Summary

Primary health care governance – based on need or demand? (RiR 2014:22)

SWEDISH NATIONAL AUDIT OFFICE

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The National Audit Office has investigated how the government's healthcare choice and healthcare guarantee reforms affect primary healthcare.

One of the primary healthcare's major problems has been insufficient availability for the patients. The availability issues have been a major factor behind the introduction of both the healthcare choice and the healthcare guarantee. The healthcare choice reform meant that patients were given the right to select the primary health centre of their choice and that healthcare providers can establish health centres wherever they like. The Parliament and the government have introduced a relatively deregulated market model where compensation is linked to the patient. This means that the primary healthcare providers are now competing for patients. The healthcare guarantee is intended to improve availability by introducing maximum waiting times for primary healthcare.

The investigation is based on the objective of the healthcare services, i.e. good health and care on equal terms for the entire population, and the three principles that are to guide the healthcare system:

- The principle of human dignity: Care shall be given on equal terms to all persons, regardless of their personal qualities or social functions.
- The need and solidarity principle: Those with the greatest need for care shall be given priority in the healthcare system.
- The cost efficiency principle: Healthcare services shall be run cost-efficiently but the cost considerations in individual cases are only applied once the two principles above have been applied.

The National Audit Office has found that the availability reforms have led to some positive result in the form of better availability to the primary healthcare and more primary healthcare centres. But the National Audit Office also found that the reforms have had strong governing effect on primary care and it has been harder to maintain the healthcare services' ethical principles. Healthcare costs appear to be increasing, the differences between the county councils are not decreasing and patients more in need of care are being disadvantaged. The intended effects regarding innovation and development in the healthcare sector do not appear to have materialised. The positive results in the form of improved contact opportunities, a greater number of primary health centres and better visiting fre¬quencies, appear mostly to have been enjoyed by patients with minor care needs and a higher socioeconomic status.

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The National Audit Office has investigated how the government's availa¬bility reforms have affected primary healthcare by posing six questions, and we have found as follows:

1. *Has it become easier to get in contact with primary healthcare?* Telephone and visiting availability has improved over time. However, the improvements were mainly made before the introduction of the healthcare choice reform and the legislated healthcare guarantee. The influence of the legislated healthcare guarantee on primary healthcare availability appears to be limited.

2. *Has free establishment led to primary healthcare centres being established where the needs exist?* The number of primary healthcare centres has increased and the proximity to healthcare centres has improved for many citizens. However, new primary healthcare centres have mainly been established in urban areas and in areas where healthcare needs are lower and the population is socio¬economically stronger than the national average. The closing of primary healthcare centres has mainly affected areas where there is a greater need for healthcare and where the need for a primary healthcare centre in close proximity to the home can be assumed to be greater.

3. *Can primary healthcare offer patients better continuity?* The preconditions for primary healthcare to be able to offer continuity in its contacts with patients vary among the primary healthcare centres and are partly depending on the location of the primary healthcare centre. The need for the temporary employment of doctors is great throughout the country but is most pressing in rural areas. In urban areas, the number of patients per doctor is greatest in primary healthcare centres in socioeconomically poor areas and in areas where the expected need for healthcare is greater. This means that a high level of expected need for healthcare is often handled by fewer doctors. New primary healthcare centres often have more permanently employed doctors but these are mainly established in areas where there can be assumed to be a smaller need for continuity. It is hard to measure the development, but the National Audit Office has found indications that the conditions for continuity have deteriorated since the reforms were applied.

4. *Has the consumption of healthcare services become more equal?* The National Audit Office's investi¬gation in two regions has shown notable changes in healthcare con¬sumption following the introduction of the healthcare choice reform. The differences in respect of ill health are increasing in society and the consumption of healthcare

services appears to be increasingly unequal. There has been an increase in visitors with minor symptoms since the intro¬duction of the reform. This group of patients also sees doctors more frequently, since the introduction of the reform. The opposite is true for the most severely ill patients, who see doctors less frequently.

5. *Have the county councils designed their healthcare choice systems so that the conditions for equal healthcare have improved?* The county councils' healthcare choice systems have not become as similar to each other as the Parliament had hoped. There are still differences between the county councils, both with regards to tasks and compensation requirements. It is also hard to see any regional differences between various parts of the country that could motivate the differences. Focusing on availability and increased micromanagement runs the risk of negatively impacting on patients with major healthcare needs. It is still difficult to compare primary healthcare across county councils. The ambition to improve openness regarding the results in primary healthcare has not been realised.

6. *Do the availability reforms affect the costs of primary healthcare?* There is nothing to indicate that the reforms have reduced primary healthcare costs. The trend of costs increasing over time has continued following the introduction of the reforms.

The National Audit Office would like to specifically highlight the following:

Demand or needs governing an inherent conflict

The healthcare markets are not traditional markets where vendors and buyers meet. They are markets with three parties – a producer (the healthcare provider) who sells a service, a customer (the patient) who consumes the services and society (the tax payers) who pays.

The healthcare choice reform has caused a power shift from politicians and civil servants to citizens, as intended. The county councils should only formulate the conditions for healthcare providers. From there, the citizens' demand should decide the result. At the same time, the healthcare services are to be run in accordance with the Health and Medical Services Act. However, it has been difficult to create compensation systems that fully adhere to the ethical principles of the Health and Medical Services Act.

According to the National Audit Office, the introduction of the healthcare choice reform also sparked a contradiction, as far as objectives are concerned. Before the introduction of the healthcare choice, prioritisations were, to a greater extent, made, admittedly with budgetary constraints, by the healthcare personnel based on the ethical guidelines and the patients' individual

needs. Today, resource pri¬oritisa-tion in primary healthcare is conducted to a greater extent in accordance with patient demand.

The purpose of the reform, to develop primary healthcare into a demand-controlled customer choice model, and the priorities of the ethical principles in respect of equality and healthcare needs, are based on different forms of logic. Demand control means that the market offers the solutions that the majority of customers request. When demand for healthcare has been allowed to control operations, the consumption of primary healthcare has increased for relatively healthy patients that are socio¬economically strong. The ethical principles are intended to steer the consumption of primary healthcare over to the patients who have the greatest issues and needs. Such prioritisation requires an actor with power and a mandate, i.e. the opposite of having the customers' demand control the consumption of primary healthcare. So far it appears that no county council has managed to create a health-care choice model which steers primary healthcare towards the ethical healthcare principles. The National Audit Office has found that the attempts made so far to balance compensation based on the degree of illness and economic standard do not seem to have successfully influenced prioritisations to a sufficient degree.

Diversity has not increased

The increase of private healthcare providers within the state financed prim¬ary healthcare sector does not seem to have stimulated development or innovation as intended. One probable explanation is that the government and county councils' demands are too governing, which limits the development of innovations in the primary healthcare sector. The overseeing from the government and county councils is too influential in deciding what actions should be taken and who should carry them out. This means that the healthcare providers are prevented from designing their own operations. Limited diversity also means that it is harder for the patient to choose a healthcare provider.

The compensation systems can miss their targets

The county councils are responsible for designing compensation systems that influence the behaviour of the healthcare pro¬viders. It must be possible to check and monitor the demands and requirements that are made. However, it is difficult to operationalise demands on medical quality. Steering systems are therefore often constructed to control the behaviour of the primary healthcare cen¬tres towards factors that are fairly easy to measure, rather than medical quality.

Diagnosing has become an instrument that affects compensation in several county councils. This fact seems to have influenced the diagnosing in these county councils, which can mean that patients receive irrelevant diagnoses. This in turn can affect the value of journal keeping. Incorrect

diagnoses in the journals devalue the journals as a source of knowledge about the patient for use in future assessments.

The fact that the patient's choice can have financial consequences and that the amount of micromanagement is increasing means that factors other than purely medical ones have an effect on the way that healthcare personnel treat the patient. The compensation systems can thus make it hard for healthcare personnel to focus on the patient's need for healthcare and that which the patient is trying to communicate during their visit.

When distortions in the compensation systems are discovered, the county councils make corrections which often lead to new detailed requirements. The more complex the compensation system, the more time required for feedback. This results in more administra¬tive work for the healthcare personnel at the expense of time spent with patients. The pricing mechanisms also increase the risk that the healthcare provided and registered is manipulated in order to increase the compensation.

A general increase in availability creates new problems

A general increase in availability does not take into consideration the care needs of various different patients. For patients with more complex healthcare needs, the number of visits is an unreliable indicator of availability unless it includes factors such as the quality of the visits. By primarily using the number of visits to indicate availability, the result can instead be a deterioration in the quality of healthcare for these patients.

Insufficient monitoring of the consequences of the availability reforms

The government launched the reforms without planning comprehensive monitoring of them. It is therefore difficult to assess the development of primary healthcare based on the information available.

The National Audit Office notes that there is a large amount of quantitative data being produced regarding the healthcare services on a national level. Some of the follow-ups that have been made by government agencies have focused on quantitative data without any deeper analysis. The National Audit Office also finds that there is a general lack of knowledge regarding how different social groups utilise primary healthcare. Important aspects of pri¬mary healthcare such as its development and its ability to offer continuity have not been followed up. Much of the data presented regarding primary healthcare is also collected through surveys which entail extra work for individuals, healthcare providers and the county councils.

Primary healthcare is considered a comparatively cost-efficient form of healthcare, but no government agency has so far analysed how the reforms have impacted on the county councils'

costs. The data available at national level shows that costs have not decreased following the introduction of healthcare choice and are instead still increasing. No corresponding decrease in the cost of specialist healthcare can be found.

The National Audit Office's assessment is that the Government's reporting to the Parliament also fails to give a completely accurate picture of the results of the healthcare choice reform.

Recommendations

The National Audit Office believes that there are some actions that are worth trying before system changes are considered. The National Audit Office therefore addresses the following recommendations to the Government:

- Unify the design of healthcare choice systems for primary healthcare
    - Make the compensation system as simple as possible and let it steer primary healthcare towards the existing ethical principles.
    - Do not formulate the task of primary healthcare too broadly.
- Work to ensure application of the Health and Medical Services Act's provision regarding discrimination.
- Clarify the monitoring responsibilities of government agencies.