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ORIGINAL ARTICLE

Primary care patients' attitudes to priority setting in Sweden

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Abstract

Objective. To analyse attitudes to priority setting among patients in Swedish primary healthcare. *Design.* A questionnaire was given to patients comprising statements on attitudes towards prioritizing, on the role of politicians and healthcare staff in prioritizing, and on patient satisfaction with the outcome of their contact with primary healthcare (PHC). *Settings.* Four healthcare centres in Sweden, chosen through purposive sampling. *Participants.* All the patients in contact with the health centres during a two-week period in 2004 (2517 questionnaires, 72% returned). *Main outcomes.* Patient attitudes to priority setting and satisfaction with the outcome of their contact. *Results.* More than 75% of the patients agreed with statements like "Public health services should always provide the best possible care, irrespective of cost". Almost three-quarters of the patients wanted healthcare staff rather than politicians to make decisions on priority setting. Younger patients and males were more positive towards priority setting and they also had a more positive view of the role of politicians. Less than 10% of the patients experienced some kind of economic rationing but the majority of these patients were satisfied with their contact with primary care. *Conclusions.* Primary care patient opinions concerning priority setting are a challenge for both politicians and GPs. The fact that males and younger patients are less negative to prioritizing may pave the way for a future dialogue between politicians and the general public.

Key Words: *Health priorities, family practice, patient participation, patient satisfaction, primary healthcare, rationing*

The importance of involving patients and the general public in different parts of the process of priority setting is discussed by several authors [1–3]. One main reason for this involvement is to increase public accountability for decisions on the allocation of healthcare resources [4]. This is important in democratic, publicly financed and politically controlled healthcare systems. However, it is difficult to accomplish, as prioritizing and rationing of healthcare are sensitive issues, for both politicians and medical staff.

Since 1997, the Swedish Parliament has provided general guiding principles for priority setting [5]. The guidelines recommend transparent prioritizing. Transparency is an important component in priority setting in order to enable public control and to support debate, as part of the democratic process [6]. Despite the guiding principles, the need for explicit priority setting in healthcare is not obvious to the general public. In both Sweden and other countries, the general public have high expectations of access to all kinds of healthcare and little understanding of priority setting [7–9].

In the Swedish guidelines for priority setting, the issue of sharing responsibility for prioritizing between politicians and physicians and other healthcare staff is raised [5]. However, there is no agreement on how this should be done in practice [7].

The literature on attitudes towards priority setting deals mainly with the perspective of the general public [8–10]. However, in this study we have chosen to focus on the attitudes of primary healthcare (PHC) patients. One reason for this is that patients and the general public have different views on healthcare, e.g. patients are more satisfied with services than the general public [11]. Patients have more personal experience of healthcare than the

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Patients in primary healthcare have a negative attitude to priority setting and they do not want politicians to set priorities. This can make prioritization difficult.

- Most patients in Swedish primary care in fact do not experience any rationing and the majority are satisfied with care.
- Young patients have a slightly more positive attitude to prioritizing.

general public. Patients also have a greater need of healthcare than the general public, e.g. more have chronic diseases [12–14]. They may, therefore, also have a different perception of the need for setting priorities.

We think it is of special interest to explore attitudes towards priority setting in PHC since most healthcare contacts are made in PHC. Decisions in this first-line healthcare have an impact on the entire healthcare system [15]. The establishment of a fair and accepted system for more transparent priority setting in PHC is therefore of great importance.

Objective

To analyse patients' attitudes to priority setting and rationing and patient satisfaction with the outcome of their contact with Swedish primary healthcare.

Material and methods

The study was conducted during two weeks in 2004, at four primary healthcare centres (PHCCs) in southern Sweden. A questionnaire concerning priority setting was distributed to patients who had contact with the PHCCs.

Questionnaire

The questionnaire included five statements. The first three statements concerned attitudes to the fact that priorities are set. They were used and validated in an earlier Swedish study regarding general public attitudes to priority setting [9]. The next two statements were constructed for the present study and dealt with whether politicians or healthcare staff should set priorities in cases of limited resources. The patients could respond, "fully agree", "partly agree", "don't agree", or "don't know".

Two questions concerning "feeling excluded due to lack of resources" and "patient satisfaction with the outcome of their contact" were added to the questionnaire. The statements and questions are listed in Table I. The respondents' age, sex, and type of contact (phone or visit), were registered.

Settings and participants

The PHCCs were chosen through purposive sampling. They were located in areas with different population mixes regarding age and social factors. The questionnaire was given to all patients who telephoned or visited the PHCCs. Parents helped to fill in the questionnaire when children were involved. Patients who telephoned received the questionnaire by mail.

Of 3509 questionnaires, 2517 were returned (72%) and 92% of those returned were fully completed.

Around 40% of the patients were more than 65 years of age and 60% were women. Of all the patient contacts 33% were with GPs, 53% with nurses, and

Table I. Results of the questionnaire.

Statements and questions	% (n = 2517)			
Priority-oriented questions	Fully agree	Partly agree	Don't agree	Don't know
1. Public health services should always offer the best possible care, irrespective of cost	66	28	3	3
2. Everyone has the right to have their healthcare needs met, even minor problems	52	38	7	3
3. Tax-financed healthcare cannot afford all treatments and some things must be excluded	9	40	40	11
Preference-oriented questions				
4. Politicians in collaboration with medical staff should decide which diseases/conditions should not be treated	9	22	55	14
5. Healthcare staff should decide what should not be treated	68	20	6	7
Question about feeling of being excluded due to lack of resources	Yes	No		
6. Did you get the impression that staff at the primary healthcare centre could not fully omply with your requirements and that you were excluded due to lack of resources?	9	91		
Question about satisfaction with the outcome of the contact	Satisfied	Not satisfied		
7. Are you satisfied with the outcome of today's contact?	91	9		

the remaining contacts were with rehabilitation staff. Some 38% of the contacts were visits and the remaining 62% were telephone calls.

Data analysis and statistics

According to the patients' answers to statements 1–3 and 4–5 (see Table I) two new categories were created based on the patients' opinion on priority setting (priority-oriented/not priority-oriented/no definite opinion) and preferred priority-setter (politicians/medical staff/no definite opinion) (Table II).

Bivariate correlations between all the variables were performed and variables with significant correlations were then analysed, in both a univariate and a multiple logistic regression. Priority-oriented and patient satisfaction outcome (yes/no) were used as dependent variables in the logistic regression analyses.

Statistical analyses were performed using Statistica 6.0 (StatSoft). A p-value <0.05 was considered statistically significant.

Table II. Number and percentage of patients in different categories based on their opinion on priority setting (upper part of table) and on who should be responsible for priority setting (lower part of table).

Categories	n	(%)
Opinion about priority setting.		
Based on answers to "priority-oriented questions" in Table I (1–3)		
Priority-oriented[1]	140	6
Not priority-oriented[2]	1656	72
No definite opinion[3]	506	22
Preferred priority-setter		
Based on answers to "questions about decision makers" in Table I (4–5).		
Politicians[4]	117	5
Medical staff[5]	1681	73
No definite opinion[6]	509	22

Notes: [1]This category includes patients who responded "Don't agree" to statements 1 and 2 and "Fully agree" to statement 3 as well as those who responded the same way in two of the statements but "Partly agree" or "Don't know" to one of the other statements. [2]This category includes patients who responded, "Fully agree" to statements 1 and 2, and "Don't agree" to statement 3 as well as those who responded the same way to one of the statements, but "Partly agree" or "Don't know" to the other statements. [3]Patients with other combinations of responses to statements 1–3. [4]This category includes patients who responded "Fully agree" or "Partly agree" to statement 4 and "Don't agree" to statement 5 and also those who responded "Fully agree" to statement 4, but "Partly agree" or "Don't know" to statement 5. [5]This category includes patients who responded "Don't agree" to statement 4 and "Fully agree" or "Partly agree" to statement 5 and also those who responded "Partly agree" or "Don't know" to statement 4, and "Fully agree" to statement 5. [6]Patients with other combinations of responses to statements 4–5.

Results

A majority of the patients did not accept any resource limitations in healthcare. They thought that the best possible care should always be offered, regardless of cost, and that all heathcare needs should be met, even minor problems. However, 49% of the patients fully or partly agreed that some services must be excluded from tax-financed healthcare (see Table I). Some 22% of the patients did not adopt a definite position on prioritizing and 6% were classified as priority-oriented, i.e. they had a positive attitude towards prioritizing (see Table II). Younger patients (<65 years old) were more priority-oriented than older patients, as were men compared with women (Table III). The type of contact was not related to priority orientation. A majority, 73% of the patients, preferred medical staff to have the main responsibility for priority setting, 22% did not adopt a definite position. Some 5% were in favour of politicians setting priorities (see Table II) and in this group patients had a more positive attitude to priority setting (Table III).

A total of 9% felt they were excluded due to lack of resources (see Table I). In total 91% were satisfied with the outcome of their recent contact (see Table I) and among patients who felt that they were excluded due to lack of resources 62% were satisfied (Table IV). Younger patients were less satisfied than older (Table IV). Gender and type of contact were not related to dissatisfaction with the consultation.

Discussion

Patients in PHC had high expectations of healthcare. They preferred medical staff to set priorities and had a negative attitude towards the role of politicians in rationing. Nearly one in 10 had experienced some kind of rationing and among these patients a majority were satisfied with the outcome of that day's contact.

More than 2500 consecutive patients from four PHCCs (approximately 10% of the population served in that area) took part in the study. Since the proportion of patients in different age categories corresponds to national figures, the sample might well reflect the entire population of patients.

A response rate of 72% was judged as satisfactory. Similar rates at the four different PHCCs indicated that there was not any systematic bias due to particular conditions at any centre. The dropout rate may have affected results but it is not possible to say in which direction, since there was no indication of systematic dropout. The internal dropout rate was up to 8%, but varied on different statements.

Table III. Priority-oriented patients and associated variables: logistic regressions, and odds ratios (ORs) with 95% confidence intervals (95% CI).

		Priority-oriented		Univariate logistic regression		Multivariate logistic regression (n = 1309)	
Variables	n	n	%	OR (95% CI)	p	OR (95% CI)	p
Age							
<65	1010	105	10	1.00		1.00	
≥65	616	21	3	0.30 (0.19–0.49)	<0.001	0.31 (0.17–0.56)	<0.001
Sex							
Women	1004	61	6	1.00		1.00	
Men	642	69	11	1.86 (1.30–2.67)	<0.001	2.05 (1.32–3.19)	0.002
Preferred priority-setter							
Politicians	1383	82	6	1.00		1.00	
Medical staff	83	28	34	8.08 (4.86–13.43)	<0.001	7.62 (4.37–13.29)	<0.001

There was a skewed distribution of responses to most of the questions. The choice of answers to the statements in the questionnaire may have influenced the results. A visual analogue scale could have encouraged more patients to take up a position instead of answering "don't know". Also the way of categorizing the patients into priority-oriented or not, and as preferring politicians or medical staff to set priorities, may have influenced the results. For instance, by including patients who answered "partly agree" to one statement, fewer patients were categorized as "no definite position".

Most patients in PHC expected to have all their healthcare needs met, although there was some acceptance of limitations. In another Swedish study, where statements similar to the ones in our investigation were used, the general public, rather than patients, were asked about their opinions on priority setting. When comparing the results, the general public thought to a greater extent than patients that healthcare should always offer the best possible care, irrespective of cost [9]. On the other hand, more patients considered that all healthcare needs should be met, even minor medical problems. The small differences in opinion between the groups in these two studies contrast with the results of the Swedish national surveys on quality in healthcare, which show a clear difference in opinion between PHC patients and the general public [11].

Younger patients were less satisfied with the contact than older, which is in agreement with other studies [16,17]. In the entire study only a minority of the patients were priority-oriented, but younger patients had a more positive attitude towards priority setting and rationing. It is possible that the opinions of the younger patients will change to become more negative when they get older, but it could also be an indication of a shift in attitudes over time. This result may be valuable when establishing a dialogue between politicians and the general public.

That women were less priority-oriented than men may be associated with lower perceived health and higher use of healthcare facilities by women, or lower political trust in general [18].

Earlier studies have shown that both healthcare staff and politicians agree to a large extent on the need for more transparent prioritizing and rationing in healthcare [8,9]. A crucial question is: Who has responsibility for priority setting and rationing? A majority of the patients in this study did not think

Table IV. Satisfaction with outcome of the contact and associated variables: logistic regressions, and odds ratios (ORs) with 95% confidence intervals (95% CI).

		Not satisfied with outcome of the contact		Univariate logistic regression		Multivariate logistic regression (n = 2086)	
Variables	n	n	%	OR (95% CI)	p	OR (95% CI)	p
Age							
<65	1310	137	10	1.00		1.00	
≥65	815	47	6	0.52 (0.37–0.74)	<0.001	0.52 (0.36–0.75)	<0.001
Feeling of being excluded							
No	2098	117	6	1.00		1.00	
Yes	208	80	38	10.58 (7.53–14.86)	<0.001	10.60 (7.37–15.24)	<0.001

politicians should have the responsibility, even in collaboration with medical staff. This was in agreement with a study from the UK where the general public thought that physicians should have the greatest influence on how healthcare resources should be allocated [8]. On the other hand, it is argued that physicians cannot act as the gatekeepers of limited resources [2] and Rosén et al. found that the physicians themselves want politicians to have the greatest influence on resource allocation in public healthcare and also want politicians to take major decisions to exclude certain diagnoses or services from public financing [9].

Hence, there is a difference of opinion about who should be responsible and most patients preferred medical staff to politicians. The reason for this could be that patients think of prioritizing only from an individual patient perspective, while healthcare staff think more about comprehensive decisions concerning resource allocation to healthcare sectors or groups of patients. Politicians have a difficult role in the prioritizing process. The legitimacy of the authorities making the decisions in the eyes of those concerned is important in transparent priority setting [6]. A key question is how to start the process to achieve this legitimacy.

Although patients who felt that they were excluded due to lack of resources were less satisfied than others, the majority of them were, nevertheless, satisfied with the outcome of their contact with PHC. One explanation could be that patient satisfaction has been shown to be higher in health centres with a heavy workload [19]. Moreover, satisfaction is not always associated with fulfilling expectations [20]. Another interpretation of the results is that there seems to be some acceptance among patients of rationing, which is also confirmed in other studies [12,21]. The relationship between satisfaction and the experience of not getting all needs met could be studied in greater depth using a qualitative approach [22].

Patient opinions are a challenge for politicians, since the legitimacy they have influences their ability to make transparent decisions concerning priority setting. Meanwhile, responsibility for rationing and hidden priority setting in daily clinical practice rests very much on the healthcare staff, especially in primary healthcare.

If medical staff were able to work systematically with priority setting, the trust that patients have in them could facilitate a dialogue about priorities in society and also help to create legitimacy for the priorities that need to be set. To support this process more knowledge is required about how staff handle situations arising from a lack of resources and about the usefulness of existing methods and models for priority setting in PHC.

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