively. It has 6200 members of whom 4200 are GPs. It has good relations with the union-side and good relations with authorities too. There are yearly 3-4 meetings with the ministry, 3-4 meetings with the medical associations directorate and 2-4 meetings with the association of local communities.

Denmark, Karin Mette Thomsen (Danske Selskap for Almen medicin)

In 2013, there was a tough situation in the working field of general practitioners. PLO had a hard time negotiating with the region regarding the renewal of the collective agreement dealing with the wage and working conditions for GPs in Denmark. The strategy to deal with these matters divided the members. Since then the organisations for general practitioners have been in some turbulence. There have been chairperson changes in both organisations. In addition, changes in the boards have happened. In 2017, a new agreement is to be negotiated again. This is a task for PLO as they are the union dealing with such matters.

DSAM and PLO are two different organisations. In some areas, the organisations work together and divide the tasks between them. DSAM as an organisation is working on a more clear profile. In various ways, they are modernising the organisation, e.g. the guidelines for our members. They think the guidelines should be electronic and relevant for their members. They are also working on a new website and focus on strategic communication. Their chairperson Anders is often in the media promoting the organisation.

The health-care legislation is about to be modernized and the healthcare organisations have often commented about imminent problems in the planned laws. Especially the matters about confidentiality and health care records have been under dispute and the input from DSAM has been crucial. Karin Mette referred to a specific law and regulations where DSAM had worked hard in order to change the legislation.

This discussion about the roles of separate GP-organisations was in some extend found going on in other Nordic countries too.

Sweden, Ove Andersson represented results from their GP questionnaire (by the Swedish medical association)

There are 6600 Physicians in health centres, 4600 answered, answers came only from those with regularly working doctors in them. 70% of GP:s work in a public health center and 30% in private center. 64% have patient-list of their own with the average size of 1745 (variation: 1358-2133). There is a vide variation in the number of health centres where there are too few GP:s. 50% of GP:s is missing in 3-36% of provinces. The situation is best in Stockholm and worst in Örebro. 83% of Gp:s are in the status of employed workforce, 10% are owners or partners and others are 7%. The GP:s have as their boss a physician in 36% of cases.

Some results: 25% wouldn´t recommend their own health center to their relatives. Explanations: If these are too few GP.s then the unit cannot be recommended. The results are better in those units where there is a physician as a boss, enough of GP:s, if you own your unit. The results are worse if the unit is a public one or is a large unit. Not feeling to be able to control the schedules at work is correlated to being female, being in a public station or there are too few GP:s. 1/3 of contacts where considered to be OK if handled by other healthcare staff.

Ove did have time to represent only a minority of the data available. Please refer to his set slides.

26.8.2016, Quality session, chaired by Jaana Puhakka (Suomen yleislääkärit)

Quality matters in Finland, Arto Virtanen, (Suomen yleislääkärit)

The 6 elements of quality in health care (as defined by the Institute of medicine, now called National Academy of Medicine) were introduced.

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Effective** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centred:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Most of these elements are not tackled in Finland. Waiting times for GP non-urgent visits are measured automatically by authorities. The results have been questionable due to technical errors. Waiting times to get into secondary care are also measured automatically. **Time-stamps in this process are:** contact with primary care, visit in primary care, sending a letter of referral, visit in secondary care

Current Care Guidelines are provided by Duodecim-foundation with 107 clinical entities and published in Finnish and Swedish. There are also versions to be used by patients. Some of the oldest guidelines have been outdated and will be discharged

There is a national primary care register of care given. When and where who is treated by whom and how and when the first contact was made. All health centres send automatically data from their electronic healthcare records to the national institute for health and welfare (THL). Some results can be seen on the internet almost real-time

The following data (among a few other things) is gathered:

- Diagnosis ICD-10 or ICPC, SPAT classification (Our own peculiar system, what happens in the consultations, 400+ codes). Vaccinations, Dental care given, what followed after the episode (Case closed, referral to hospital, follow-up visit …..)

The **Health promotion capacity** in municipalities is measured. It is possible to search in the database and compare results of areas and municipalities and separate providers of care.

Evidence-Based Medicine electronic Decision Support is integrated into most electronic healthcare programmes - by the Duodecim-foundation. It uses data of diagnoses, medication, laboratory results, drug interactions, patients medication list, and soon also genetic drug metabolism. If a diagnosis is given the systems create a link the guidelines

But what we miss: How the people are coping ? We don´t know (except time/place limited project-data). If we do something; do they cope better ? We don´t know (except time/place limited project-data). If we knew this then we could know quality of care

Quality matters in Finland, Klas Winell

Measuring outcomes and quality in health and social services is done by several bodies:

Ministry of health and social affairs (STM), a company called Nordic healthcare group (NHG), the national institute of health and welfare (THL) The fund of Finnish independency (SITRA), provinces and producers

The needs of these of the state, the provinces and the producers vary. Healthcare production will be handled as packages (for example psych care. elderly care, rehabilitation, emergency care, dental care etc.). Different data will be gathered from each package at three levels: State, province and producer

THL introduced in the first list: over 600 indicators, in the next to final version: 216 indicators, OK in Klas´s opinion: 36, and of them OK in Primary care:

- % of services provided within the time limit
- % of patients getting vaccinations
- % of women participating in mammography screening
- Patient satisfaction
- Treatment of chronic diseases (hbA1c…)

Here an example how specific quality disease oriented data can and is gathered

- Choosing the indicators is crucial. You must choose the dimension of IOM. In different levels of the healthcare system there are different needs. With major health benefit comes major financial benefit. Basic ”rules” should be chosen.

Reliability = inter-observer reliability.
2: Kappa >0.6: criterion is specific, little room for interpretation
1: Kappa 0.5-0.6: criterion not specific but not normally contentious
0: Kappa <0.5: criterion vague and contentious

Acceptability = services be confident about the feasibility and the data collection.
2: clear yes: data already being collected, though not necessarily extracted, and quality indicators (QI) not contentious
1: not clear: either: data not normally collected, but no major changes to service necessary, QI not contentious; or: data available but QI likely contentious amongst occupational health services.
0: clear no: either: proposed services not available in considerable proportion of OHS, and major changes required to implement; or: data not collected and QI likely contentious amongst occupational health services

Sensitivity to change = change in quality of service will change score.
2: clear yes: measurable scale of achievement (% of workers...)
1: not clear: well defined binary criterion
0: clear no: vague binary criterion

Discriminatory = discriminates between good and bad services.
2: clear yes: 25%-75% will meet the QI;
1: not clear: 10%-25% will meet or not meet the QI;
0: clear no: <10% will meet or not meet the QI.

Primary care quality in Sweden, Ulrika Elmroth (Svensk förening för allmänmedicin)

PrimärvårdsKvalitet is a kind of quality registry, containing 82 quality indicators (measures) and the technical solutions for collecting data automatically and making it available, both at the national and local level. This is a cooperation project with many some other professions in healthcare and the central office of Provinces (SKL, Sveriges kommuner och landsting)

In Sweden there are over 100 quality registries. Nowhere in the world, nor Sweden has it been possible to make a quality registry for primary care. Now it is possible in Sweden. Aggregated data is automatically collected at the national level. At the health center the permits individual patients to be found

Data can be used to seeing patients' results, finding the patients with the greatest needs, identifying areas where we need to improve, measures in local improvement work, scientific projects (resident physicians, other professions), training, continuous professional development and as a basis for local/regional dialogue. Here are some examples:

- How many of our patients with congestive heart disease has RAAS-blocker treatment
- How high is the continuity at our health center?
- What proportion of patients with AOM is treated with PCV?
- Which of our smoking patients with a chronic disease have not yet been offered help to quit?

There are different indicator areas, for the time being there are no patient reported indicators

Primary care specific indicators	Diagnosis specific indicators	Patient reported indicators
Multiple chronic diseases	Cardiovascular disease	PREM
Continuity	Diabetes	PROM
Lifestyle habits	Musculoskeletal disease	
	Psychiatric disease	
	Infections	
	Asthma/COPD	

100+ health centres have joined and can see data. Enthusiasm is great and most of the provinces have decided to have this system, launched in May 2016

Iceland, Gunlaugur Sigurjonsson, (Icelandic collage of general practise)

GP´s have documented manually everything and there are Problems with documentation in patient journals, especially in afterhour's services when problems may arise with complaints. They demand for documentation in processing of complaints. So there is high service demand and doctors are under time pressure, especially in afterhours services. No financial basis for secretary service in primary care in Iceland

Then there came this one fellow, Sveinn Rúnar Sigurðsson didn´t go the short way to become a doctor. He finished a university degree in business. Then worked as a stock trade, did computer programming on the side. Soon the programming became his main job. He worked mainly on software for telephone companies in Iceland and Norway. Later he moved to Ukraine and founded a software business. When the internet bubble burst his company went bankrupt. He then started in medical school in Hungary, in the University of Debrecen. He payed for his studies by upgrading the computer system of the university. After his graduation he has been working in general medicine in Iceland and Sweden. He is also a talented musician. He has composed two Eurovision Song Contest entries for Iceland.

The he made Medsys; a facelift app for electronic health records. It is not a health record system but something to be put on top of them, for easier and fast documentation. The app is easy to use. In the discussion there came up worries that the actually consultation with its talks are not documented. For these purposes there is separate window to record this data. There are 15.000 specific clinical findings to be coded, from all fields of medicine. One practical issue to be mentioned: all abnormalities are recorded in red, differentiating them from normal black text. The findings can then be translated into many other languages. (SNOMED vocabulary??).

Norway: Petter Breilin (Norwegian college of general practise)

OECD experts where invited to help in the quality work as it seemed that the progress was not good enough. Here are some findings. Patient-information must be kept confidential. Opt-out from the database in the records should not be allowed. A feedback should be provided for the medical professional. Every visit creates a bill for the state, including a diagnosis

Tor Carlsen (Norske förening för allmenmedisin)

Quality takes a little work to be done but it gives advantages. There is triangle: Population health, experience of Care and Per capita cost (The IHI triple aim).

Not everything that can be counted counts and not everything that counts can be counted

Influence on national policy goes mainly through Nordic medical association with its committees and 20 Reference groups within defined professional fields. The Center for Quality improvement in Medical Practices – SKIL (SENTER FOR KVALITET I LEGEKONTOR), was founded to courage CME. The aims are to integrate Quality Improvement in Norwegian doctors' offices, cooperate with the state and communities and with researchers

There are online courses with quality checks. However more popular and fruitful are Guided Peer group programs. The normal setting is 3 x 3 hours long meetings over a period of 8 months over some specific matters. Discussions around quality measurements have been the most wanted ones. Lessons learned:

- Quality control/measurement does NOT improve quality by itself
- Quality Improvement requires good measurements as basis for learning, reflection and change
- Quality Improvement engages clinicians! - but must be planned well

The Five P: s of success. Pleasure, Positiveness, Prestige, Pride and Profit (your pay will diminish 20% if you are not within this system

- Norway uses the same quality-measuring program as Sweden (Medrave). SKIL has been successful. It is still in a pilot-phase and funded by the Norwegian medical association. The funding will go to the responsibility of the users.

The state is planning the develop a Norwegian electronic health record of its own to replace the 3 market leaders of today. The medical profession has serious doubts about this. The new record system: planning by the state, with the aim of access to data across all platforms. One or several commercial products will be acquired. The future of the present GP systems is unknown.

Recertification came to Norway in 1984 when general practice became a speciality to emphasize its role as a real speciality. General practice is the only medical speciality with mandatory recertification.

Group work (led by Pekka Honkanen)

It was decided, that from the 6 fields of quality in healthcare (by IOM) each country (however Denmark and Iceland together) will chose 5 themes for further work. The Patient-centred approach will be changed into Person-centred. From these 5 themes from each group suggested will 3 be chosen for the actual work by multinational 3 group

The 3 themes (number of votes in brackets) to be further worked upon where:

- Continuity of care 17,
- How to improve electronic medical record data 14,
- How to stimulate profession driven initiatives for quality improvements 13

Other themes proposed:

- Medication review,
- Overview of the patient who is in need of follow up,
- Accessibility
- Patient satisfaction
- How to choose quality indicators
- Which incentives should be used to encourage CME
- How to manage quality of self-care in primary care
- Develop/Provide Primary care that meets persons needs
- Use tools at the local level, closest to the patient

- Collecting data
- Analysing data
- Improving quality
- Quality manual
- Avoid micromanagement
- Reflection – transparency
- Nordic statement on quality improvement

Continuity of care

- There must a list of patients for whom the GP is responsible. Patients should be able to choose their own GP. Also those patients with random and few visits gain from a stable patient-GP relationship
- GP:s should be stable in their jobs and there should be incentives to promote this, even financial ones
- Accessibility of care helps to achieve the goal of continuity of care
- Also the stability of other professionals in the health centres should be taken into consideration.
- The amount of visits in emergency out of hour units tells also about the continuity of care
- Measures: The swedes have found the continuity index: The % of visits by the same GP, simple.. Patients experiences can be asked, care seeking behaviour can be measured too.

How to improve electronic medical record data

- We should have better modern electronic medical records
- Systems should work with a health care professional., not against him/her
- There should be integrations with external sources (such as lab systems and monitors etc.)

How to stimulate profession driven initiatives for quality improvements

- Professionals are individuals and the different professions should be taken into consideration. The cooperation in these matters should be around the patients
- The management is in the key position. There should be curiosity, positivity, an inspirational open minded culture with a possibility to put the down on the ground when necessary. The goals should be common and shared. The units should have common goals
- Work satisfaction and the continuity of employs helps. The number of sick-leave days tells something about this.
- There should be time for reflection for new iniatives to be able to rise. But how to measure these

Conclusion

Norway has prepared a **paper on overdiagnosis and treatment**. It was send in June to all Nordic GP-associations. The majority of national associations have not discussed the paper. It was decided that this paper shall be discussed in all Nordic associations and comments send to Norway, so that we could sign this in Reykjavik on our next meeting (in June 2017) as a common Nordic paper on this important matter. The comment that each country would use this paper as a basis for a national paper was rejected.

There was a consensus how the quality-issue work will go on. This field of quality work is important. The Nordic federation will work upon this further. In Norway and Sweden there is already work going in. Further work can be carried on via emails and local level. This **quality in primary healthcare issue** will be tackled next year in Reykjavik. The goal is to prepare a common statement about quality in health care.

Minutes were recorded by Arto Virtanen