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Research Paper

International Journal of Care Coordination

International Journal of Care Coordination
2018, Vol. 21(4) 153–159
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DOI: 10.1177/2053434518816792
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General practitioners' perspectives on care coordination in primary health care: A qualitative study

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Abstract

Introduction: To explore Norwegian general practitioners' experiences with care coordination in primary health care.

Methods: Qualitative study using data from five focus groups with 32 general practitioners in Norway. We analysed the data using systematic text condensation, a descriptive and explorative method for thematic cross-case analysis of qualitative data.

Results: The general practitioners had different notions of care pathways. They expressed a wish and an obligation to be involved in planning and coordination of primary health-care services, but they experienced organisational and financial barriers that limited their involvement and contribution. General practitioners reported lack of information about and few opportunities for involvement in formal coordination initiatives, and they missed informal arenas for dialogue with other primary health-care professionals. They argued that the general practitioner's role as coordinator should be recognised by other parties and that they needed financial compensation for contributions and attendance in meetings with the municipality.

Discussion: General practitioners need informal arenas for dialogue with other primary health-care professionals and access to relevant information to promote coordinated care. There might be an untapped potential for improving patient care involving general practitioners more in planning and coordinating services at the system level. Financial compensation of general practitioners contribution may promote increased involvement by general practitioners.

Keywords
Primary health care, general practitioners, health services

Introduction

An increasing number of patients live with chronic conditions or functional decline, and they are in need of coordinated efforts from a team of health professionals and care providers.[1] While coordination of care is essential for high-quality care, challenges may occur both within primary health care and at the interfaces between specialist health care and primary health care. In the literature, care coordination, case management and collaborative care are commonly used to denote various efforts to integrate care. The current focus on care coordination among policymakers and professionals may be seen as a response to the challenges that arise due to increased specialisation and fragmentation within health care.[2]

Norway has a two-tier health-care system with an organisational division between specialist and primary health care. State enterprises, regional health authorities, are responsible for specialist health services, including hospitals, while the municipalities are responsible for the delivery of primary health-care health services. Most general practitioners (GPs) work as private professionals that run their own practices on a contract with the municipalities. A typical GP practice consists of two to six physicians and auxiliary personnel, where the GPs have their individual lists of patients (average around 1100–1200 patients). The GPs have

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personal responsibility for the patients on their list. Primary health care provided by GPs is financed from three sources: The municipalities (capitation), patients (co-payments) and The Norwegian Health Economics Administration (fee-for-service). Capitation payments amount to about 30% of GPs' income, while the other two sources provide the remaining 70%. GPs may also be salaried and employed by the municipality, in which case the municipality receives a subsidy.[3] There is no official statistics on the mean annual income of GPs in Norway. The capitation payments are on average approximately 56,500 Euro, giving an approximate earning of 188,200 Euros, but the expenses related to facilities, helping personnel and other operations vary greatly. The minimum wage for specialists in hospitals is approximately 75,300 Euros.[4]

Several projects on integrated care pathways exist in Norway, funded by regional health authorities, municipalities, and the Norwegian Association on Local and Regional Authorities (KS). One example is "Good patient pathways," which is an initiative involving KS, the Norwegian Institute of Public Health, the Ministry of Health and Care Services and the Norwegian Directorate of Health. The initiative involves 200 municipalities. The aim is that users should experience being a partner in the planning of his/her care pathway, municipalities and health authorities working systematically with care pathway and documenting the effect for the users, the culture of municipalities and health authorities being characterized by health promotion. The financial cost of this initiative, however, is largely paid for by the individual municipalities.[5] In specialist health care, standardisation and development of care pathways have been an important approach to improving care coordination.[6–9] Coordination of care through standardised care pathways may be less suitable in primary health care because patient trajectories are less diagnosis-focused and more based on patients' broader functioning.[10]

Skrove et al.[11] interviewed chief municipal executives and health-care managers in Norwegian municipalities about their experiences with developing and implementing care pathways. A common experience reported in this study was that GPs were not involved and did not want to be involved in this work. The study found that various stakeholders held the view that GPs did not consider themselves part of the primary care system, and the authors concluded that there was a lack of obligation among GPs to collaborate with the rest of the primary health-care services.[11] A Norwegian study, on the contrary, found that GPs experienced being left out from important decision-making processes in the municipalities.[12] Projects in Denmark, Germany and the Netherlands, where the GPs also act as gatekeepers, have been successful in involving GPs. The projects showed robust evidence of improvements on a number of service and patient outcomes, and these findings were central to their wider impacts, shaping country-wide integrated care policies.[13]

There is considerable variation in the extent to which GPs in Norway participate in multidisciplinary meetings.[14] A study on primary health care found that the structural context of primary health care, such as geography, time pressure and financial conditions, influenced collaborative patterns between GPs and other actors.[15] The study suggested individual differences between GPs in terms of the extent to which they participated and were willing to participate in interprofessional collaboration.

Previous research suggests that implementing care models with a focus on population health, professional networks and enhanced teamwork may promote coordination of care.[16,17] A study from Canada has shown that a more formal collaboration among primary health-care professionals in integrated health services networks resulted in improved quality of care.[18]

In most care pathways in Norway, the visits to the GP are usually the first and last consultations. GPs in Norway have been assigned an important role as gatekeepers, patients' advocates and coordinators in the health-care system, and they are in a key position to promote coordinated and integrated health services.[3] More knowledge about GP's experience with care coordination at the individual and system level will therefore benefit patients as well as decision makers. As health services researchers, we had an interest in identifying ways to maintain and promote coordination in the primary health service. We therefore did a study to explore Norwegian GPs' experiences with care coordination in primary health care.

Methods

Study design

We found that a qualitative study, using focus groups[19] to collect data, was suitable to explore GP's experiences with care coordination.

Study population

We conducted five focus group interviews with 32 GPs. Maximum variation sampling was used to obtain a variety regarding gender, years in practice, practice setting and geography, resulting in 20 women, 12 men, from 33 to 61, with a mean age of 46 (standard deviation = 9.48). The GPs worked in rural settings, villages and cities, from various regions of Norway. They had

on average 17.7 years of working experience as doctors (standard deviation = 10.21).

Data collection

The participants were asked to discuss their perspectives on and experiences with care coordination in primary health care, both at the individual and system level. Focus group (FG) 1–3 consisted of 16 GPs who attended a 5-day course on leadership in primary health care that was jointly arranged by the University of Oslo and The Norwegian Medical Association. The course content covered theories and models about leadership, quality initiatives and change processes. All of the course participants were invited to participate in the study. None of them declined to participate. FG 4 consisted of seven "practice consultants"; GPs who have part-time positions at hospitals as coordinators at a system level. FG 5 consisted of nine GPs in a peer supervision group. The focus group interviews were conducted at the facilities of University of Oslo and at the workplace of the participants and lasted from 60 to 90 min. The focus groups had 1–2 moderators, and all authors contributed as moderators. The interviewers consisted of researchers with different backgrounds, such as medicine, political science, health management and psychology. An interview guide (online Appendix) was developed jointly by all the authors, based on findings from previous research on care coordination in primary health care in Norway.[11,12]

The interviews were conducted face-to-face and centred on Norwegian GPs' experiences with care coordination in primary health care. Participants were asked specifically about care pathways and about factors that they thought could work as barriers or facilitators to care coordination within primary health care. After conducting the five interviews, we assessed the material and found sufficient variation and depth and decided to not conduct any more focus groups. The interviews were audiotaped, and they were subsequently transcribed by two of the authors, and checked by the other authors.

Data analysis

The material was analysed by three of the authors (ADV, JF and IS) using systematic text condensation, which is a descriptive and explorative method for thematic cross-case analysis of qualitative data, based on phenomenology.[20] We jointly developed a coding frame, and two of the authors subsequently coded the FGs. The analysis followed four steps: (1) reading all the materials to obtain an overall impression and bracketing previous preconceptions; (2) identifying units of meaning representing different aspects of care coordination in primary health care and coding for these units; (3) reducing, condensing and summarising the vital aspects' contents of each of the coded groups and (4) synthesizing the condensates from each code group making a re-conceptualized description of each category concerning GPs' experiences with care coordination. Two of the authors wrote a preliminary condensation of the analysis, with all authors joining in the final stage. Quotes from the interviews were translated from Norwegian to English by the authors, with focus group numbers and participant number denoted after each quote. Written consent to participate in the study was obtained from all of the study participants. Approval to conduct the study was granted by the Norwegian Centre for Research Data (project number 45929 and 51280).

Results

Our findings are organized under five themes: notions of care pathways, GPs' views on organisational barriers to care coordination, financial barriers to care coordination, facilitators to care coordination and strategies to overcome barriers to care coordination. A number has been assigned to each FG and participant.

Notions of care pathways

The GPs conveyed different notions of care pathways. The concept was denoted as "patient flow" and several times mixed with coordination. A group of participants felt that the concept had no meaning. Some definitions of pathways focused on patients' healing or return to their habitual state:

> The time between first contact with the health service until the problem is solved. And all the processes that take place in-between these points in time. (FG2, P5)

GPs also described pathways as a journey between various services:

> The fact that they travel between several places, that it is not just about the contact with the GP. (FG2, P6)

Pathways were also conceptualised as processes within the health centre. Several GPs underlined that good pathways were characterised by a clear structure but also with room for flexibility.

Organisational barriers to care coordination

GPs did not disagree with care pathways as an instrument or strategy but reported barriers in the development and implementation of care pathways. The GPs in our study told that they wanted to be more involved in

care coordination at the system level on primary health care, but often experienced collaboration with the municipality as a one-way dialogue with little involvement and room to give medical input and advice. They recognised the importance of improving the system to provide better and more coordinated care, but they had little experience with developing standardised care pathways. They were often informed late about initiatives, workshops and meetings, and the reported experiencing little involvement in processes in the municipality:

> You are never asked. That's the short version of care pathways, and that's the short version of care coordination. (FG2, participant 5)

GPs told about episodes where the municipality had not responded to their inquiries, and one GP assumed that municipalities deliberately avoided involving GPs in order to avoid questions and to speed up processes and projects focusing on care coordination:

> In the local municipality they have [an action plan] about development of the health services, and GPs were not represented in the steering committee, it was not circulated for input, not even to the District Medical Officers in the municipality ... Maybe they fear that physicians may get a dominating role, that there will be resistance? (FG2, participant 1)

As individual contractors, the GPs experienced that they were not visible in the municipalities' organisational structure. They lacked contact with District Medical Officers in the municipalities or physicians who held public health positions in cities. Additionally, GPs believed that more leadership and devoted District Medical Officers could facilitate and promote GPs involvement in improving coordination and develop standardises care pathways at the system level:

> I think a dedicated District Medical Officer could have made a huge difference. Personally, I have never met the district medical officer where I have worked. They have been completely absent. (FG3, participant 5)

Participants mentioned that GPs who had a low percentage of a full-time equivalent as District Medical Officers had too little time to take part in health-care system work, service development and planning.

GPs described other challenges related to communication and coordination of care for individuals, such as the use of different and incompatible electronic health record systems within the health service. They described a lack of informal contact points and arenas within the municipality's department of health to clarify and to negotiate expectations and roles. They described the dialogue as sparse between the different professionals in primary health care:

> The way our days are organized, with the heavy work load, there is no room for informal contact with collaborators. And, clearly, there is little coordination. It is one-way communication, one or the other direction. We do not have arenas [to meet]. (FG2, participant 3)

Another challenge GPs reported was lack of experience with interprofessional work and lack of information about actors and services, as conveyed in the following quote:

> We lack an overview and a map in relation to coordination, what to know, whom to collaborate with and whom to contact so that the patient gets the smooth pathway everybody is talking about these days. (FG1, participant 4)

Financial barriers to care coordination

GPs expressed that "cultural differences" between professional groups represented a challenge in work to coordinate and plan services at the system level. They conveyed that other professionals and managers often lacked an understanding that GPs were contractors and that the time was valuable and that they needed to be compensated for their contributions within the current financial scheme. GPs cited negative comments when they had asked for financial compensation to participate in planning and project meetings:

> You may be in a meeting with the Chief Municipal Executive, and then the councilman starts saying that "Oh, yes, we have to feel sorry for you physicians" [imitates the voice of the Chief Municipal Executive], who says "Oh, because you earn so well, so it was physicians we should have been to earn a whole lot of money." So, there is no dialogue because they are totally detached ... I am so provoked by this. (FG5, participant 6)

GPs described a tension between clinical work and participation in meetings and planning work in the municipality, especially concerning financial matters. They also expressed that interprofessional meetings demonstrated the difference between the GPs as private contractors and other health-care personnel as fully paid by the municipality:

> To take one day off means that we lose money. So, for example, meetings that are arranged from 10 AM to 2 PM with interprofessional collaboration on the agenda; all the nurses, midwifes, they want to participate to get

a day off at a course fully paid for, while GPs look at it and think: No, between 10 AM and 2 PM, means that it occupies my whole day. (FG4, participant 6)

Facilitators to care coordination

Participants underlined that GPs participation in care coordination initiatives could be enhanced if the GPs' role as coordinators were recognised by other parties in the primary health-care system. GPs needed timely information and meeting schedules that were in alignment with their clinical duties. Co-location of other professionals and services with the GPs' office could promote informal coordination and collaboration:

In my office we have physiotherapists in the next room, so if anything is urgent I can walk in there and ask: "Do you have time to see this the next week?" and usually it is solved. I do not have the same easy access to the other physiotherapists in the municipality. (F3, participant 3)

GPs expressed that they wanted to be more involved in care coordination and experienced that establishing informal collaborative relationships and working closely with other professionals could promote coordination of care and prevent referrals. They also expressed that good relationships with hospital doctors and specialists could improve quality of care. Some GPs told that they had asked for and had been granted compensation by the municipality to participate in committees and meetings, and they argued that such compensations facilitated contributions and involvement.

Strategies to overcome barriers to care coordination

Doctors' reluctance to seek positions of leadership and power emerged as a theme. GPs in leadership positions were reported as one way of making the GP perspective recognized in decision-making processes and the GP's heard. One participant said:

Doctors need to get involved in municipal governments, doctors must apply jobs as healthcare managers in municipalities, and we must be better at taking the lead and to participate where the decision is made, and not be on the side-lines and whine about others not listening. (FG 2, participant 4)

Discussion

This study found that GPs had different notions of care pathways. They expressed a wish and an obligation to be involved in planning and coordination of primary health-care services, but they experienced organisational and financial barriers that limited their involvement and contribution. GPs reported lack of information about and few opportunities for involvement in coordination initiatives, and they missed informal arenas for dialogue with other primary health-care professionals. They argued that the GP's role as coordinator should be recognised by other parties, and that they needed financial compensation for contributions and attendance in meetings with the municipality.

Our study suggests, in alignment with previous research,[13–15] that GP's experience organisational and financial barriers that limit their involvement and contribution in the planning and coordination of primary health-care services. A recent declaration from the WHO states that the primary care should provide services which are continuous and integrated, to avoid fragmentation.[21] Leutz[22] has published a typology of degrees of integration of services, comprising the "linkage," "co-ordination" and "full integration," denoting coordination in loose networks to a more structured and institutionalised collaboration. Our study suggests that the current regular GP scheme in Norway by large operates on a linkage basis in relation to other services. In such a linkage model, with relatively low degrees of formal integration, organisations have their own service responsibilities, operational rules and funding schemes.[22] Given the current division between services and management levels, full integration of health services (i.e., integrated systems and organizations with joint funding and responsibility) appears unlikely. The more realistic option seems to be improving coordination efforts in the network, e.g., through explicit procedures and collaborative structures and IT systems that grant access to the same information.

We found that GPs highlighted that their role should be recognised by other parties in the health services. Coordination efforts and integration of care involves bringing together a range of professionals that bring their respective professional and organisational cultures into their interactions. Commitment to one's professional norms, values and working methods may hinder collaboration. Glouberman and Mintzberg[23,24] argue that fragmented health-care settings require the use of several coordination mechanisms, with emphasis on mutual adjustment (two or more people adapting to each other, often by informal communication) and standardization of norms (establishing common values and beliefs). Professionals may thus more easily collaborate when they share values and beliefs. Improved coordination of care will require professionals to incorporate a more system-wide identification characterized by a mutual attitude of respect, understanding and trust.[23,25]

GPs work alone or in group practices, and they are private contractors who may focus more in the individual patient than the health system as a whole. The GPs in our study emphasised that they need financial compensation for attending meetings with the municipality, as co-payments from patients and remuneration represent a considerable amount of the GP's income. Approximately 70% of the income of GPs is activity based, and the GPs are thus being incentivised to manage individual patients rather than participation in the planning of the health system as a whole. Health professionals who are employed by the municipality may easier find time to contribute in planning activities. These differences may nourish cultural differences between groups of professionals. In other countries where GP's act as gatekeepers, such as the UK and the Netherlands, the GPs are more integrated in the rest of the health system, which may be because of income systems based more on per-capita than activity. Our findings are in alignment with previous studies that suggest GP participation in integrated care models benefits from more formal collaboration, and that the GP's perception of their own role has to be considered when creating models for teamwork in primary care systems.[15]

There is an increased focus on interprofessional collaboration in primary health care. Our results indicate that there could be a tension between GPs and other professionals related to different work practices and cultures, and that all stakeholders need to be involved in the planning and coordination of services. Policy makers and managers may look to ways to change the times and formats of meetings to accommodate GPs' participation, which could include the use of digital media and other digital platforms. Compensatory financial mechanisms could also be considered. The effects of these measures on GPs' participation could be investigated in future studies. We believe that there might be an untapped potential for improving patient care involving GPs more in coordination of services at the system level, and that such involvement might be achieved without major changes in the institutional and financial bonds between the municipalities and GPs.

We wanted to explore GPs' perspectives on and experiences with coordination and care pathways in primary health care, and hence interview GPs. The GPs in our study gave consistent accounts across five focus groups. The consistency across our five focus groups, as well as with findings from other studies, increases our confidence in the results and in the internal validity of the study. This is also strengthened by the fact that the GPs interviewed in our study were from different regions of Norway and they worked in municipalities and cities that differed regarding geography and size. Our sample consisted of engaged and experienced GPs, but we think their views are transferable to experienced GPs in Norway. We used more than one moderator to involve all the authors in the whole process and believe that this gave the authors a better understanding of the themes discussed.

Some of the GPs we interviewed in this study participated in a five-day course on leadership in primary health care that was jointly arranged by the University of Oslo and The Norwegian Medical Association prior to participating in the focus groups. Although two of the interviewers had a dual role as teachers and researchers, the material for this study was based on participants' own perspectives and experiences with coordination and care pathways in primary health care. Due to this position, they were able to address specific issues and concerns.

GPs need informal arenas for dialogue with other primary health-care professionals and access to relevant information to promote coordinated care. There might be an untapped potential for improving patient care involving GPs more in planning and coordinating services at the system level. Financial compensation of GPs contribution may promote increased involvement by GPs.

Ethics

Approval to conduct the study was granted by the Norwegian Centre for Research Data (project number 45929 and 51280).

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship and/or publication of this article: One of the authors has received a scholarship from The Research Council of Norway, as a medical research student. The other author(s) has received no financial support for the research, authorship, and/or publication of this article, but received salary from the University of Oslo.

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