Provider Induced Demand-undermining Primary Health Care?

EFPC Amsterdam
September 1st 2015
PID and the PHT

• How can PID lead to medicalization, - and hereby undermine the main commandment in the Hippocratic oath: ”Primum non nocere”? 

• Is PID growing proportionally with the size of the primary health care team?

• How does professional interests influence the development of PID? 

• How can good leadership of the PHCT reduce PID?
Supplier-induced demand is defined as the change in demand for health care “associated with the discretionary influence of providers, especially physicians, over their patients.”[58] Some research suggests that when patients are faced with a choice of treatments for a condition, local medical practice patterns tend to determine which procedure is used more often.[59]

Authors: Chris L. Peterson and Rachel Burton
The effect that doctors, or other groups of professionals, as providers of services, may have in creating more patient demand than there would be if they acted as perfect agents for their patient
Physician - superior knowledge

Patient-dependency on the physician
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It's not what you say it’s the way that you say it:

Do encounters between health professionals and patients in primary care make a difference to Provider Induced Demand?

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Individual and community participation

The Declaration of Alma Ata (WHO, 1978) states in Paragraph IV:

‘The people have the right an duty to participate individually and collectively in the planning and implementation of their health care’

Primary Health Care is seen as:

‘essentially health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation.’
Hypothesis: the way that health professionals use the encounter can affect demand on services by:

1. Disempowering talk that leads to patients misuse of medicines or not making lifestyle desirable changes e.g. leads to further appointments or prolonged illness and more prescriptions.

2. Trying to be empowering by responding to patients demands e.g. for medication or other treatments that may not be necessary (e.g. antibiotics).

3. Empowering talk that enables patients to be involved in treatment or lifestyle decisions e.g. patient uses less nurse or GP service as they are able to make appropriate supported decisions.

4. Provider induced demand in a state funded health care system such as the NHS is driven by an imbalance in power relationships.
Perspectives on power

Starkey 2003
Argues that empowerment must be underpinned by a conceptualisation of power = handing of power from one to another

Lukes 1974 Three dimensional view of power focuses on a critique of the ways in which those exercising power succeed in ensuring that certain issues do not appear on the agenda, refers to ‘a contradiction between the interests of those exercising power and the real interests of those they exclude’ as latent conflict.

Foucault argues that any exercise of power is accompanied by associated discourses. Some of which are more dominant than others. Notions of disciplinary power (e.g. medical or judicial authority) and pastoral power (nursing or social work) Empowerment would involve redefining the dominant discourse or producing an Alternative discourse (e.g. the disability movement)
Empowerment as professional practice

Empowerment is not something professionals can ‘do’ to people. Rather:

‘..it is a reflexive activity, a process capable of being initiated and sustained only by the agent or subject who seeks empowerment or self-determination. Others can only aid and abet in the process …by providing a climate, a relationship, resources and procedural means through which people can enhance their own lives’

Simon, 1990:32
D: this condition is caused by your smoking. I want you to give up smoking at once. No more cigarettes, do you see? I want you to stop now, do you understand what I mean?

P: Well, doctor its not that easy is it?

D: Well I cant continue to treat you if you keep on smoking in this way

P: well I can try to cut down, but cant you give me some tablets to help?

D: I don’t place much faith in tablets. All you have to do is stop
Scenario 2 Health Visitor – Mother encounter (Kendall, 1993)

M: I was going to ask you, when do you start giving babies cereal, because, err, I've got no idea (laughs)

HV: Yes

M: I know she's only seven weeks now...

HV: Yeah, well the findings from all the experts and nutritionists and the professors and whatnot, is that it's really best if you leave it until about 4 months

M: Really?

HV: Yeah, see there's no real reason for them to have anything else other milk, um, for ever if you like.

M: Really?

HV: Especially breast milk because its proportioned exactly for them... (Four lines on the benefits of breastfeeding)

....er but we say to start at about 4 months and to go very easily to begin with, not a large amount, just small little tastes

M: No I won't give her...

H: You'd be amazed at some babies, I tell you. Some are on more than 3 meals a day by the time they're six weeks...
Scenario 2 Nurse prescriber – patient encounter  
(Knight, Kendall and Thomas 2015)

Becky (*Renal NPx*): So, last time we changed you to...

Keith (*Renal patient*): *[interrupts prescriber]* Do you know what, I’m going to be honest with you, Becky. I do take them. I’m not going to say I don’t take them because I do take them. My wife... You know what my wife’s like, it’s like living with Hitler but... I do take them but it’s like.. I hate the sight of them. I can’t stand the taste of them and they do physically make me heave

Becky: Well, what about going back onto the Sevelamer again?

Keith: Yeah, will you? Because they’re tablets, I’ll swallow ’em, I promise

Becky: Yeah, but we only changed them because you weren’t taking those either

Keith: Yeah, I know, but I was very good... I’ll be very good with them. If you change them back to the other ones, I’ll promise you I’ll take them. I really honestly...

Becky: But you’ve got to take three with each meal

Keith: I’ll take four if I have to but I can’t get them bloody things [lanthanum] down. I love the size of them, they’re quite handy to have but they taste disgusting

Becky: Okay. So if I put you back to Sevelamer, you’re going to try and take those ones?

Keith: Promise you, promise you, promise you

Becky: Okay, but I will check your phosphate next week (laughs)
Some objections to user participation and empowerment

• Patients/users don’t want to make decisions

• Information about risk and uncertainty can be harmful

• It’s too difficult, costly and time consuming to provide relevant information

• Some patients/users will demand too much and thus increase inequity

Coulter, 1997
Empowerment and the encounter

• What are the issues about patient empowerment within an encounter?

• Why would we be concerned with empowering people in health care?

• What have we learned from 40 years of evidence?

• Does an imbalance in the power relationship influence provider induced demand?
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Questions please!
Is PID growing proportionally with the size of the PHT?

Marije Bolt
Occupational therapist
“What is the Matter?”

“What Matters to you?”
Coordinated & integrated care
Is PID growing proportionally with the size of the PHT?
Integrated and coordinated Care

Buurtzorg Plus
How do professional interests influence the development of provider induced demand?

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Introduction

• changes in the health care delivery systems in countries throughout the industrialized world are a threat to the values of medical professionalism

• unprecedented challenges in virtually all cultures and societies influence the practice of medicine
Overview

- definition of medical professionalism
- „disease mongering“
- the strategy to confront the provider induced demand
What is medical professionalism?

*Professionalism is the basis of medicine's contract with society. It demands:*

- placing the interests of patients above those of the physician,
- setting and maintaining standards of competence and integrity, and
- providing expert advice to society on matters of health.
Disease mongering and its players

- Ivan Illich in 1970s argued polemically that the medical establishment was “medicalising” life itself
- 1990s Lynn Payer described widening the boundaries of illness as “disease mongering”
- aspects of ordinary life, such as menopause, being medicalised; mild problems portrayed as serious illnesses i.e. irritable bowel syndrome and risk factors, such as high cholesterol and osteoporosis, being framed as diseases
- stakeholders: pharmaceutical industry, media and medical professionals with common interests
Why/how so?

Medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization.

- Disease mongering exploits the deepest atavistic fears of suffering and death.
- Higher societal expectations: an assumption of boundless needs and wants is at the heart of marketing theory.
- Taking a normal function and implying that there’s something wrong with it and it should be treated.
- Imputing suffering that isn’t necessarily there.
- Practising defensive medicine.
A Physician Charter: principles and responsibilities
Conclusions

• physicians must reaffirm the active dedication to the principles of professionalism
• help improve the healthcare system for the welfare of society
• urge decision makers to promote a renovation in the way diseases are defined
• maintain the fidelity of medicine's social contract during this turbulent time
The truth is rarely clean and never simple.

Oscar Wilde