

Choice of primary care provider: a review of experiences in three countries

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Summary

Choice of healthcare provider has become an increasingly important feature of healthcare policy in many countries. Much of the debate has focused on choice of secondary provider, while choice in relation to primary care has received less attention. In England, following the introduction of increased choice of secondary care provider in the early 2000s, recent reform efforts foresee the implementation of free choice of GP practice following a 12-month pilot scheme during 2012 and 2013. In light of the proposed changes in England, we sought to understand choice of primary care provider as a policy issue in different health systems in Europe. A literature review was undertaken, complemented by country case studies involving document review and key informant interviews. We examined three countries, Finland, Norway and Sweden, on the basis that these had recently introduced changes to choice of primary care provider.

Our study identified a range of drivers and expectations that have contributed to the design and implementation of reforms designed to increase choice of primary care provider in Finland, Norway and Sweden

The timing and scope of choice reforms differed between the three countries. In 2001 Norway introduced the 'regular general practitioner' scheme, giving every resident the right to register with a GP of their choice anywhere in the country. In Sweden, a 2010 reform introduced the right of individuals to register with any public or private primary care practice accredited by the local county council, a practice that had already been implemented by some county councils from 2007. In Finland, since 2012, individuals have been allowed to register with a health centre of their choice, initially in the municipality of residence but, from 2014, with any centre in the country.

In all three countries, the main motivations for modifying choice in primary care were to enhance access to and improve the quality of care. In Sweden and Finland, this was to be achieved through increased competition, while in Norway the emphasis was on enabling GPs to better manage their patient load, with the expectation that this would lead to a more efficient use of resources. In Norway and Sweden, introducing choice was also seen as an opportunity to restructure care, with a particular focus on enhanced coordination between primary and secondary care. Overall, reform efforts have to be seen within the wider context of recognising the importance of patient and public preferences in decisionmaking, with choice in healthcare being seen as part of a wider debate around choice in the public sector.

Documented evidence of the impact of reforming choice of primary care provider is scant

Whether citizens make use of increased options to choose their primary care provider can be assessed by measuring the rate of 'switching' between providers. However, the empirical evidence on patterns and trends of switching of GP or GP practice is weak, although informants in all three countries noted that choice of provider was more likely to be exercised in urban areas than in rural settings. There was an expectation in all three countries that those most likely to choose would be active and educated, living in urban areas and better informed about the options available.



The empirical evidence of the impact of other reform efforts to increase choice in primary care remains scant. Examples include enhanced access to care as measured by a change in the number and distribution of primary care providers, and there is some suggestion that new providers did enter the market in Norway and Sweden. Conversely, in Finland related impacts of the reforms were not yet visible and indeed access to primary care providers continued to pose a challenge. Overall, the evidence on outcomes of the reforms on service users, service providers and the system as a whole in each of the countries remains weak and there is a need to systematically monitor and evaluate developments and trends.

The relative lack of publicly available information presents one of the main challenges facing choice reforms

Where introducing or modifying choice of primary care provider involves permitting registration beyond administrative boundaries, this might be expected to pose challenges with regard to coordinating and following payments and in relation to financial flows. However, this was not found to be the case in the three countries studied. Indeed, key informants highlighted that local governments traditionally work collaboratively on healthcare and other public sector issues; also transfers are limited in number and value, and systems to manage flows are well established.

However, informants in all three countries identified publicly available information as one of the main challenges facing the choice reforms; information that is available to patients tends to focus on basic indicators of practice size and opening hours and was regarded as limited in all three settings. Initiatives that encourage patients to post comments on the internet about their experience in primary care or that make data available on the quality of care delivered are only beginning to emerge.

Our study offers important lessons for the planned implementation of choice in primary care in the English NHS

On the basis of our findings we conclude that the implementation of policies seeking to enhance choice of primary care provider may be more straightforward in settings where transfers are limited in number and value, where it is easy to let money follow the patient, and where the existing IT infrastructure allows for easy transfer of medical records. One concern that has been identified as particularly pertinent for the three Nordic countries reviewed here is the challenge of creating choice of primary care provider in remote areas. While this poses less of a difficulty for the current GP choice pilots in England, which are focused on more populous, commuter regions, issues around remoteness will be important to consider if the scheme is to be expanded nationally. Providing choice in remote settings is challenging because of lack of sufficient market. There is a need to carefully monitor the impact of enhanced choice in primary care in order to ensure that related policies truly enhance access to and improve the quality of care and do not only benefit those who are more able to exercise choice.



Introduction

One of the main objectives of the reforms of the English National Health Service (NHS), as set out in the 2010 White Paper, *Equity and Excellence: liberating the NHS*, was to 'put patients at the heart of the NHS' (Department of Health 2010). This included a commitment to give every patient in England free choice of general practitioner (GP) practice from April 2012. Further consultation saw the introduction of a 12-month pilot scheme from the end of April 2012, permitting patients from anywhere in the country either to register with a volunteer GP practice within one of the pilot areas or to visit a pilot practice as a day patient (Department of Health 2012).

Enhancing choice of primary care provider sits within the wider choice policy agenda that has been pursued in the English NHS since the early 2000s. It can be seen to be rooted in the consumerist policies introduced under New Labour to increase the responsiveness of public services in England (Peckham, Mays et al. 2012). Introduced from 2001 with a focus on secondary healthcare provision, successive reforms saw the implementation of choice of four to five local hospitals from 2006, subsequently extended to any provider of hospital treatment nationally (2008) and becoming a patient right within the 2009 NHS Constitution (Dixon, Robertson et al. 2010).

The concept of 'choice' has become an increasingly important and widely debated feature of healthcare policy in many countries across Europe (Allen and Hommel 2006; Thomson and Dixon 2006; Bevan, Helderman et al. 2010; Or, Cases et al. 2010), particularly in systems that had traditionally limited choice of specialist care provider (Cacace and Nolte 2011). Thus, similarly to England (Peckham, Mays et al. 2012), countries such as Denmark and Sweden have sought to increase choice of hospital provider to relieve pressure on waiting times in secondary care and to increase the responsiveness of the system (Thomson and Dixon 2006). For example, patients in Denmark have been able to choose their hospital provider since 1993, a policy that was subsequently reinforced by a waiting time guarantee (2002, 2007) for patients to be seen within one month of referral by their general practitioner (Strandberg-Larsen, Nielsen et al. 2007).

Choice of primary care provider has been given less attention, possibly because most countries already offer at least some form of choice. For example, countries such as England and Denmark allow patients to switch primary care provider within defined geographical areas, although choice may be limited because of capacity limits (Ettelt, Nolte et al. 2006). In the Netherlands, patients are required to register with a general practitioner but they can in principle choose any practitioner (Schäfer, Kroneman et al. 2010); a similar system is in place in Italy (Lo Scalzo, Donatini et al. 2009). In the statutory health insurance systems of Germany and France, patients were traditionally able to see any general practitioner without prior registration, although more recently there have been attempts to promote registration with a GP to strengthen the gatekeeping and coordinating role of the primary care physician (Ettelt, Nolte et al. 2006).

It is against this background that this study seeks to better understand choice of primary care provider as a policy issue in different health system contexts in Europe.



Specifically, we are interested in two aspects of the policy debate. First, we explore the motives for and drivers of choice of primary care provider among service users to better understand the (potential) ‘demand’ for patient choice in primary care. Second, we examine the drivers, expectations and impacts of measures to modify choice of primary care from a policy perspective in a selection of other countries in order to contribute to a better understanding of how planned developments in England to expand choice might be informed by international experience.

Methods

We first carried out a review of the literature to assess the drivers of choice of primary care provider from a service user perspective. We then undertook a detailed exploration of experiences in three countries that have recently introduced changes to choice of primary care provider, by means of a document review and interviews with key informants. Before describing these two approaches, it is necessary to operationalise the notions of ‘choice’ and ‘primary care provider’ used here.

Operationalising ‘choice’ and ‘primary care provider’

In countries that require registration, choice in primary care can principally refer to: (i) choice to register with a given GP or primary care practice; or (ii) choice of GP or family physician within a GP or primary care practice the service user is registered with. Choice can also refer to having the opportunity to choose (and availability of providers to choose from), whether or not this possibility is acted upon, and exercising choice, that is making an active selection of provider or switching from one to another.

In our study, we sought, as far as possible, to distinguish between these different uses of ‘choice’. However, frequently the literature or policy context reviewed did not permit such differentiation. This was most often the case in relation to choice of GP practice or primary care practice and choice of GP or primary care doctor; here we used choice of ‘primary care provider’ as an overarching term. Where the reviewed evidence did not permit making these distinctions, we highlight this accordingly.

Literature review

We carried out a comprehensive search of the published and grey literature, using the bibliographic databases Embase, Pubmed, Econlit and PAIS. Given the nature of the subject under study, we chose very broad search terms, using combinations (‘/’ indicating ‘OR’) of ‘patient/consumer/client’, ‘physician/doctor/general practitioner’, and ‘choice/ch*/judg*/decid*’. Searches were performed for all fields and not restricted by publication date or language. Titles and abstracts were screened for inclusion into the review. We included primary and secondary research, as well as commentaries or editorials where appropriate. Studies focusing on choice of secondary care provider or choice of health insurance were excluded unless the abstract specifically mentioned links with choice in healthcare as a broader policy initiative. Reference lists of included studies were followed up.



Country case studies

We selected three countries for detailed review: Finland, Norway and Sweden. These countries were chosen primarily because recent policy developments in each have seen changes to the system by which patients can access non-urgent care outside hospital, with modification or relaxation of requirements to register with a GP or a GP or primary care practice. Similarly to England, all three countries have a commitment to providing universal and equitable access to healthcare for their populations and operate primarily tax-funded systems. However, they differ in the overall approach to healthcare governance, with the three Nordic countries having administrative and political responsibility partly or fully devolved to local or regional authorities. In England, health policy is set nationally while the organisation of care is devolved to local healthcare organisations, with clinical commissioning groups replacing primary care trusts from 2013, overseen by a newly established national NHS Commissioning Board (Department of Health 2010).

Country case studies were informed by an initial review of the published evidence. The document review principally followed the same approach as described above, using the same search terms but combining these with 'policies' or 'reform' and the country (Finland, Norway, Sweden). The search of peer-reviewed literature was complemented by an online search for grey literature using a Google, alongside a country-focused search, targeting governmental or institutional websites such as ministries of health and physicians' associations. References of included documents were followed up. Where possible, we retrieved formal governmental documents describing relevant reform and policy changes; however, because of language constraints this additional element had to be restricted to publications in English or that contained an English summary.

We then conducted key informant interviews to enhance our understanding of the more salient issues pertaining to the context and processes of policy reform to patient choice in the three countries and to identify further (empirical) evidence and documents describing or analysing the reform effort. This was particularly important as the documented evidence identified in the peer-reviewed and grey literature provided limited insight, especially where reform efforts have been recent, such as in Finland.

Study participants were identified through a combination of purposive and 'snowball' strategies using official websites, the authors' professional networks and recommendations from study participants. We focused on a range of stakeholders involved in or acting as close observers of the policy process as it relates to patient choice in each of the three countries in order to capture different perspectives, seeking to interview three stakeholders in each.

Potential study participants were invited by letter, with an explanation of the background of the study. Interviews were undertaken by telephone, using a semi-structured interview guide that was shared with the interviewee beforehand. The interviews explored broad themes around the existing system of patient choice in primary care, the drivers behind policy changes, and expectations of



the reforms and their impacts on the various stakeholders in the system, with a particular focus on providers (GPs), funders and patients, alongside other issues that the informants raised.

Interviews were undertaken by two researchers to allow for reflexive questioning (with one exception in which only one interviewer was present). Interviews lasted 30 to 60 minutes; they were audio-recorded following consent, and transcribed verbatim. Analyses of interviews were informed by the key themes guiding the interviews as described above, while also seeking to identify additional emerging themes.

We interviewed a total of nine informants, representing national government (ministry of health; 1 in each country), and academia (2 in each country).

Results

Literature review: Service user motivations for choosing a primary care provider

Reasons for choosing a particular doctor within a practice most frequently include continuity of care with a given GP or primary care doctor. Thus, patients value the fact that they can see 'a physician who knows them well' (Cheraghi-Sobi, Hole et al. 2008). The value placed by patients on continuity has been quantified in a discrete choice experiment in a sample of patients from six family practices in England, which found that patients prioritise continuity over reduced waiting times (by 1 day) or more convenient appointments (Cheraghi-Sobi, Hole et al. 2008). Similarly, Rubin et al. (2006) reported on how patients from six GP practices in Sunderland, England, would trade-off shorter waiting time against seeing their own choice of doctor, in particular when they had a long-standing illness. This highlights the importance to the patient of seeing someone who knows about them and their medical history. This latter point was also reported by Turner et al. (2007), who, in a small study of a random sample of 646 community-dwelling adults in selected geographical areas in England (London and Leicestershire), found patients willing to trade waiting time against seeing a medical practitioner who knew their case. Gerard et al. (2008), in a survey of just over 1,000 general practice patients, also found that patients were willing to trade off speed of access for continuity of care, although preferences varied according to a person's gender, work and carer status.

Preference for continuity of care might explain, in part, the typically long duration of the therapeutic relationship in primary care, averaging 10.3 years in one US study (Mold, Fryer et al. 2004) and 15.6 years in the private sector in Ireland (Carmody and Whitford 2007), even in systems that provide principally free choice of any GP.

Conversely, reasons for changing primary care provider, to the extent where this is possible, typically include proximity to home or workplace, and dissatisfaction. The evidence is patchy, however. For example, one study from the early 1990s in one area in England found that where patients chose to switch, the most common reason was distance from home (41%), followed by dissatisfaction with personal care given by the GP (35%) or with practice organisation (36%) (Billinghurst and



Whitfield 1993). Proximity to home was also given as the most common reason for choosing a new doctor (53%), followed by recommendation or reputation (36%) and positive expectations of service (37%). Gandhi et al. (1997), in a qualitative study of 41 patients who had changed their GP within their area of residence, found a combination of accessibility (mainly perceived as distance from home) and attitudinal problems of the treating doctor to be the most common reasons for change. Distance from home or the workplace was also reported as a main reason for changing GP in France (UNAF 2005). In Germany, where patients are generally able to consult any GP without prior registration, a 2010 survey found that about 10 per cent of patients had changed their GP during the preceding 12 months because of dissatisfaction with the services provided (FGW Forschungsgruppe Wahlen Telefonfeld GmbH 2010). The survey did not analyse the reasons for dissatisfaction that prompted an actual change of GP, and other reasons for changing GP, such as distance, were not explored, so it is difficult to compare these findings. When querying the reasons for dissatisfaction with a GP more generally, the most common problems were perceived medical error (31%), treatment not as expected (21%) and not being taken seriously (20%) (FGW Forschungsgruppe Wahlen Telefonfeld GmbH 2010).

The option of being able to choose a primary care doctor is a common preference among patients in different health systems. For example, a survey of patients in eight European countries by Coulter and Jenkinson (2005) found that between 86% (Sweden) and 98% (Germany) of respondents believed that they should have free choice of primary care doctor. There is some evidence that where patients are able to register with the primary care doctor of their own choice, they tend to report being more satisfied with the care they receive (compared to those who were assigned a doctor, for example on the basis of their employment) in settings as diverse as Norway (Lurås 2007), Estonia (Kalda, Polluste et al. 2003) and the USA (Schmittziel, Selby et al. 1997; Kao, Green et al. 1998). Choice appears to be particularly valued where it allows for selection of a primary care doctor with specific socio-demographic characteristics, such as race or ethnicity (Laveist and Nuru-Jeter 2002) or gender (van den Brink-Muinen, Bakker et al. 1994).

The degree to which people will actually exercise choice in primary care, beyond reasons of distance or dissatisfaction, is likely to be influenced, in part, by the level of information available to them. Thus Coulter and Jenkinson (2005), in their survey of patients in Europe, found that less than half of respondents felt able to make an informed choice of primary care doctor. There was also considerable variation in the extent to which patients rated their opportunities to make healthcare choices. These ranged from 30% of respondents in the UK, just under half in Sweden and Germany, and up to 73% of respondents in Spain. However, these figures relate to choice of any provider, including in secondary care; it is difficult to say whether and how they would vary in the case of healthcare choice in primary care specifically. Even where such information is available, options to exercise choice might be limited because of supply or capacity issues (Robertson, Dixon et al. 2008).

Barnett et al. (2008), in a small qualitative study of people in southeast England, found that while participants valued the possibility of choice, there was scepticism



about offering choice 'for its own sake'; that is, choice would have to be meaningful for the patient. This was most often discussed in relation to choice of secondary care provider, however, with the role of the GP seen as important in helping interpret choice options. It is unclear whether and how these findings are applicable to choice in primary care.

In summary, focusing on the service user perspective, the available evidence suggests that within practices, patients most commonly exercise choice in order to see a GP whom they know. Where patients exercise choice by switching between providers, this seems to be prompted, typically, by factors such as distance from home or the workplace as well as the perceived quality of the care provided. This evidence has to be interpreted against a background of the ability to exercise choice, which may be limited because of lack of information, or lack of supply or capacity.

Country case studies: experiences of choice reform in Finland, Norway and Sweden

In this section we trace the specific features of the approach to providing choice of primary care provider in the three Nordic countries under study.

Table 1 provides an overview of the public primary care systems in place in each of the three countries, and details the main features of choice policies. We then identify the main drivers, expectations, impacts and challenges of the different approaches to providing choice.

Table 1 Main features of the public primary healthcare system and choice of primary care provider in Finland, Norway and Sweden

	Finland ^b	Norway ^c	Sweden ^d
Population size (2010) ^a	5.39 m	4.95 m	9.45 m
GDP per capita (US \$ PPP, 2010)	37,572	56,886	41,503
Health expenditure total (% of GDP, 2010)	8.9%	9.6%	9.4%
Health expenditure per capita (US \$ PPP, 2010)	3,251	5,388	3,758
Main sources of funding for healthcare (% of total health expenditure in 2010)	Central and local (municipal) taxes (58.9), social security (15.2), VHI (2.2), OOP (20.2)	Taxation (73.3%), social security (12.1), OOP (15)	Central and local taxes (69.2%), VHI (0.3), OOP (17.8)
Annual growth rate of public expenditure on health (real terms, 2000–2009)	4.9%	4.0%	3.4%

Continued >



	Finland ^b	Norway ^c	Sweden ^d
Principles of healthcare provision outside hospital			
Administrative unit responsible for organising primary care	Municipality	Municipality	County Council
Provision of primary care	The principal unit of primary care provision is the municipal health centre; health centres comprise a range of health professionals who provide a range of services (incl. women and child health, minor surgery) ^f	The principal unit of primary care provision is the GP practice with two to six physicians	The principal unit of primary care provision is the primary health centre, comprising four to six GPs and non-medical staff (nurses, physiotherapists, psychologists, etc.)
GP gatekeeping	Yes	Yes	Varies across regions
Payment of physicians in primary care	Basic salary, capitation fee and fee-for-service payments	Capitation fee and fee-for-service payments (95% of GPs); basic salary for GPs employed by the municipality	Basic salary for individual physician; payment of healthcare centres varies across regions but in general includes a combination of capitation, payment based on visits, and performance-based payment based on meeting certain goals
Choice of primary care provider			
Choice of primary care provider before reform	Allocation of individuals to municipal health centres based on place of residence; some choice of physician within centre possible in some municipalities	Allocation of individuals to GP practice based on residence	Free choice of public primary care provider available since the early 1990s
Changes introduced following reform	2010 Health Care Act (implemented from 2012) foresees registration with health centre of choice in municipality of residence; from 2014 choice of any centre in the country including the option to register with a second centre in the municipality of a holiday home or place of work/study	2001 Regular General Practitioner scheme introduced the right for patients to register with a GP of their choice with no administrative or geographical limits; those not actively registering are assigned to a GP based on availability, unless they actively opt out. Patients retain the right to a second opinion from another GP	2010 Health and Medical Services Act introduced right of individuals to register with any public or private primary care practice accredited by the local county council; those not making an active choice of primary care provider are registered passively based on last visit or geographical location (except in Stockholm county council); the 2010 Act introduced nationally the stipulations that had been implemented in some county councils from 2007
Frequency of change permitted	Once a year	Twice a year	Frequency defined by county council; in theory unlimited

Continued >



	Finland ^b	Norway ^c	Sweden ^d
Choice of primary care provider			
Information available to patients	Information provided by municipalities includes: waiting times, patient feedback	Information provided by the Norwegian Health Economics Administration (HELFO) includes GP list size and available spaces on the list ^e	Information provided by the County Councils website includes: opening times, names of doctors. Information provided at the national level includes performance indicators, waiting times and patient experience
Mechanism for changing provider	Registration with new practice of choice by contacting old and new practice in writing. Process can take up to three weeks	Online registration with new GP possible since 2007	Registration with new practice of choice
List system management	Practice lists are not publicly available. A practice may not decline a new patient wishing to register	GP lists are publicly available. GP defines a maximum number of patients for the list. Once the number is reached, no more patients are accepted. Rejected patients are redirected to their second choice	Practice lists are not publicly available. A practice may not decline a new patient wishing to register

NOTE: GDP: gross domestic product; PPP: purchasing power parity; VHI: voluntary health insurance; OOP: out-of-pocket payments; **a** OECD 2012; **b** Vuorenkoski, Mladovsky et al. 2008; Ministry of Social Affairs and Health 2010; **c** Ministry of Health and Care Services 1999; Ministry of Health and Care Services 2000; Johnsen 2006; **d** Anell, Glengård et al. 2012; **e** HELFO 2012 and key informants; **f** in addition, employed persons can access occupational health services, funded by National Health Insurance (NHI) – approximately 50% of employed persons use occupational health services.

Drivers and expectations of choice reforms

Our study identified a range of drivers and expectations that have contributed to the design and implementation of reforms of choice of primary care provider in Finland, Norway and Sweden.

A common driver among all three countries has been enhancing access to care, which poses a particular challenge for countries characterised by large geographical areas with low population density and uneven distribution of GPs, with GP shortages in remote settings in particular (Magnussen, Vrangbaek et al., 2009), alongside a perceived need to improve the quality of care provided. However, the mechanism by which choice was expected to achieve this differed in the three countries.

In Sweden and Finland, both countries that had traditionally limited choice in primary care (Magnussen, Vrangbaek et al. 2009), there was an expectation among key informants that increasing choice would promote competition among primary care providers and so enhance both access to and quality of care provided:



There was also, I think, an element of freedom of choice having an impact on the quality of [...] primary care so that there would be a competitive force that would make some health centres, some public health centres better than the others, and through this mechanism, the whole quality of the public primary care, at least somebody thought it might get better, because of the pressure from the choice by customers and patients. (Policymaker, Finland)

In order to maximise this effect, the Swedish reform included three main components: choice of practice, freedom of private primary care providers to establish new practices and payments following the patient. It was anticipated that this combination would give 'providers [an] incentive to actually respond to patients' or individuals' needs or preferences in primary healthcare' (Academic, Sweden). There was also a perception among key informants that through facilitating entry of private providers into the market the Swedish reforms had stimulated competition and increased capacity, so enhancing access to services through, for example, extended opening hours:

[Access] to primary care was very low before the reform and there was also an incentive for the provider to establish because they knew that people were fed up with having to wait too long, too much or whatever so they could sort of, address individuals by saying that we have great company hours. (Academic, Sweden)

Policymakers also voiced an expectation that private providers would be more efficient than public providers and that the resultant mix of public practices and increased number of practices operated by private providers would enhance the overall quality of care:

It is thought that private companies are good at working with processes, patient oriented ways to work and also when it comes to quality control [...] If you have a mix of private and public providers that is bound to increase efficiency. (Policymaker, Sweden)

The 2001 reform in Norway required patients to register with a 'regular' GP. Those choosing not to participate in the regular GP scheme would have to pay higher user fees when consulting a GP (Ministry of Health and Care Services 1999). This move was explicitly aimed at improving 'the quality of the services provided by general practitioners by making it possible for everyone who so wishes to have their own regular GP' (Ministry of Health and Care Services 1999). The reform sought to enable GPs to more effectively manage their patient list and patient load, while planning and delivering care in a more equitable manner. One key informant emphasised the notion that the reform would work through an overall more 'efficient use of resources' rather than through competition to enhance service delivery, the latter being among the main drivers behind the Finnish and Swedish reform efforts.



The Norwegian reform specifically mentions a patient's 'right' to register with a regular GP (Ministry of Health and Care Services 2000) as opposed to the previous system in which patients were seen by the first GP available in their area. This emphasis on patients' rights has been recognised as valued by the public, as argued by one policymaker, who based the following observation on a 2009/10 survey of public services (Direktoratet for forvaltning og IKT 2010):

From a citizen point of view, it was regarded an improvement to be guaranteed a certain doctor that was valued higher than being able to jump from one doctor to the other. (Policymaker, Norway)

It is important to emphasise that in Norway patients choose to register with a GP, whereas in Finland and Sweden they register with a practice, or, more specifically, a health centre.

From a policymaker's perspective, the reform in Norway was also perceived as providing the potential to restructure health services and enhance coordination and integration across primary and secondary care, so potentially reducing GP 'hopping'. This was reinforced by subsequent reforms to strengthen coordination in the healthcare system (Romoren, Torjesen et al. 2011). Similar expectations were voiced by Swedish key informants, who also noted a broader and long-standing concern about the lack of coordination between primary and secondary care, with ongoing reform efforts over the past decades seeking to transfer care from the hospital and specialised care sectors to primary care. There was a perception that for successful transfer to occur there would be a need to 'give individuals the possibility to actually have a primary healthcare [system] which they are satisfied with in order to make them go there instead of seeking care at the hospitals' (Academic, Sweden). The introduction of choice in primary care was expected to address this issue more systematically.

The notion of formally recognising the importance of patients' and the public's preferences in decisionmaking was perceived as an important political argument by key informants in Sweden and Finland, with choice in healthcare seen to be part of a wider debate around choice in the public sector. In Sweden, for example, the reforms to enhance choice in healthcare originated in earlier efforts to increase choice in education and elderly care, and relevant measures as set out in the 2010 Health Care Act (Ministry of Health and Social Affairs 2011) built on the 2008 Act on System of Choice in the Public Sector (Swedish Competition Authority 2008). Similar observations were made by key informants in Finland, who noted that freedom of choice has been on the agenda in Finland for a while:

It's very hard to oppose something which is in the air. I mean, this is a cultural phenomenon also [...] We cannot restrict the modern patient's rights in the way we used to. (Policymaker, Finland)



Impacts of reforming choice of primary care provider: service users

Whether citizens make use of increased options to choose their primary care provider can be assessed by measuring the rate of ‘switching’ between providers. We here refer to ‘provider’ as the unit of primary care provision that, in Norway, is the GP and in Sweden and Finland the primary health centre. Available evidence suggests that, in Norway, the proportion of people who change their GP may have risen over time. For example, Iversen and Lurås (2011), drawing on data from the Norwegian regular GP scheme, found the annual number of switches to be 3.6 per 100 patients on a GP’s list in 2001–2004. The authors considered this figure to be higher than those reported elsewhere. We were unable to identify published analyses of trends in switching; however, according to one Norwegian informant, government figures seem to suggest that rates of switching had risen over time, to between 6 and 7 per cent in 2007–2011. It is difficult, in the absence of knowledge of the underlying data, to compare this rate with that reported by Iversen and Lurås (2011) and to derive conclusions with certainty as to the drivers behind the increase. However, one informant highlighted the coincidence between the reported increase in switching rates and the introduction, in 2007, of an online system offering a simplified mechanism to change GP (see Table 1). It is possible that this new system has reduced the barriers patients might perceive when considering switching between GPs, although this hypothesis would require confirmation through further research.

Data for Sweden provide insights into the uptake of choice. For example, Glengård et al. (2011), using data from a survey in three Swedish counties conducted between 2007 and 2009, found that 61 per cent of respondents reported having made a choice of primary care provider following the introduction of free choice in their county. It is not entirely clear whether exercising choice as reported by the majority of respondents also included an actual switch between providers.

The empirical evidence on patterns of and trends in switching of GP or GP practice is weak, although informants in all three countries noted that choice of provider was more likely to be exercised in urban areas than in rural settings. This was particularly the case in those parts of the country characterised by small municipalities or county councils with a low population density:

In the north, you don’t have that many options, it’s not densely populated at all, there are very few people per square kilometre or whatever. So they don’t have that many alternative providers to choose from. (Academic, Sweden)

Glengård et al. (2011), based on their survey in three Swedish counties, reported that there was a perception, among some respondents, that opportunities to choose would be compromised by lack of capacity, with 11 per cent of respondents highlighting the lack of alternatives. Similar issues were reported by Grytten and Sørensen (2009) for Norway, highlighting the need to distinguish between areas where there is additional capacity and those where options are limited.



Given that, in Finland, choice of primary care provider was only implemented in 2012, and that it was initially limited to choice within a given catchment area, it is difficult to assess patterns and trends of uptake of choice, although informants noted that relatively few patients have chosen to change practice so far. However, one interviewee mentioned that some people are making use of the opportunity to register with two practices, typically relating to their home and holiday residences. One potential issue of concern was raised in relation to language groups, with the Swedish speaking (about 5.5 per cent of the population) and Sami minorities less likely to be able to exercise choice because of limited availability of primary care providers offering services in these languages.

There is some limited evidence from Sweden and Norway on the characteristics of those who do exercise choice. Glengård et al. (2011) noted that those who did actively choose a new provider or GP when the possibility became available tended to have used their primary care provider at least once during the preceding month, were older and did not work or study. Godager (2012), using revealed preference data from the introduction of the regular general practitioner scheme in Norway and focusing on the city of Oslo, showed how patients tended to register with those GPs who resembled themselves in terms of characteristics such as age, gender or marital status. There was also a preference for GPs who were Norwegian-born, with some suggestion of a preference, among some, to register with a GP near the workplace. Key informants acknowledged the relative lack of sound evidence regarding the characteristics of those who do or do not exercise choice. There was an expectation among interviewees in all three countries that those most likely to choose would be active and better-educated people, living in urban areas and better informed about the option to choose. There was also an expectation that while older people and patients with chronic conditions might be more likely to decide to register with a preferred provider, they would not want to change provider (i.e. switch).

From a policymaker and provider perspective it is notable that the analysis by Iversen and Lurås (2011) demonstrated that the ratio between expected and actual GP patient list size was associated with switching rates among patients. GPs whose actual patient list was smaller than the list they anticipated when declaring an expected list size to the health authority by at least 100 patients (conceptualised as 'patient shortage') experienced a higher rate of patients switching than those who reached the anticipated number of patients. Specifically, they found that the occurrence of patient shortage increased the proportion of patients switching physicians by 50 per cent. The authors noted that this observation confirms an earlier finding that patient shortage was related to patient dissatisfaction with several characteristics of a GP (Lurås 2007). While they did not analyse these specific characteristics further, the authors highlighted how the measure of patient shortage might reflect issues around quality such as technical quality of care provided, communication skills and waiting times.



Impacts of reforming choice of primary care provider: service providers

Overall, direct measures of the impact of reform efforts to increase choice in primary care remain scant. One crude measure in all three countries is the change in the number and distribution of primary care providers. In Sweden, for example, the phased introduction of choice in primary care from 2007 accelerated an existing growth in the share of private providers over time, with increases of between 15 per cent in Stockholm (30 new practices opening between 2008 and March 2009) and over 60 per cent in Halland county council (from 12 private providers in 2007 to 20 in 2008) (Anell 2011). Key informants confirmed that the size of the change in the 'private market' varied across county councils, but also the type of provider, with new entrants in some areas and new branches of large healthcare chains, or former specialised care providers in others.

Glenngård et al. (2011) reported that the establishment of new providers in connection with the reform was associated with a significantly increased likelihood of patients exercising choice of primary care provider, that is, registration with a primary healthcare centre of their own choice (odds ratio, OR 1.51, 95% confidence interval, CI, 1.12, 2.02). Conversely, there was no significant association between the likelihood of making a choice, i.e. registration with a primary health centre, and the number of alternative providers, suggesting, according to the authors, that 'the dynamic competition created by establishments of new providers' constituted an important (initial) factor for the system of choice to work. However, as the study by Glenngård et al. (2011) focused on only three Swedish counties, it is difficult to draw conclusions about the impact of the reform on access to primary care provider across the entire country. We noted earlier how, as highlighted by key informants, access has also been increased by means of extending opening hours, with practices seeking to increase their competitive advantage and retain patients.

The entry of new primary care providers as a consequence of the choice reform was also reported for Norway, with an increase of 18 per cent between 1998 and 2001 (Iversen and Lurås 2011). Evidence from Norway further suggests that this increase in supply may have contributed to an enhanced geographical distribution of GPs across the country, as with excess supply in urban areas, some practitioners had moved to suburban or rural areas to achieve a financially viable patient list (Magnussen, Vrangbaek et al. 2009). Interviewees from Finland were unable to cite evidence of changes in the number and distribution of primary care providers, highlighting that access to primary care remained the 'biggest problem' because of a continuing 'under-supply of primary care physicians' (Academic, Finland).



Impacts of reforming choice of primary care provider: the health system

Other measures of impact highlighted by key informants include the development of delivery models seeking to move care out of hospital and enhance coordination among providers. There was a perception, among interviewees, that initial expectations with regard to these measures may not have been met. Thus, in Sweden, the expectation that 'there should be a greater diversity in primary healthcare compared to before the reform [...] has not happened to the extent anticipated' (Academic, Sweden). Limited and anecdotal evidence is available from 'early adopter' counties in Sweden that sought to expand the role of primary care. For example, Halland county council expected that primary care centres would employ specialist providers alongside GPs and specialist nurses, thereby ensuring that the majority of outpatient visits would take place in the primary care setting (Anell 2011). This was accompanied by changes to the payment schedule, which involved financial penalties for those providers that did not meet a certain threshold for services provided in the primary care setting (80% in Halland county). According to Anell (2011), in Halland county in 2009 a proportion of primary care providers (mostly private providers) had risked not meeting the threshold, so incurring significant penalty payments. This was most likely because they sought to retain patients who might have changed provider otherwise. Other anecdotal evidence reported by Anell (2011) points to large profits made by some private providers at the expense of the quality of care provided.

Initiatives to reconfigure the care delivery model are also being pursued in Norway. From January 2013, municipalities are required to contribute 20 per cent of the costs of specialised healthcare. This move presents a substantial departure from the past, when the role of municipalities in healthcare financing was largely limited to processing payments to providers (Johnsen 2006). There is an expectation among key informants that this move will stimulate the interest of municipalities in the behaviour of GPs, 'because it now has an economic consequence' (Policymaker, Norway), and the placing of greater emphasis on care coordination. At the same time, there is recognition of the potential of provider competition to undermine such developments:

If you consider referrals to specialist healthcare for instance, you could argue that more competition for patients would make it more difficult to maintain a policy of efficient gate-keeping. It is felt that if a patient would like to be referred to specialist healthcare, then it would be more difficult for a GP to reject the referral if there are many other physicians who are interested in listing that particular patient. [...] But of course there is also a possibility to lean in the opposite direction. (Academic, Norway)

As noted above, the evidence on outcomes of the reforms around choice in primary care in the three countries under study remains scant and there is a need to systematically monitor and evaluate developments and trends. Recent evidence from Sweden suggests that the new 'competitive conditions' have improved technical efficiency among private and public providers, although not the quality of care provided (Anell, Glengård et al. 2012).



Finally, it is important to note that there might have been an expectation that introducing or modifying choice in primary care, in particular as it relates to permitting registration beyond administrative boundaries, would be challenging, creating difficulties for managing financial flows and funding (Magnussen, Vrangbaek et al. 2009). However, key informants did not report any major technical or logistical issues with regard to possible administrative blockages or limitations of information technology required to coordinate and follow payment and financial flows. For example, interviewees from Norway and Finland highlighted that municipalities are used to working collaboratively on healthcare and other public sector issues that they are accountable for, because the majority of municipalities in either country tend to oversee small populations. Key informants in the three countries reported that transfers are limited in number and value, and systems to manage flows are well established, thus constituting ‘a very very marginal issue in Norway’ (Academic, Norway), while in Sweden it was conceded that ‘[it] is rather easy to let money follow the patient, so that hasn’t been any problem’ (Policymaker, Sweden). Interviewees from Finland highlighted the importance of functioning IT systems to allow for the transfer of medical records, noting that ‘Finland is pretty far on the way to having national electronic health records[...] Two locations [...] should be able to read each other’s health records’ (Policymaker, Finland). However, it was acknowledged that the further expansion of choice from 2014 will require ‘smooth solutions’ to facilitate transfers and information exchange (Academic, Finland).

Challenges of reforming choice of primary care provider

Informants in all three countries identified publicly available information as one of the main challenges facing the choice reforms; what is available to patients tends to focus on basic indicators of practice size and opening hours and was considered to be limited in all three settings. For example, in Norway, the Health Economics Administration makes available information on GP list sizes and the number of places available on a given GP list (HELFO 2012). While not providing direct indicators of the quality of care provided, there was an understanding among interviewees in Norway about the importance of this type of information. For example, the study by Iversen and Lurås (2011) demonstrated how the ratio between actual and expected GP patient list size was associated with switching rates among patients, based on the assumption that the most popular GPs are likely to provide higher quality of care. In Sweden, information is available at the national and county council levels, and includes details about practices such as opening hours and waiting times, alongside patient feedback (Anell, Glenngård et al. 2012). In contrast, in Finland, despite ‘quite open access to information on waiting time’ (Academic 2, Finland), relevant information on quality is not yet available, although plans are underway to publish performance data:

What is available these days is on a very superficial level, and doesn’t really help if somebody wants to [...] compare different health centres. So it is not on a good level for the time being. (Policymaker, Finland)



Initiatives that encourage patients to post comments about their experience in primary care or that make available data on the quality of care delivered by primary care providers are just beginning to emerge. For example, in Norway, 'just in the past couple of months there's a website that's emerging where people are invited to sort of make [available] their experiences with GPs and give them star ratings (Academic 1, Norway). In Sweden, there are private initiatives that use information provided by patients to rank individual doctors, hospitals and primary care units (Anell, Glenngård et al. 2012). Also in Sweden, Glenngård et al. (2011) found that having sufficient information was associated with a significantly increased likelihood of choosing a primary care provider (OR 3.0; 95% CI 2.15, 4.17). More recently, a governmental report in Sweden noted that 64 per cent of patients believed they had sufficient information to actively choose a primary care provider (Swedish Competition Authority 2012).

Discussion

In this study we sought to better understand choice of primary care provider as a policy issue in different health system contexts in Europe. We explored the motives and drivers of choice among service users to better understand the (potential) 'demand' for patient choice in primary care by means of a review of the literature. We found that choice is valued by patients although it may not be exercised actively and that the availability of choice, or perception of meaningful choice, may be associated with improved outcomes such as satisfaction. A core challenge in assessing and interpreting the evidence relates to the way choice in primary care has been conceptualised. We argue that, in countries that require registration, choice can principally refer to choice to register with a given GP practice or primary care practice or choice of GP or family physician within a GP or primary care practice the service user is registered with. A large share of the literature focuses on the choice of a given doctor, and existing evidence highlights how continuity of care, convenience with regards to access, and dissatisfaction with the current provider appear to be the main driving factors. This allows us to understand motivations for choosing (and changing) providers from the service user perspective.

We further investigated choice policies in primary care in Finland, Norway and Sweden with a document review and key informant interviews. We showed how the main drivers behind choice policies were to improve access to and the quality of care, although this was to be achieved by different means. In Finland and Sweden, increased choice was expected to introduce or increase competition among primary care providers and so enhance access to and the quality of care. The situation was different in Norway, however, where reform efforts and the introduction of the regular GP scheme sought to enable GPs to better manage their patient lists and thus enhance access to care. In discussing the evidence from the three countries under review, our unit of analysis was choice of GP in Norway, and choice of primary care health centre in Finland and Sweden. Conceptually, the reforms in the three countries were therefore not equivalent, which needs to be kept in mind when interpreting our findings.

However, overall it is fair to say that choice policies in the three countries can be seen to be situated in the context of a broader political agenda aimed at



transforming the way health services are organised and administered. In Sweden, for example, efforts to enhance choice were accompanied by a shift towards greater private provision in the healthcare sector and the public sector more generally. In Finland and Norway, choice initiatives were embedded in the broader context of administrative reforms. Thus, in Finland, these involved an ongoing process of creating larger administrative areas through merger of municipalities in order to enhance collaboration on service arrangement and provision (Ministry of Social Affairs and Health 2012), alongside reassessment of the balance of power between national and local governments. This is important to understand since the effects of changes in choice policy may be difficult to distinguish from broader contextual changes in health or administrative systems. Similarly, the pilot scheme in England is occurring (and will need to be understood) within a context of significant changes to commissioning and provision of services in the NHS.

Given the relative novelty of reform efforts in Sweden and Finland in particular, it is perhaps unsurprising that robust evidence of impact remains scant, with findings from systematic evaluation lacking. There is some suggestion that new providers have entered the market, and that some patients have used the opportunity to exercise choice by means of actively registering with a (new) healthcare centre. Early analyses and expert opinion from the countries studied here seem to support some of the findings of our review of the motives and drivers of choice among service users, such as distance. An important distinction was drawn between rural and urban areas, with choice of primary care provider reported to be more pertinent in urban areas, while access to care in less densely populated areas remains a challenge in all three jurisdictions.

The degree to which people will exercise choice in primary care may also be influenced by the level of information available to them (Coulter and Jenkinson 2005), although the evidence of patients making use of information to inform their choices remains patchy (Fung, Lim et al. 2008; Dixon, Robertson et al. 2010; Cacace, Ettelt et al. 2011). Key informants in all three countries confirmed that the relative lack of publicly available information to enable an informed decision has posed a challenge for the implementation of the choice reforms. Some initiatives were reported, including encouraging patients to rate their experience, but there was little evidence of systematic provision of information around quality or supply-side information beyond opening hours. Early evidence from the UK provides some insights into the potential use of patient ratings to inform organisational learning and an understanding of the quality of primary care from a different perspective (Greaves, Pape et al. 2012; Greaves, Ramirez-Cano et al. 2013).

Although the overall evidence on the impact of policies to enhance choice of primary care provider in the three countries examined here has been somewhat limited, our study provides important lessons for the planned implementation of choice in primary care in the English NHS. At the risk of simplifying an inherently complex situation, it can be concluded, on the basis of the analyses undertaken here, that implementation of policies seeking to enhance choice of primary care



provider may be more straightforward where transfers are limited in number and value, where it is easy to let money follow the patient, and where the existing IT infrastructure allows for easy transfer of medical records.

In contrast to Finland, Norway and Sweden, issues of remoteness and rurality are less likely to pose a challenge to the current GP choice pilot in England, which is focused on more populous commuter regions. However, this will be an important factor to consider if the scheme is to be expanded nationally. If a driver for expanding choice is to increase access to and quality of care through competition, this is likely to have differential effects in rural and urban areas. Providing choice in remote settings is challenging because of a lack of a sufficiently large number of participants in the market. There is also a suggestion that patients in rural areas may value longitudinal relationships with primary care providers more than patients in urban areas (Farmer, Iversen et al. 2006). Although not directly related to choice of primary care provider, the question of GPs contracts and payment structures was identified as an important driver of providers' responses to reforms and this may in turn have implications for choices available to patients. This is an area not fully understood beyond anecdotal evidence, indicating the need to carefully monitor the impact of enhanced choice in primary care in order to ensure that related policies truly enhance access to and the quality of care and do not only benefit those who are more able to exercise choice.



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