



# Primary health care nurses' views on patients' abilities and resources to make choices and take decisions on health care



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## ABSTRACT

Recent health reforms in many European countries have emphasised patient choice as a tool for patient participation, and for the improved efficiency of services. Little attention has been paid to experiences of the nurses in these reforms, even though the reforms directly concern all health care personnel and cannot be implemented without their contribution. This study looks at patient choice from the perspective of the nurses working in primary health care clinics in Finland. In Finnish primary care, nurses have a central role in coordinating patient care and advising patients. The data come from 31 interviews conducted in 17 health care clinics. The approach adopted in the analysis is data-driven and brings forth nurses' experiences in their daily work with patients. A detailed analysis of the nurses' responses and views was conducted with discourse analysis. While nurses positioned some patients as knowledgeable, able to search for information and make use of different services without nurses' help, some of the patients were positioned as those needing nurses' advice and guidance through the complex system of health and social care services. Nurses' positions varied from co-actors and gate-keepers to advocates and spokespersons. In order to succeed future health care reforms need to take better into account the realities of health clinics and the grassroots-level knowledge that primary care nurses have on patients and clinical practices.

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## 1. Introduction

Health care organisations are expert organisations in which patients have traditionally had little influence on the care they receive, let alone on the practices of health care facilities. While this view has not completely disappeared, we can observe a general trend towards patients' increasing involvement in their care [1]. One example of this is the increased amount of choice that patients have, which has been an important aim in many health care reforms implemented around Europe (e.g. [2–6]).

Some scholars have claimed that choice can be interpreted as a mechanism for redressing the power inequality between health professionals and patients [7]. Health reforms that aim to increase patient participation and choice also aim, either implicitly or explicitly, to change the patient-professional relationship and shift decision-making power from the latter to the former [8]. In a similar fashion, Le Grand and Titmuss [9] have argued that patient choice reforms are attempts to change patronising and top-down health care practices, which would facilitate a more equal rela-

tionship between the patients and the professionals. Following this line of thought, choice reforms might act as broader democratising forces in social and health care [6].

However, it is not self-evident how professionals and patients view these aspirations. Tonkens and Newman [4, 205] have pointed out that recent health care reforms have put professionals into an ambivalent position. Reforms require professionals to combine traditional and new forms of expertise, and balance their work between their old and new positions. They still need to use their expertise to assess who needs and is entitled to services, but they are also required to act to encourage and empower service users [4].

Health care personnel may support patient choice in principle, but in practice feel that their time is too limited and information is insufficient to give a proper guidance to the patients in making choices [10]. A Swedish study [8] argues that, while doctors approve choice policy and greater patient involvement, in practice they have retained their power to make referral decisions, and make them mainly on medical grounds. Paradoxically, for nurses, health reforms may mean having more power over one's own work tasks, or less power and more job strain, which gives reason to resist reforms [11].

Patients are often portrayed as a unitary group of agents wanting to have a chance to execute choice in health care services. The

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increasing number of patients with higher education and improved access to health and medical information through the internet has indeed increased patients' chances and abilities to seek information and weigh their options in seeking health care services. This has been predicted to diminish the authority of health care professionals [12,13]. However, it has also been noted that, while people may value choice in principle and see that having options in making choices strengthens their sense of autonomy, they may still prefer professionals to make care-related decisions in times of being in pain or feeling insecure and vulnerable [2,14]. In particular, people with a serious life-threatening illness expect a professional to make decisions on the basis of his or her expertise and experience. Thus, having a choice may be "unwanted", as the patient may trust that professionals will make the best choices for them [2, 612]. Consequently, choice reforms also bring forward the question of equity between patients and different groups of professionals [5]. People who are sick, and who lack the needed skills and health literacy, may not be able or willing to engage in negotiation with professionals [4]. The concern expressed by Fredriksson & Winblad [15] that choice reforms may improve care services of vocal and well-informed patient groups at the expense of less vocal and less mobile patient groups is thus well-founded.

The interaction between professionals and service users forms an important part of the process of service delivery [16]. Whether the outcome is positive or negative also depends on the role of professionals in the process [1]. These findings draw attention to the knowledge possessed by grassroots health care workers and their role as professionals who have close and frequent contact with patients. From this perspective, more research is needed on the actual care decisions and realities in health care clinics.

To this end, we studied the encounters between health professionals, namely nurses, and patients in primary health care clinics (PHCCs) in Finland. In particular, we explored how nurses view patients' abilities and resources to act as independent decision-makers. That is to seek information on services, make their own appointments in health care and seek other health or social care services after initial contact with a medical professional. In order to enact choice, patients need to be able to take up these tasks. In addition, we looked at how nurses' daily work and contribution is related to the patients' above-mentioned abilities and resources. Thus, the core aim of the study was to illuminate current reality and daily work in PHCCs to increase knowledge on the role of professionals and the challenges they face in their work with patients. This knowledge is needed to facilitate future health care reforms and make full use of professionals' knowledge on what is needed to strengthen the patient's role, while taking into account the realities of the work required of professionals in health clinics.

We focused on the nurses' perspectives because, in the context of this study, that is the Finnish primary health care setting, a nurse is many times the first person a patient has contact with and the worker they see most often. Further, nurses are a key group of professionals in providing advice and assistance in matters related to finding services and enacting choice [17].

While patient choice has been an important goal in many European countries, health care users in Finland have traditionally had fairly limited possibilities of choice in the municipally-run core health care system. However, the Health Care Act, which came into effect in 2011 allows residents to choose their PHCC and the hospital at which they want to be treated. Finnish patients can choose between municipal PHCCs and private PHCCs commissioned by the municipalities. In hospital care, the Act requests that the treating hospital is chosen in conjunction with the referring doctor [18]. Thus, Finland is following in the footsteps of other Northern European countries that have implemented wider patient choice [5,6]. Moreover, as a part of a wider reform package, the government that took office in 2015 is aiming to further expand choice in health

and social care [18]. The overall aim is to tackle the flaws in the current service system—especially the long waiting times at the level of primary health care—through enhancing patient choice and competition [19].

The Finnish health care system has some unique features. The core system is based on a universal municipal-run health care system, which accounts for primary and specialised care services to all permanent residents with the private sector complementing municipal care in ambulatory care (see [20]). Ambulatory health care for working people is, to a large extent, organised as a separate occupational health care system, and the services are generally provided by private providers. The users of primary care services in Finland, often are outside work life, have chronic conditions, and many of them need a wide range of health and social care services. This means that a significant number of them also have special needs in regard to choice [20]. As noted by Dixon and Poliakhoff [21] a key challenge facing health systems is multiple comorbidities and people with complex social and health care needs. Thus, the overall structure of the clientele in Finnish primary health care clinics makes them particularly interesting targets of studies focusing on patient choice. Knowledge of choice in Finnish primary health care provides material to discuss and develop health and social care reforms also in other countries as well.

## 2. Material and methods

The study employs data from interviews collected in a research project studying patient choice and integrated care in PHCCs in Finland (Client centred primary care – patient choice and care integration VALINT, 2014–2016). The interviews were conducted in five (5) cities in Southern Finland at 17 PHCCs. All interviewees (N = 31) were female care workers who were trained professionals and had experience in working in PHCCs.

The interviews were recorded and transcribed. The analysis was data-driven, that is, no pre-existing categories or theories were used in analysing the nurses' responses, but any topics, broader themes or categorisations formed were done so on the basis of the nurses' experiences as they described them in the interviews. In the first stage of the analysis, the data was organised and coded with the NVivo programme, which is developed to facilitate systematic organisation and coding of qualitative data. The coding process consisted of reading and re-reading the data corpus, grouping codes into broader themes representing content of the nurses' responses and their own roles in relation to patients' roles and health care needs, descriptions of patients' abilities to seek information and health and social care services as experienced by the nurses, and variation of their own work in respect to different groups of patients. The aim of this process was to ensure that the analysis would reflect the content of the entire data and the variety of themes within it. The amount of data does not allow quantitative generalisations, but the analysis shows common and repeated themes to explicate the complexities of nurses' daily work and the heterogeneity of patients in primary health care clinics.

After the coding process, the analysis proceeded into a detailed study of the speech of the nurses using discourse analysis [22]. The discourse analysis offered tools to analyse the arguments made in the nurses' interviews in detail. Following the data-driven approach, and principles of discourse analysis, the focus was on the nurses' responses and how they described encounters with patients, practical situations in which care decisions were made, and their own roles and decision-making in relation to patients' actions and needs. In this context, analysing nurses' views of patient choice refers to analysing if and how nurses describe patients as agents who can make decisions on health care and seeking treatment, and are able to execute their decisions. The analysis resulted

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