Primary Care in Transition – Options for Sweden

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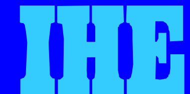

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Different models of primary care

- Private general practitioners (GPs) working alone or in small groups common within OECD
  - Payment according to fee-for-services
- Private GPs with list of patients in the UK, Netherlands, Denmark, Norway
  - Capitation + fee-for-service + target payment
  - Development towards group practices
- Publicly owned health centres with salaried staff in Sweden and Finland
  - Geographical responsibility

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Swedish primary care – some problems

- Increasingly difficult mission!
  - diagnostics/treatment, referrals, coordination/integration of care
- Gap between available resources and mission
  - work load and financial/physician resources
  - mission and trust (decision-makers, specialists, population)
- Changed conditions (both supply and demand)
- Uncertainty about ’the best’ primary care model
  - Focus on family physicians or primary care team?
  - Choice for population or geographical responsibility?

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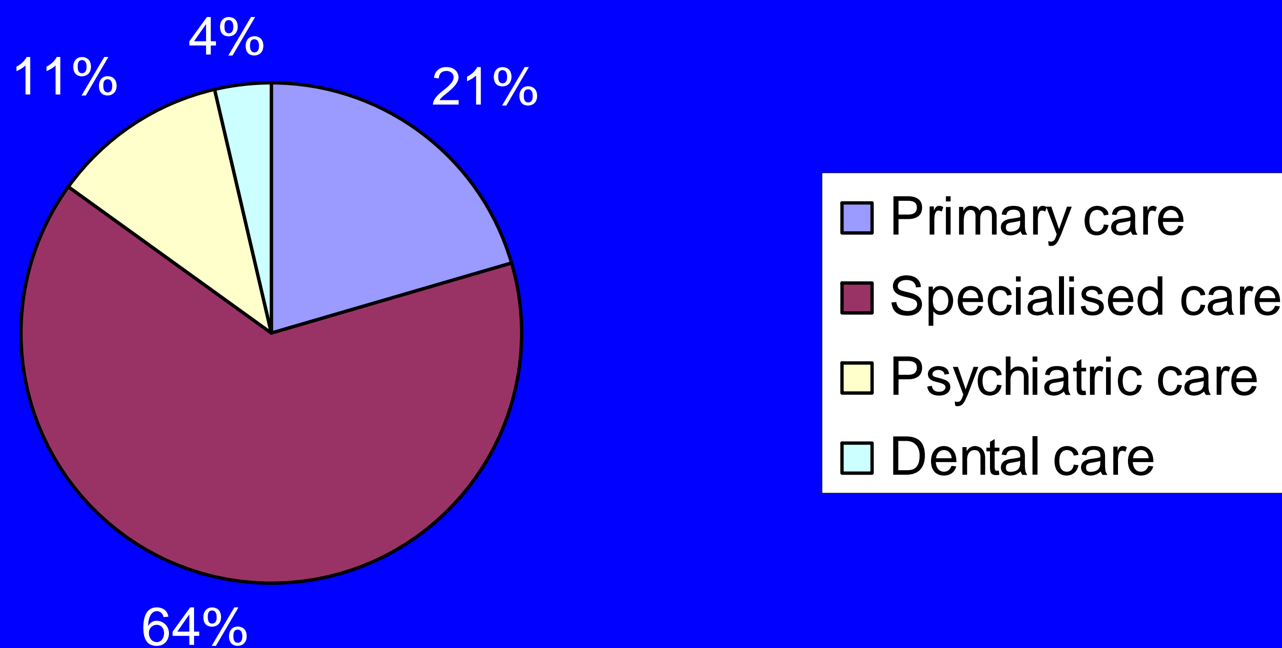
Expenditures by area in 2004, excluding prescription and OTC drugs



Source: Statistik om hälso- och sjukvården samt regional utveckling 2004. SKL.

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Inequity in distribution of physician visits due to weak primary care services

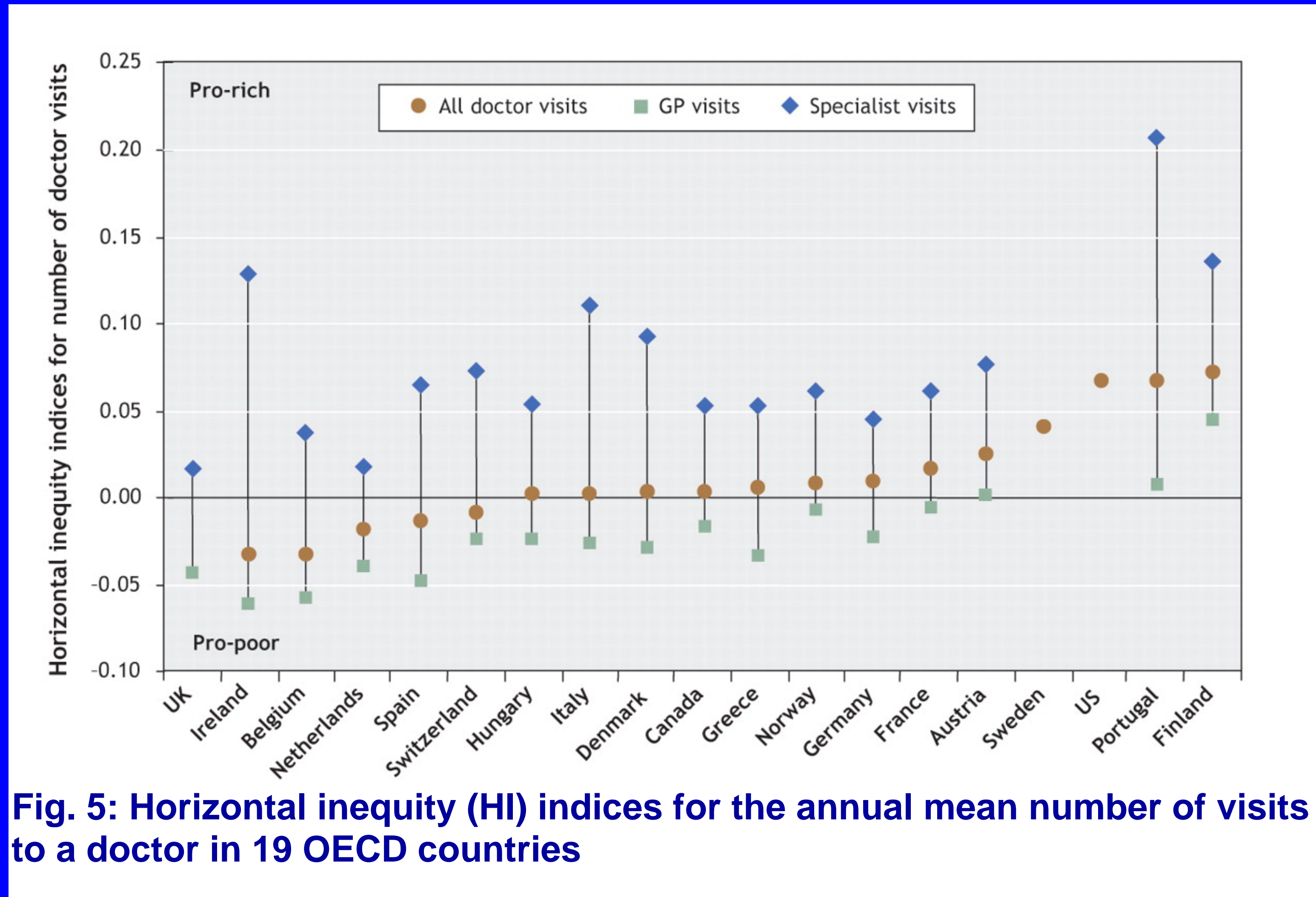

Fig. 5: Horizontal inequity (HI) indices for the annual mean number of visits to a doctor in 19 OECD countries

van Doorslaer, E. et al. CMAJ 2006;174:177-183

History of competition between family physicians and hospital specialists

- Primary care developed in the early 1970s
  - salaried primary care team, geographic responsibility
  - gate-keeping function not accepted by other specialists
- Professional struggles with surgeons in late 70s
  - ”*Family physicians* (in a gate-keeping function) *is uncalled for and will lead to higher costs and lower quality*” (Gyllensvärd et al 1978)
- And with specialist in internal medicine more recently
  - *”Dangerous for both the economy and patients to allow family physicians to take responsibility for elderly with multiple diseases”* (Clyne et al 2003)

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Specialisation and professional incentives

- Natural for professions to compete (Abbott, 1988)[1]
  - Claiming the privilege to perform a defined task (e.g. decide treatment for a patient group) on rational grounds
  - Professions with most developed knowledge/skills and best organisation 'wins'
- How develop a profession including it´s status?
  - Defining own are of work for development of knowledge/skills
  - "This is our area of work. The rest is for others."
  - More difficult for generalists like family physicians

[1] Abbott A. (1988) The systems of professions. An essay on the division of expert labour. University of Chicago Press: Chicago and London.

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An important side-effect of specialisation

”Where professional knowledge is highly systematized, complex problems are likely to be ignored. Parts of them will be handled by various professions, but there will be no service to them as unified wholes.” (Abbott, p. 110-11)

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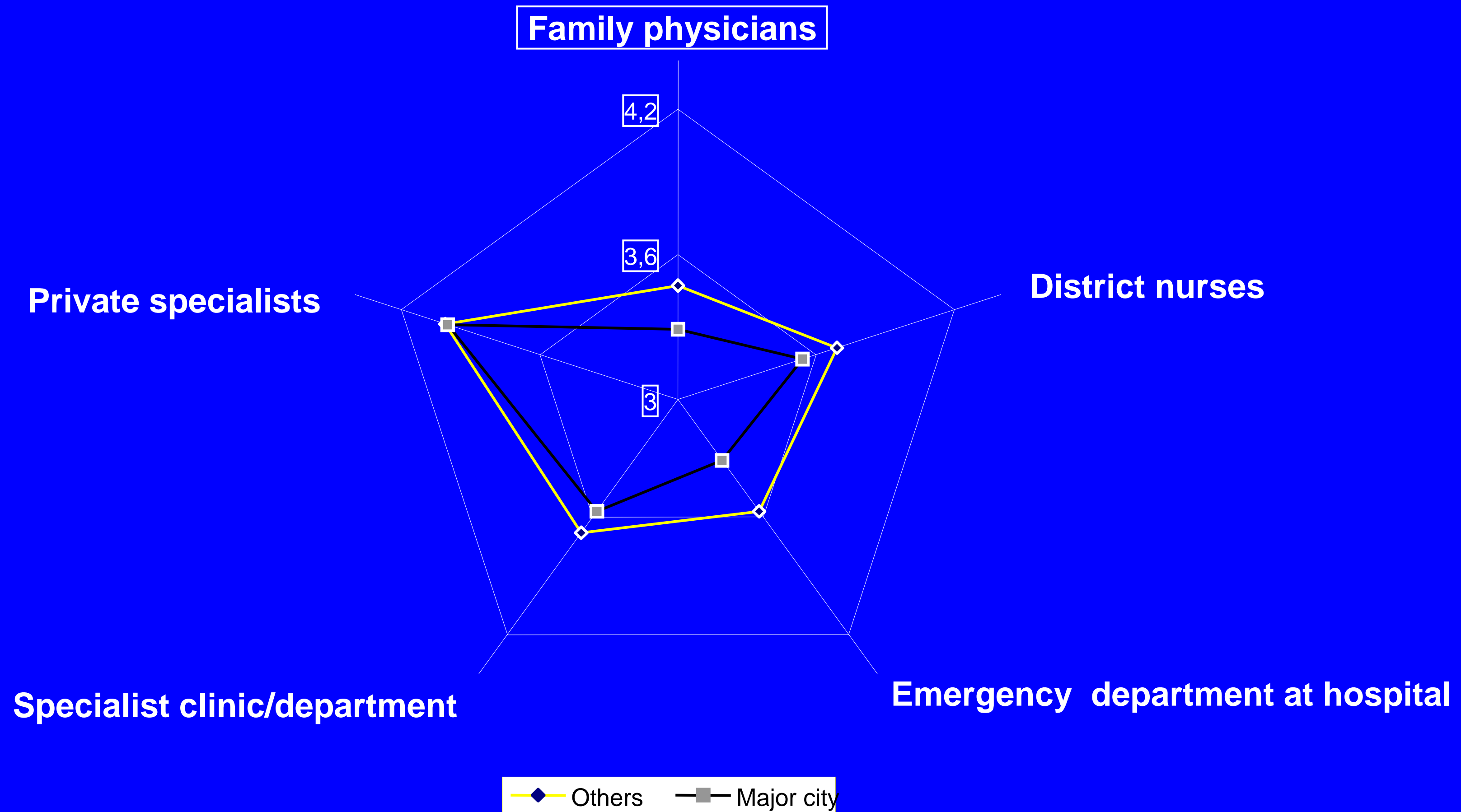
Trust for different types of care according to the general population



Source: ’Vårdbarometern’. Based on 82 000 respondents year 2001-2003.
”Major city” means respondents living in the three largest cities.

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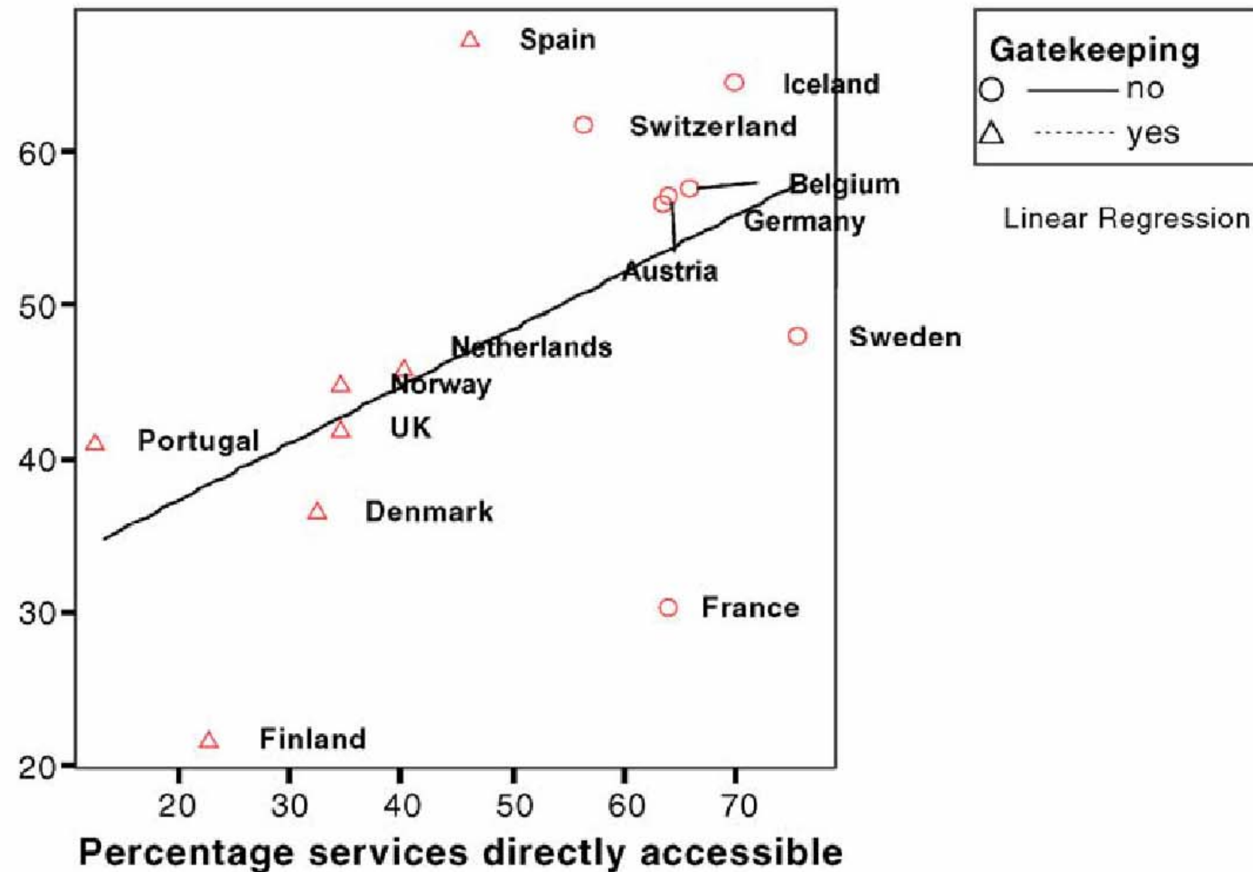

Fig. 2. Patient evaluation of GP-care (overall) related to direct accessibility in 14 countries.

Kroneman et al. Direct access in primary care and patient satisfaction: A European study. Health Policy 2006; 76: 72-79.

	Professional models		Community models	
Vision	“designed to deliver medical services to patients who seek these services or to people who choose to register to obtain these services (subscribers)”		“designed to improve the health of populations living in a given geographic area and to promote development of the communities served; mission to meet healthcare needs of a population”	
	’Professional contact model’	‘Professional co-ordination model’	“Integrated community model’	‘Non-integrated community model’
Egenskap	- Family physicians practising alone or in groups - Fee-for-service to physician - Limited formal integration with other components of health care	-Family physicians practising alone or in groups and in collaboration with nurses and other staff - Funded by payments to physician (capitation or mixed payment) - Formal integration with other components of health care - Follow-up of patients by physician or nurse	- Caregiving teams of professionals from various disciplines - Broad range of medical and social services - Fixed payment for professional activities - Integration of primary care into other components of health care - Available 24 hours a day, seven days a week	-Similar to ”integrated community model” - More limited integration with other components of health care - More limited availability
Exempel	US, Canada, several EU countries	UK, Denmark, Netherlands, Norway	Sweden, Finland	

Källa: Chauvette M. Ed. (2003) *Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada.* Canadian Health Services Research Foundation (www.chrsf.ca).

	professional contact	professional co-ordination	integrated community	non-integrated
Effectiveness	4	3	**1**	2
Productivity				
- cost	3	3	**1**	**1**
- use (substitution)	4	**1**	2	3
Continuity	3	4	**1**	2
Accessibility	**1**	**1**	3	4
Equity	3	3	**1**	2
Responsiveness	**1**	**1**	3	3
Quality	3	3	**1**	2

Note: '1' is highest ranking and '4' lowest. In case the models could not be separated they received the same ranking.

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Population preferences and choice of primary care model[1]

- How important is choice of provider? How important is choice of family physician?
- Discrete choice experiment
- 1 600 surveys (58% response rate)

Attributes and levels

Type of provider - *PCT/FP*

Influence - *large/limited*

Choice of provider – *choice/no choice*

User charges - *0/100/200/300 SEK*

Waiting times (non-acute) - *2/4/7 days*

[1]Hjelmgren J, Anell A. Population preferences and choice of primary care models: A discrete choice experiment in Sweden. *Health Policy* (forthcoming).

Design of experiment

Type A

- Registration with family physician
- Large influence
- No choice (geographical respon. for provider)
- 200 SEK user charge
- 2 days waiting time

Type B

- Registration with primary care team
- Limited influence
- Choice of provider
- 300 sek user charge
- 4 days waiting time

Choice of A, B or equally good?

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Conclusions from study

- Individuals trade-off attributes differently; preferences vary systematically
- Choice of provider, influence and waiting times are generally important
- Choice of family physician more important for elderly, the unhealthy and individuals pre-registered with family physician (others prefer choice of primary care team)
- Maintaining a system of choice and multiple organisational models supported by expressed population preferences

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List of activities for purchasers of primary care

- Approval of primary care providers
- Development of mixed payment systems
- Conditions for registration and choice
- Information to population!
  - ’Ombudsman’ for people with special needs
- Evaluation and follow-ups

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Arguments against 100% capitation

- Risk selektion (providers avoid ’bad risks’)
- More referrals, lower productivity and lower responsiveness
- Lower trust from population (cost control too important)

[1] Anell A. (2005) *Primärvård i förändring* Studentlitteratur: Lund.

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