

Dermato-Venereology in the Nordic Countries

Challenges for Norwegian Dermato-venereology Towards the Year 2020

Claus Lützow-Holm, MD

Chairman of the Norwegian Dermatological Society (1999-2000).

Department of Dermatology, Ulleval University Hospital, NO-0407 Oslo, Norway, Tel: +47-22 118303, Fax: +47-22 118260. claus.lutzow-



holm@ulleva.no

General remarks

Norway's prosperity due to the North Sea 'gold mine' has made it possible for Norway to spend more money on health (measured as health care expenditures per capita) than any of our neighbours (1). Paradoxically we use substantially less money for research and development (R&D) than any of our Scandinavian neighbours (only one third of Sweden's and half of Denmark's investments) (2). A concrete result of this is our low volume of scientific medical publications (3). An additional low budgeting

among universities underlines the difficult situation for academic medicine, and dermatovenereology is no exception.

Further, the financing of public health is, as in every other Western country, a subject for political debate, resulting in a high degree of reforms and reorganisation. There is more focus on 'production' (quantity) than quality (2). Norwegians seem to be more impressed by football players and business tycoons than brilliant scientists.

Shortage of dermatological service for the last 20 years

In Norway there has been a constant scarcity of all types of physicians for at least 20 years (4). A parallel general lack of dermatovenereologists exists, with a narrow geographical distribution of specialists (5,6). Academic positions outside Oslo have been vacant for years, and recruitment to research has been low.

In 1995 the Norwegian Dermatological Society estimated a need for an additional 25-50 dermatovenereologists (DVs) to fulfil a goal of one DV per 40,000 inhabitants. This situation remains unchanged today (5). The largest shortage was in venereology and occupational dermatology, but there is a substantial geographical disproportion of DVs, with a lack of specialists in especially the northern and western parts of the country.

Table I: Dermato-venereologists in the Nordic Countries 1996-2000

Year	Norway	Denmark	Finland	Sweden	Average
1996	2.6	3.1	3.2	3.9	3.3
1997	2.5	3.1	3.2	3.8	3.3
1998	2.6	3.1	3.3	3.8	3.3
1999	2.5	4.5**	3.3	3.9	3.6
2000	2.7	3.1	3.3	3.9	3.4

Approved dermatovenereologists, age <67 years per 100,000 inhabitants per 1.1.2000. Tidsskrift Nor Lægeforening 2000; 120: 2209 and Tidsskrift Nor Lægeforening 2000; 120: 2083. ** A too high number. (Ref: A Taraldset, Norwegian Medical Ass, personal communication)

How is shortage defined?

The definition of 'shortage' is difficult to define precisely as long as there is no 'gold standard,' but it has been proposed that an acceptable degree of DV service to a Scandinavian population would be one active clinical DV per 30,000 inhabitants. According to this definition there should be 147 active DVs in Norway, but there are only 119, a shortage of 28 (23%) (6). This shortage can also be illustrated by the number of vacant positions for specialists, which has increased from three in 1990 to ten in 2000 (7). As illustrated in Table I, Norway has the smallest coverage of DVs in Scandinavia, with about 21% less than average (8).

What has happened the last 5 years - and current status

The recent and present situation supplies a certain basis for prophecies of the future, and there has been one main trend in recent years: a substantial influx of DVs to Norway from the other Nordic countries and Germany has taken place. In 1994 only one foreign DV licence was transferred; from 1997 to 1999 the

numbers were eleven, five and six, respectively. This year (2000), there have been three licences transferred so far (7). Of a total number of 55 new DV licences since 1994, 33 (60%) were from outside Norway. These figures are somewhat misleading since not all new specialists are actually working in Norway, but they are still representative of the trend.

The dynamics of dermatological growth and differentiation

To analyse the situation one has to know more about the demographic distribution of DVs, including not only the number of new DVs entering the speciality (*influx*), but also how they move into various career paths, whether they stay on through specialisation, and if they eventually leave the speciality at pension age.

The limit of the system is the total number of positions at hospitals and in all segments of private practise, and the possibility of getting enough candidates from medical schools. The number of official positions at both regional and university centres is under strict governmental regulation (*Nasjonlråd*). But it is still possible to establish private practice outside the system, at chosen locations, thus making it possible to escape the regulations.

The *influx* of new doctors into dermatology is basically from two groups, recently educated doctors from medical school or with some years' experience from other specialities (in Norway or other countries) or highly experienced DVs from other countries.

The national capacity of dermatological expansion at the five university Departments of Dermatology is a total of 18 clinical educational posts. This implies that a maximum of 4.5 new DVs can be licensed every year, as the minimum educational time in a dermatology department is four years (out of a total of five years). But the actual number the last five years has been between 2 and 6 (6). This low number stems from a number of reasons: First, most candidates stay in an educational position for more than 4 years, some as long as 8–10 years. This may be good for their professional maturation and therefore for their patients, but the influx flow is obstructed. This situation is due to several factors: formal contracts, wherein positions are given for up to 6 years; a low mobility of DVs out into vacant positions in the periphery of the country; and a scarcity of attractive positions for further professional differentiation at hospitals. A few candidates even drop out during specialisation. There is also a low mobility between the university departments, as there is no requisite to be educated in different departments. Thus, there is now a maximum influx of three new domestic dermatologists into the segment of specialists per year.

The *flow* is a description of how the doctors move in their careers. Ideally the supply should meet the demand, with a certain percentage (about 25%?) continuing academic careers, and the rest moving to the most needed local or regional locations. But, doctors tend to do as others: perform a calculation of market possibilities and

choose the most appropriate possibility for themselves and their families, which can differ from the needs of the population. Young doctors entering into the field of dermatology are also increasingly female (50% female students, 33% female DVs now, rapidly increasing), who are possibly less prone to working 100% throughout their careers.

Why do these candidates of potential academic excellence not choose to enter the academic ladder? As long as the private DV market allows it, it may be very rational to avoid 4–5 years of strenuous research work, with a personal loss of income of around 0.6–1.5 million NOK compared to clinicians (9). Add to this the prospect of a relatively low paid clinical position with impaired possibilities for continuing research (albeit with excellent opportunities of meeting clinically interesting dermatology) and it is easy to see why a candidate might forfeit an academic career.

How will Norwegian dermatology develop as we move towards 2020?

One of the factors that is predictable is the ageing of the cohort of DVs who are active today (Fig. 2). If one assumes that they will **all** work until the age of 67, there will be a low number of DVs leaving the cohort from 2000 to 2005 (mean one, but from year 2005 there will be an efflux exceeding the previously estimated domestic influx of three; e.g. an increase of the present 20% deficit). From 2010–2020 the annual deficit will increase with a mean of 2 DVs each year, and more than 40% of those

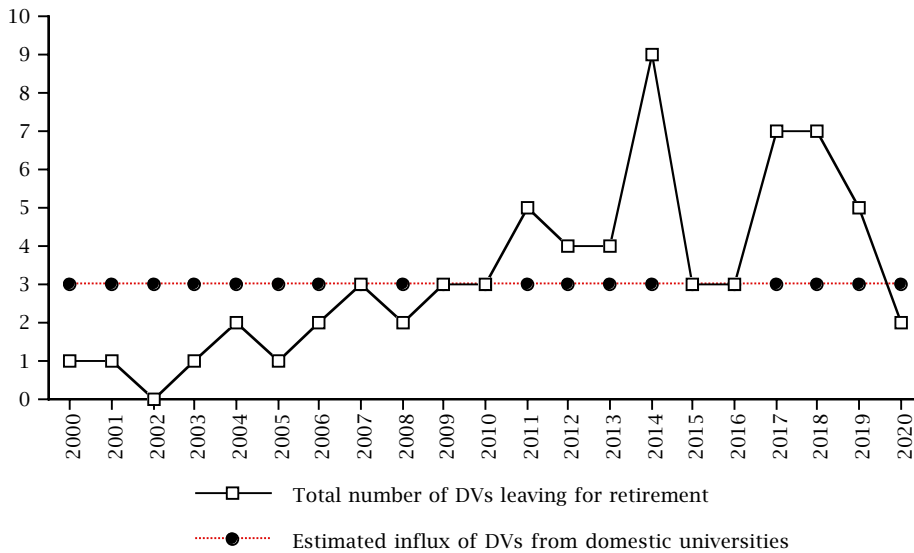


Fig. 2. Number of domestically educated new dermatovenereologists (DVs) (mean 3 per year) versus Norwegian DVs more than 67 years old (usual age for retirement in Norway) based on the Registry of active doctors working in Norway today. (The Norwegian Dermatological Society and The Norwegian Medical Association Registry of specialists – from 2000–2020.)

retiring will be from academic hospitals.

There are several variables that may additionally worsen this scenario:

- 1) foreign doctors moving back to their homelands before pension age due to an improvement of the employment markets there
- 2) increased leakage into private practice outside the health system as the health market further develops
- 3) academic leakage into the pharmaceutical industry ('hunting our best heads')
- 4) shorter working hours for older doctors
- 5) female (and male!) doctors may increasingly work only part-time due to family reasons
- 6) morbidity/mortality until the age of 67 is not taken into account (are dermatologists healthier than others?)

- 7) a possible general tendency to start second careers (leaving clinical hospital work for the private sector ('easier' work, cosmetology))

Academic versus practical dermatology

The distribution of doctors between third-line academic hospital service and second-line specialist service should be of proper balance to serve the whole population, independent of domicile. There is a high interest in dermatovenereology among young doctors, but too few choose an academic career. The 'stem cells' of academic dermatology are the doctors who pursue the basic scientific training by finishing a thesis, then being able to initiate and supervise further research of the next generation of doctors in our field. In Norway only about 40% of the academic staff in departments are medical

doctors. Of the six dissertations performed over the last five years, only three of the authors are presently active at academic hospitals.

A number of skilled academics have moved from academic hospital positions to private practice the last decade. These facts show that our problem is not only recruiting doctors into dermatological research, but just as important, attracting and keeping academic doctors for further research and clinical work inside the hospitals. It has to be possible to establish a situation at academic hospitals that can compete with private practice concerning professional challenges, meaningful work, personal flexibility and salary. To rank professional and career considerations above social life seems to be increasingly less acceptable to dermatologists as well as most professionals; it must therefore be possible to combine reasonable working hours with family life and leisure activities.

If the present lack of understanding for the need of strengthening academic medicine in Norway continues, the quality of our clinical medicine will decline to unacceptable levels within the next 10 years (10).

Norway has been saved by the influx of highly competent DVs from our neighbouring Scandinavian countries. This import has kept us at the 1990 standard, and is highly appreciated, but it must continue to a large extent in the years to come to make it possible for us to reach the average Nordic level of dermatological service (Table I and Fig. 1).

What can be done to improve the situation?

Because it takes about 10-15 years from the start of specialisation until a DV has reached academic competence, we have to act **now** to improve the situation in the year 2010 and beyond. According to present estimates, the situation then will probably have become more aggravated when compared to the situation today.

First, it is necessary to increase the number of training positions to maintain an adequate production of new specialists. By establishing one new educational post in each of all five university departments, about one new DV would graduate every year. This measure must be combined with new academic positions to absorb these doctors into academic dermatology. Hence, it must be made attractive enough for those who have finished their theses to stay with the hospital.

Rays of light in the dark....

Even in the darkest tunnels, some light may break through, and there are some tendencies in the Norwegian medical employment market that give some hope:

- Young doctors are coming back to hospital medicine due to the increased regulation of the primary physician market.
- Research can be integrated in the speciality training due to new rules for specialist training.
- It may become possible for senior staff members to become affiliated with the academic university system.

I hope that more focus on quality assurance can open the eyes of politicians, as quality means more money for R&D. More documentation might then highlight the embarrassing fact that we have a health service that may be qualitatively quite a bit behind our fellow Scandinavians (10,11).

Import of DVs from other countries – pros and cons

There is already a rapidly increasing percentage of DVs from other countries in Norway. From our records of 134 dermatologists, there are 17 non-Norwegians (12.6%). Most are from Scandinavia or Germany. As long as we are not able to educate our own academics we can only hope that they will stay as long as possible, thrive and enjoy life in Norway, and not bid us farewell as the employment markets in their home countries improve.

What more can be done?

- Establish 'twin' positions at regional hospitals to prevent burn-out and to secure the opportunities for CME for all doctors, to keep up with high standards.
- Organise positions for older colleagues to continue, thereby taking advantage of their experience and skill.

Conclusions

- Norway has a dermato-venereological service 20% below the average Scandinavian level
- One main problem is to attract

- DVs for life-long academic careers
- There is an influx of dermatologists from Scandinavia and Germany saving Norwegian dermatology from academic misery
- There is constant impaired academic proliferation, which will lead to a further shortage and will threaten the education of new DVs in Norway from 2005-2020, due to increased retirement.

References

- 1) Bjornestad S. Norge på helsetoppen. Aftenposten 17.08.00. OECD Health Statistics 2000.
- 2) Stene Larsen G. Kronikk: Helsepolitikken – trenger forskning. Aftenposten 4.11.1999.
- 3) May RM. The Scientific Wealth of Nations. Science 1997; 275: 793:7793.
- 4) Skoglund E, Taraldset A. Legemarkedet i Norden 1980-2000. Tidsskr Nor Lægeforen 2000; 120: 2030.
- 5) NDS. Dermatovenerologi i Norge mot år 2010. Plan for utvikling av faget. 1995.
- 6) Statistics from the Norwegian Medical Association (Dnlf). Small corrections made by the author due to personal knowledge of the actual numbers from updated NDS Membership Directory/ The Norwegian Medical Association Membership Directory.
- 7) Dnlf statistics from Taraldset A, personal communications.
- 8) Nordika Läkarfakta, ref av Taraldset A. Helsefakta. Tidsskr Nor Lægeforen 2000; 120: 2209.
- 9) Brandtzaeg P. Rekrutteringskrise i akademisk medisin undergraver helsevesenet. Tidsskr Nor Lægeforen 1997; 117: 3992-3994.
- 10) Thelle DS. Hva hender når medisinerne ikke vil forske. Tidsskr Nor Lægefor 1998; 118: 2303.
- 11) Hambro C. Forskning avgjørende for fremtiden. Kronikk Aftenposten 10.09.1996.