

Choosing not to choose—Patients' justification of a disengaged choice of primary care provider

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Abstract

A key underpinning of choice of health care provider is that patients make active and informed decisions which stimulate quality competition. By imitating the principles of a market in the steering of health care, patients thus assume the role of consumers. Few patients however neither consider alternative providers nor seek information about quality. The aim of this study was to investigate if and how patients engage in the role of being active and informed consumers in the setting of primary care, and how they argue for their choice. The study was based on semi-structured interviews with 18 respondents in a municipality in mid-Sweden. Respondents were purposefully sampled and interviews were analysed using an inductive thematic approach. Findings demonstrated that patients disengaged from choice by arguing, for instance, that they were satisfied with their current provider or because they perceived no differences in quality. Overall, results were in line with previous studies performed in US and European hospital settings, indicating that patients present some similar arguments regarding disengagement from choice irrespective of level of care or geographical setting. Arguments specifically related to the primary care level were that patients found it more important to achieve continuity in the patient-doctor relationship than 'shopping around' for the best provider,

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or that they desired more profiled services to actively make a choice. In contrast to previous literature, patients refuted the 'patient-consumer' role by referring to, for instance, the belief that care should be of equal quality independent of what choice they made.

KEYWORDS

choice of primary care provider, information search, pragmatic sociology of critique, primary care, public reporting, Sweden, thematic analysis

1 | INTRODUCTION

Active and well-informed patients are a cornerstone in the governance of health systems allowing for choice of health care provider. By applying the principles of the market to the steering of health care services it is expected of patients to act as informed consumers by considering different providers on the basis of information about their services and clinical performance (Le Grand, 2007, 2009). The overall aim of applying market logic to the governance of health systems is to strengthen the role of patients with respect to the health system and improve the quality and efficiency of services being provided (Victoor, Delnoij, et al., 2012). However, the potential benefits of letting patients choose their health care provider are not indisputable. Critics argue, for instance, that the introduction of choice in health care has tendencies to increase inequalities in the provision of care as affluent patient groups may benefit more from choice reforms than those less well off (Fotaki, 2010; Fredriksson & Isaksson, 2022). Also, a vast body of literature shows that patients to a large extent do not conform with the role of a health care consumer. Although patients consider their choice to be active and are interested in information about the quality of services, most patients do not seriously assess other alternatives prior to their choice, and choose default alternatives (Victoor, Friele, et al., 2012; Yang et al., 2018). Furthermore, evidence suggests that few patients in practice seek the types of information or use those information sources that could underpin an informed judgement about the clinical quality of health care providers prior to their choice (Hoffstedt et al., 2021; de Cruppé & Geraedts, 2017; de Groot et al., 2011). This includes information from unbiased information sources, which may describe various aspects of the quality of services, for instance, the staff's competence, patient satisfactions rates, or waiting-times to get an appointment (Hoffstedt et al., 2021).

Knowledge about why patients choose not to actively engage in the choice of a health care provider is limited. Most studies to date have focused on patients' individual characteristics, for example, cognitive, physical, or socio-economic limitations to understanding and making use of quality information (Hibbard et al., 2007; Laverty et al., 2015; Rademakers et al., 2014). The focus on individual characteristics reduces patients' lack of concern for making active and informed choices to a matter of barriers owing to their intellectual or socio-demographic qualities. Previous studies thereby underestimate both patients' awareness of the context they find themselves in, that is, a marketised health care system, and their ability to formulate and choose a countervailing position with respect to this context. Previous studies have furthermore mainly been performed in the hospital setting, restricted to patients who undergo specific treatments, and their experience of the choice process in relation to the organisation of the health system (Aggarwal et al., 2018; Bergin et al., 2017; Victoor et al., 2016). By narrowing their scope to a question of how patients experience the *process* of choice, for example, the use of public performance reports or the impact of providers' geographical distance, these studies limit the range of reasons for not engaging in choice and fail to consider other arguments patients may refer to, such as ideological beliefs or personal rationales to exercise choice. Previous research has thus largely taken patients' approval of their role as active and informed consumers as

self-evident, assuming that patients conform with the market principles behind choice of health care provider. Patients' self-understandings, that is, the extent to which they accept their role as consumers, and how they act to negotiate with or even resist this role is frequently overlooked in the literature.

This study takes patients' own comprehensions of the right to choose a health care provider as its point of departure and assigns them a capacity to critically reflect upon and relate to the expectation of acting as active and informed consumers in a marketised health care system. Furthermore, it complements previous studies by investigating how patients respond to the practice of choosing a primary care provider. Primary care differs from specialised care as it entails a broader population and a set of services which are more commonly utilised. When seeking care at a primary care provider, patients are usually not aware of the cause of their illness or what treatments to expect, which often is the case upon referral to a hospital. Health care treatments offered at the primary care level also seldom comprehend acute and immediately life-threatening conditions. This may result in other rationales to engage or disengage in an active and informed choice than what has been previously found in studies of hospital choice. The first specific aim of this study is thus to study if and how patients engage in the role of being active and informed consumers of health care services in the setting of primary care. The second aim is to investigate how they argue for their commitment, or lack of commitment, and how they negotiate with the expected role of being an active and informed consumer of primary care services.

In the following sections of the study, the theoretical principles behind models of choice in health care are outlined, together with a conceptual framework to support the analysis of patients' arguments for their standpoint on choice of primary care provider. Thereafter, a description of the study setting as well as the methods used in the study is provided. Results are then presented and discussed with respect to previous literature and the conceptual framework. The final section concludes with main results, discussion, and conclusions of the study.

2 | CONCEPTUAL FRAMEWORK

The steering of health care by means of choice of health care provider is based on the principles of a so-called quasi-market. This implies that the state imitates the steering principles of a free market, by allowing for both public and privately run providers to compete for users of their services. Payment then follows the users' choices. However, unlike a traditional market, the price on a quasi-market is fixed and reimbursed through public funding so as to not exclude any users from accessing services due to variation in purchasing power (Carey et al., 2020; Jordahl, 2019). The creation of a pseudo-competitive situation is expected to incentivise providers to increase the quality of services and to be more attuned to the preferences of their users. Providers not chosen by users risk losing income and will eventually have to exit the market (Le Grand, 2007, 2009).

To achieve the aims of provider choice, users are expected to make active and informed choices (Le Grand, 2009; Victoor, Friele, et al., 2012). In a health care setting, this requires of patients to actively consider and compare alternative health care providers by seeking information about their clinical quality and the range of services being offered (Jepson et al., 2005; Victoor et al., 2016). If this prerequisite is not fulfilled, the 'threat' of losing patients due to inferior quality is attenuated. Accordingly, some scholars have argued that the introduction of provider choice not only provides patients with the right to choose, but also entails a duty to make responsible choices. Patients are redefined as consumers, responsible for their own self-realisation and autonomy by means of conscious consumption and life-style choices. Or, to use the terminology of Hirschman (1970), patients are urged to respond to inferior quality of services by means of switching provider, that is, to 'exit' the relationship with a provider if dissatisfied, rather than verbally and directly articulating discontent to the provider in question, that is, using 'voice'. Choice, in this sense, is understood as a liberal practice, a socially sanctioned norm to which adherence is perceived as necessary (Nordgren, 2010; Rose, 1999).

The theory of pragmatic sociology of critique (Boltanski & Elliott, 2011; Boltanski & Thévenot, 1999) takes a different stance in the matter. Rather than adherence it underlines the importance of contestation and hence

individuals' abilities to gain knowledge and to understand, critically reflect upon, and even resist social conventions such as the exercise of choice. It emphasises individuals' abilities to step outside a social context and critically examine not only the practices suggested but also the norms by which the practices gain their status as self-evident. The theory was developed during the mid-1980s by a group of French sociologists, represented by its' leading proponent Luc Boltanski, as well as Laurent Thévenot and Eve Chiapello, and has been recognised as an important contribution to the field of empirical sociology (Holmqvist, 2020; Susen, 2014). Although not commonly used in the field of health policy, it has been widely applied in the similar fields of organisational structures and policy change. The object of interest has been to, for instance, understand competing rationales between profit- and non-profit arrangements in the nursing home sector, and how actors make sense of market reforms in the educational sector (Graß, 2017; Jagd, 2011).

This study argues for the usefulness of the pragmatic sociology of critique in order to illuminate how patients respond or negotiate with their role as consumers of primary care services. The theoretical paradigm of Boltanski and others rose as a critique against a sociological perspective on people's actions as socially sanctioned behaviours, shaped by societal power structures and norms (Blokker, 2011). Instead, it argues in favour of understanding human actions as a result of conscious interpretations and reflections in relation to shifting contexts (Gadinger, 2016; Garnier, 2013). Essential to the understanding of the pragmatic sociology of critique and its application in the current study are the intrinsic notions of *reflexivity*, *critique*, and *justification*. According to the theory of pragmatic sociology people are assigned with a reflexive capacity, which entails the ability to distance themselves from the immediacy of their daily life and reflect upon the world as it is, and the world as it is constructed by norms or self-perceptions (Susen, 2014). People's reflexive capacity is an indispensable part of their ability to practice *critique*. By means of *reflexivity* people not only interpret their own and other's actions, but make moral and critical judgements regarding them.

Critique in this sense, is a means to verbally or through actions denounce people, social conventions, or events that are characterised as unjust by reference to particular situations or contexts (Dansou & Langley, 2012). People often turn to their critical capacity in situations where they perceive inconsistencies in their reality, and feel compelled to restore order to a situation to avoid feelings of anxiety or awkwardness (Boltanski & Thévenot, 1999). According to Boltanski and Chiapello (2018) *critique* of a social convention may appear in different forms and be both explicit and implicit. The first type of explicit critique is labelled as *radical critique*. It is conceptualised as a means to change reality or bring to light perceived injustices of social norms or actions. Hence, radical critique is the 'highest' form of critique as it goes beyond offering resistance within the frames of social conventions and rather points to the possibilities of an alternative value-system (Boltanski & Chiapello, 2018). The second type of explicit critique is referred to as the *corrective critique* and is defined as a way to criticise a system or an event as unfair but without questioning the underlying norms underpinning the unfairness in the situation (Boltanski & Elliott, 2011; Holmqvist, 2020). The third and final type of critique is implicit in its' character and is illustrated by individuals who choose not to conform with the established rules of a given social order by circumventing or refusing to play along with established norms, so called 'exit critique' (Boltanski & Chiapello, 2018).

The notion of *critique* is closely related to the notion of *justification*. *Critique* presupposes *justification*, as critique may not be arbitrarily grounded, but must be underpinned by arguments that the counter-part accept as legitimate. Hence, by *justification* it is implied that people try to convince others of the legitimacy of their critique by providing arguments for their acceptance or rejection of prevailing norms. The legitimacy of the argument rest on what Boltanski and Thevenot call 'orders of worth', that is, various forms of value-systems (e.g., the market order, the domestic order or civic order) which people turn to when criticising or defending deviant actions in relation to established social norms (Boltanski & Thévenot, 2006; Gadinger, 2016).

Different people addressing the same issue of dispute may turn to different value-systems or mixtures of value-systems to justify their critique (Holden & Scerri, 2014). However, most importantly, acts of critique and justification may be perceived as crucial to societal change. Without these abilities, individuals would not be able to challenge

institutionally confirmed truths and realities, reproduce them, or open up for new ways to organise social life (Boltanski & Elliott, 2011; Diken, 2015).

3 | STUDY SETTING

The study was performed in the setting of a Swedish primary health care system, which provides scheduled and unscheduled health services relating to general medicine, rehabilitation, psychosocial care, health promotion, and preventive care (The Swedish Agency for Health and Care Services Analysis, 2017). Both primary care and specialised care is politically governed through 21 geographically organised regional health care authorities. The health system covers all Swedish residents and is mainly publicly financed through taxes. Voluntary private health insurance exists, but remains rare (Glenngard, 2020). In contrast to the organisation of primary care in many other western European countries, where care is mainly organised around single General Practitioners, primary care in Sweden is mostly organised in larger units called primary health care centres (PHCCs). The PHCCs consist of multi-professional teams covering competencies such as doctors, nurses and counsellors (Glenngard, 2020).

Since 2010, when the provider choice reform in primary care was introduced, patients have had a legal right to choose between public and privately run PHCCs (Vengberg et al., 2019). Three regions also offer the opportunity to choose a specific doctor at the PHCC (Choose a health care provider, 2022).

For the purpose of the study, the setting is interesting for two reasons. First, the introduction of choice of primary care provider in Swedish health care has been seen as a rupture with the tradition of organising health care according to the collectivistic principles of universality and equity (Fredriksson et al., 2013). The reform entailed that a form of quasi-market replaced the earlier planned system of primary care, where the regional authorities determined reimbursement levels and where to geographically establish PHCCs in order to distribute resources evenly and to guarantee equal quality. Patients had no choice of provider, but were assigned to the provider closest to their residence (Isaksson et al., 2016; Vengberg et al., 2019). With the legislation on choice of primary care provider, regions were required to allow both for-profit and non-profit private providers to freely establish their businesses with the right to receive public funding, and that reimbursement should follow patients' choices (The Swedish Parliament, 2017). This potentially paved the way for providers to establish their businesses in areas with a healthier population, thus creating an uneven distribution of health care resources. Furthermore, it entailed a risk that only patients who valued choice and who had the personal resources (e.g., educational level, social capital, cognitive skills) to choose the optimal provider in terms of clinical quality would benefit from the reform, and that other groups of patients would be less advantaged (Fredriksson et al., 2013).

Hence, the study setting offers a possibility to investigate how people position themselves in the face of a new social order, which potentially challenges a strong belief in that health care should be of equal quality regardless of socio-economic preconditions or what choices are made.

Second, the design of the patient choice system offers both opportunities and barriers to engage in an active and informed choice of primary care provider. Among the opportunities is the right for patients to choose between both privately and publicly run primary care providers within as well as outside their region free of charge, and switch providers up to two times a year (Choose a health care provider, 2022). Most patients in Sweden also have access to more than one provider within a reasonable geographic distance (Swedish Competition Authority, 2014). Furthermore, regions are mandated to provide patients with easily accessible information about their right to choose a PHCC and the different PHCCs to choose from (The Swedish Parliament, 2008). Among the barriers is that choosing a PHCC is not required. Patients may seek care at any PHCC they wish without being enrolled with a specific provider. In some regions, patients are also automatically enrolled with the geographically closest PHCC if they do not actively make a choice (Choose a health care provider, 2022). Consequently, as patients may choose between several courses of action in seeking care, the study setting provides a broader range of positions in terms of critiques and justifications with respect to actively choosing a primary care provider.

4 | METHODS

4.1 | Study design

Central to understand how people critique or try to negotiate with existing social conventions, such as the expected role of being an active and informed consumer in the setting of primary care, are their verbally expressed arguments. Therefore, we made use of a qualitative design, based on interviews with individuals who had encountered a choice situation in primary care.

4.2 | Sample and data collection

To obtain a sample suitable for investigating how patients engage or rather negotiate with the role of being active and informed consumers of health care services in the setting of primary care we used a purposeful sampling technique. Purposeful sampling is commonly used in qualitative methods with the purpose of better understanding individuals' or groups' experiences and to develop concepts or theories. This is achieved by selecting 'information-rich cases', that is, individuals that have experience from or have great insight in the studied phenomena (Devers & Frankel, 2000; Palinkas et al., 2015). In this study a 'maximum variation' sampling strategy was selected with the objective of achieving heterogeneity concerning respondents background characteristics, and thus to cover the widest possible range of experiences of choosing a primary care provider (see Table 1) (Flyvbjerg, 2006; Patton, 2002). This study received ethical approval from the Swedish Ethical Review Authority (Dnr. 2020-01796).

The respondents were recruited via contacts with local non-profit associations, workplaces, trade unions, political associations, and public institutions. Respondents were in turn asked to forward the request to other potential respondents. Some respondents were also recruited directly through social networks and by means of snowball sampling. Consent to participate in the study was obtained both orally and in written form. Prior to each interview the interviewer described the written information orally and invited participants to request any clarifying information about the study. The principle of data saturation was used to assess the adequacy of the purposeful sampling. By data saturation is meant that additional interviews are performed until the new data collected no longer contained new perspectives on the studied phenomenon not already found in the data collected in the former interviews (Saunders et al., 2018). We made the assessment that data saturation was reached already after having performed 9–10 interviews, after which point no new perspectives on the studied phenomena were identified. Interviews nevertheless continued in order to fully ensure that all essential aspects on the matter were covered until the final sample size of 18 was reached. Interviews were conducted from June 2020 to November 2020 with residents from a municipality in mid-Sweden, including both densely populated- and rural areas. The interviews were held through the online meeting program Zoom ($n = 11$), by telephone ($n = 6$) and face to face ($n = 1$). On average, they lasted 55 min and were conducted, recorded, and transcribed verbatim by the first author. All interviews were performed in Swedish, but in one case an interpreter was used as the respondent had another native language and was not fluent in Swedish.

Inclusion criteria for participating in the study were: age 18+, registered as living in Sweden, and experience from choosing and seeking care at a PHCC. The interviews were semi-structured and based on a protocol with open-ended interview questions. Interview questions invited respondents to talk about their experience of the choice situation, how they made their choice of primary care provider, and their position towards the ability to choose. One pilot-interview was conducted to test a draft protocol, which was then scrutinised by the research group to which the authors belong.

TABLE 1 Demographic characteristics of study participants ($n = 18$).

Gender	Numbers
Female	9
Male	9
Age	
20–30	4
31–40	2
41–50	4
51–60	3
61–70	3
71–80	2
Place of living	
Urban	14
Rural	4
Level of education	
Elementary school	1
Upper secondary school	9
University studies	8
Employment	
Full time/part time employed	7
Entrepreneur	2
Student	2
On sick leave	2
On parental leave	1
Pensioner	4
Country of birth	
Sweden	14
Other European country	0
Outside Europe	4

4.3 | Analysis

Inductive thematic analysis inspired by Braun and Clarke (2006) was used to analyse the transcribed material with the purpose of identifying, organising, and reporting patterns (themes) within the material which could describe the arguments respondents used for their commitment or lack of commitment in the choice. Its strengths as an analytical tool are that it allows the investigation into how respondents experience a phenomenon and how those experiences relate to-, or diverge from one another. It is particularly useful as a tool to grasp and summarise key features of a rich data material (Nowell, Norris, White, & Moules, 2017). Hence, this method of analysis was deemed suitable to examine patterns in how patients argue for their choice or non-choice of primary care provider.

According to Braun and Clarke (2006) there are no explicit criteria to determine a theme. A theme is not identified through quantifiable measures, but rather by merging different descriptions of experiences which often have no meaning when viewed alone. Its significance is determined in relation to its ability to bring meaning to the overall research question and has been defined as something that '(...) captures and unifies the nature or basis of the experience into a meaningful whole' (DeSantis & Ugarriza, 2000). Table 2 describes the steps that were taken to identify the essential themes and subthemes which may describe respondents' arguments for adhering or not adhering to the social conventions of an active and informed choice of primary care provider. Hereafter, main- and subthemes are

replaced with the terms main- and sub-arguments to better align with the terms used in the conceptual framework. The arguments were identified on a semantic level, meaning that only meanings on a manifest level of the data, and not anything beyond what respondents had said, emerged in the arguments.

Table 3 below reproduces an excerpt of the coding scheme to illustrate the process of thematic analysis.

5 | RESULTS

Overall results confirmed conclusions in previous studies by demonstrating that a dominant share of the sampled respondents did not engage in the role of being an active and informed consumer of primary care services. Although some respondents indicated that they had experience from switching or seriously had considered switching PHCC, it

TABLE 2 Process of thematic analysis inspired by Braun and Clarke (2006).

Steps of thematic analysis	Process	Outcome	Performer/-s
Step 1	Reading through the entire transcribed material.	Obtaining a sense of the whole.	First- and co-author
Step 2	All text segments that included arguments related to engagement or disengagement from making an active and informed choice of a primary care provider were marked and organised in a table in the form of meaning units.	Table with meaning units	First author
Step 3	Summation of each meaning unit into condensed meaning units.	Table with meaning units and condensed meaning units.	First author
Step 4	Coding of each condensed meaning unit.	A first coding scheme to be used in the further analysis.	First author
Step 5	Scrutiny of the coding scheme's adherence to the transcribed material. Supplementing of new codes which were missing in relation to condensed meaning units. Revision or removal of codes which overlapped or had similar wording.	Revised and validated coding scheme	First- and co-author
Step 6	Application of revised coding scheme on condensed meaning units. Further adjustments of coding scheme. Preliminary organisation of codes into main- and sub-arguments.	Final set of coding scheme with adhering preliminary main- and sub-arguments.	First author
Step 7	Main- and sub-arguments checked and revised in relation to the final coding scheme.	Twelve main-arguments Eleven sub-arguments	The entire author team
Step 8	Reduction of the number of main-arguments through merging arguments with a similar or overlapping meaning.	Four main arguments Twelve sub-arguments	The entire author team

TABLE 3 Example of coding of the transcript.

Informant	Meaning unit	Condensed meaning unit	Code	Sub-argument	Main-argument
Respondent 7, pp. 104, line 4952–4959	<p>Interviewer: but the choice of a PHCC, does it feel the same way, that it influences the society?</p> <p>Informant: 'No, it does not, because in this case I believe it should not matter so to say, you should be able to be completely calm about wherever you live, somehow, it should be good care, it should be a good school, somehow, and it should not be segregated in any way... it should fall under one and same...and it's a part of a welfare society somehow, I mean because this, somehow, has an impact on segregation and everything I would somehow guess...'</p>	It should not matter which PHCC you choose. They should be of equal quality regardless of their geographical location.	There should not be differences	Care should be equal	Do not want to choose

Abbreviation: PHCC, primary health care centre.

was found that all respondents, but one, had neither considered more than one alternative prior to choosing or switching, nor searched for the types of information or information sources that could underpin an informed choice. Hence, in the following section respondents' main and sub-arguments for disengaging in the choice of a primary care provider are further described.

5.1 | Don't want to choose

Respondents' first main argument for their non-choice of a primary care provider was that they did not want to make a choice in order to access primary care services of good quality. Two sub-arguments were used to support the main argument including *Tired of Choosing* and *Care should be equal*.

5.1.1 | Tired of choosing

The first sub-argument concerned being tired of choosing and feeling overloaded by all the choices one had to make. This lack of enthusiasm towards actively choosing a primary care provider made respondents question the value of choice, but also made them less eager to seek and consider information about different alternatives.

(...) sometimes it feels like it would just be easier if there was a good alternative from the beginning.
(Respondent 13)

5.1.2 | Care should be equal

The second sub-argument was underpinned by the ideological standpoint that health care services should be equally provided. Although respondents were somewhat aware of the differences in quality between providers, they argued that the health care system should ensure equal care independent of what choice they made.

(...) it shouldn't matter so to say, you should be able to be completely calm about wherever you live, somehow, it should be good care (...) it should fall under one and the same...and it's a part of a welfare society (...) (Respondent 7)

5.2 | Can't choose

The second main argument 'Cannot choose' revolved around the lack of sufficient knowledge to be able to perform the choice and to judge the differences in quality between primary care providers. The argument was based on three sub-arguments: *Lack of system-knowledge*, *Lack of quality information*, and *Lack of experience*.

5.2.1 | Lack of system-knowledge

Not being aware of the right to choose or how to practically perform the choice, that is, the lack of system-knowledge was one of the sub-arguments which underpinned the main argument 'Cannot choose'. For instance, respondents did not always understand how and where to register at a primary care health centre or where to turn to get in touch with someone who could assist them in choosing or switching to a different provider.

(...) I don't know whom to call to like switch Primary Health Care Centre... Ehh... So that may be the reason why I don't... Dear... Dear to make a call for it to happen. (Respondent 14)

5.2.2 | Lack of quality information

The second sub-argument concerned the lack of sufficient information describing similarities or differences in the clinical quality of providers, which made it difficult to have an opinion of what provider to choose over another.

(...) I haven't done any large-scale information seeking, but it's nothing that I've found...ehh...that these primary health care centers try to promote themselves if you see what I mean (...) (Respondent 4)

5.2.3 | Lack of experience

Respondents also argued that they lacked sufficient experience to be able to evaluate the quality of primary care providers in advance, but that they rather preferred to choose a primary care provider through trial and error.

(...)in my case it's more about how I think, what I feel and that's not something I will know about until I actually tried it out. (Respondent 16)

5.3 | Want other choices

The third main argument 'Want other choices' was the belief that the alternatives to choose from were not sufficient or adequate, and consisted of two sub-arguments: *No clear options* and *Would rather choose a doctor*.

5.3.1 | No clear options

The first sub-argument—'No clear options'—revolved around what services providers could offer for it to be worth choosing. Respondents had the impression that providers did not offer any special kinds of services or excellence in quality, and that they appeared to provide similar services. A desire was expressed that providers should target their services to different groups of patients, for example, to specialise in sports medicine or maternity care, in order to make it more relevant to engage in choice.

No, but I guess, anyway that's something you should develop, you should maybe niche the primary health care centers a bit. So today, to me everyone is a grey haze, in my opinion. (Respondent 6)

5.3.2 | Would rather choose a doctor

The second sub-argument raised to not engage in the choice of a primary care provider was the desire to choose a doctor rather than choosing a PHCC. Respondents highlighted the importance of achieving a personal patient-doctor relationship based on continuity, as they thought this would better ensure the doctor's knowledge of their medical history and health status.

(...) but I believe this opportunity to choose a doctor is more important (...), because, after all, at the Primary Health Care Centre you're a nobody, while with the doctor you become a patient (...)
(Respondent 6)

5.4 | Don't see any reasons to choose

The fourth and final main argument 'Don't see any reasons to choose' concerned the lack of a true rationale to choose. The main argument was supported by the use of five sub-arguments including *No need of care*, *Satisfied with current provider*, *Trust in equal care*, *Convenience is more important* and *Seeking care elsewhere*:

5.4.1 | No need of care

In the interviews it was argued that not being in need of care or feeling sufficiently healthy made it unnecessary to actively consider different primary care providers, or to search for information about the types and quality of services offered.

(...) but maybe I would have made a more active choice if I had been a recurrent patient or somebody who had to seek care several times or more often or so. (Respondent 4)

5.4.2 | Satisfied with current provider

An overall satisfaction with the quality of services being provided by the current primary care provider was another sub-argument to not engage in the choice.

But why should I know about that (the quality of other PHCCs) if I say so? I think so, and it works. And then I don't believe there's any reason to start look for another. (Respondent 3)

5.4.3 | Trust in equal care

Furthermore, respondents argued they had an overall trust in that PHCCs provided equal care, which made them believe they did not have to engage in a choice to receive care of good quality.

I believe it's like...ehh...all clinics follow the same law and they have, well they do the same stuff, so I don't believe there is a big difference if I'm enrolled at this place or if I stay at the other place. (Respondent 12)

5.4.4 | Convenience is more important

Another sub-argument raised to not consider different primary care providers on the basis of information about their services and quality was the issue of convenience. Respondents described that the choice was more or less based on a routine or old habit and argued that it was, for instance, more important to be geographically close to a provider or to belong to the same provider as one's family members than optimising the choice in terms of superior quality or services.

(...) it's usually like that, when you're in need of a primary health care center then public transport or going by bike is not the first option, but it will be, it will be (...) inconvenient to take the children over there. (Respondent 17)

5.4.5 | Seeking care elsewhere

Respondents also argued that they did not see any reasons to engage in the choice of primary care provider since they believed they could receive equal and faster health care services by turning to other health care providers, for instance by calling the national telenursing service, turning to an outpatient emergency care clinic or directly to the hospital nearby. Making use of private insurance, and thus turning to providers outside the public system, was another example mentioned.

In my mind, either I call "1177" (Swedish national telenursing) or I go to the local emergency ward if it's something urgent...because what I heard from my friends who live in town or who come from here, you have to wait quite a while to get an appointment to a doctor. (Respondent 12)

6 | DISCUSSION

The aim of this study was two-folded. First, it was investigated if and how patients engaged in the role of being active and informed consumers of health care services in the setting of primary care. Second, it was investigated how they argued for their commitment, or lack of commitment, and how they negotiated with the expected role of being an active and informed consumer of primary care services. Overall results confirmed what has been identified in previous studies, namely that few patients engaged in the active and informed choice of a primary care provider by seriously considering different alternatives on the basis of unbiased information about the clinical quality of services. To some extent, the study also verified previously identified reasons to disengage from the active consumer-role. Yet, it also uncovered new arguments not found in previous work. Generally, results suggest that patients justified their disengagement from choosing a primary care provider using several distinct arguments. Patients argued they did not see any reason to choose, for instance, due to satisfaction with the current provider or because they trusted providers would offer equal clinical quality. Patients also argued they could not choose, for instance, due to the perceived lack of information about the alternatives to choose from. These results were similar to those found in previous studies performed in an Anglo-Saxon or Dutch specialised health care setting (Aggarwal et al., 2018; Bergin et al., 2017; Victoor et al., 2016), indicating that several arguments to resist the consumerist role within primary health care may be independent of health care- or country setting. However, findings in this study also point to there being certain arguments which were more salient with respect to the primary care level. One example was patients' desire to choose and stay with their own doctor instead of 'shopping around' for the 'best' PHCC. As patients in general more frequently attend a PHCC than the hospital, they regarded it as more important to remain with the same doctor to ensure that someone kept track of their medical history and were familiar with their health care needs. Another example was patients' dissatisfaction with the range of services they could choose from, and the perception that choice would only be meaningful if services were more differentiated among PHCCs. It could be, however, that these results were specific to the Swedish health care setting. Unlike other Nordic and Western European countries where patients can choose and register with a specific GP, most regions in Sweden only offer the opportunity to register with a PHCC. Furthermore, the perception that PHCCs did not differ with respect to offered services could be the result of country-specific characteristics such as the design of the reimbursement system.

In contrast to previous findings (i.e., Aggarwal et al., 2018; Victoor et al., 2016), this study also demonstrated that patients actively refused the role of active and informed consumers of health care services by arguing the responsibility of actively choosing a primary care provider in order to ensure quality should not be imposed on them. Patients also indicated they felt an overall 'choice fatigue', which made them less eager to engage in choice. From a theoretical perspective, findings thus support the principal ideas of the theory of pragmatic sociology of critique (Boltanski & Elliott, 2011; Boltanski & Thévenot, 1999) as they demonstrate patients' capacity to both critically reflect upon and actively negotiate with the social conventions of choosing a primary care provider by means of verbally expressed justifications. In the following, patients' main and sub-arguments justifying their disengagement from making an active and informed choice of a primary care provider are discussed with respect to the different types of system critique outlined in the conceptual framework of pragmatic sociology of critique (see Figure 1 for an overview).

'Don't want to choose' was a main argument to justify disengagement from an active and informed choice and may be conceived of as a justification of the radical type of system critique in the framework of pragmatic sociology (Boltanski & Elliott, 2011). By arguing that access to primary care services of equal quality should not be dependent on choice, patients partly invoked other norms which they thought should guide the steering of primary care and thus tried to disrupt the very premises of choosing a primary care provider.

Other main arguments used by patients to justify their disengagement in the choice of a primary care provider, 'Can't choose' and 'Want other choices' concerned practical barriers to assuming the role of an informed consumer of primary care services. This overall dissatisfaction with the 'system design of choice of primary care provider' may be understood as the corrective system critique in the framework of pragmatic sociology (Boltanski &

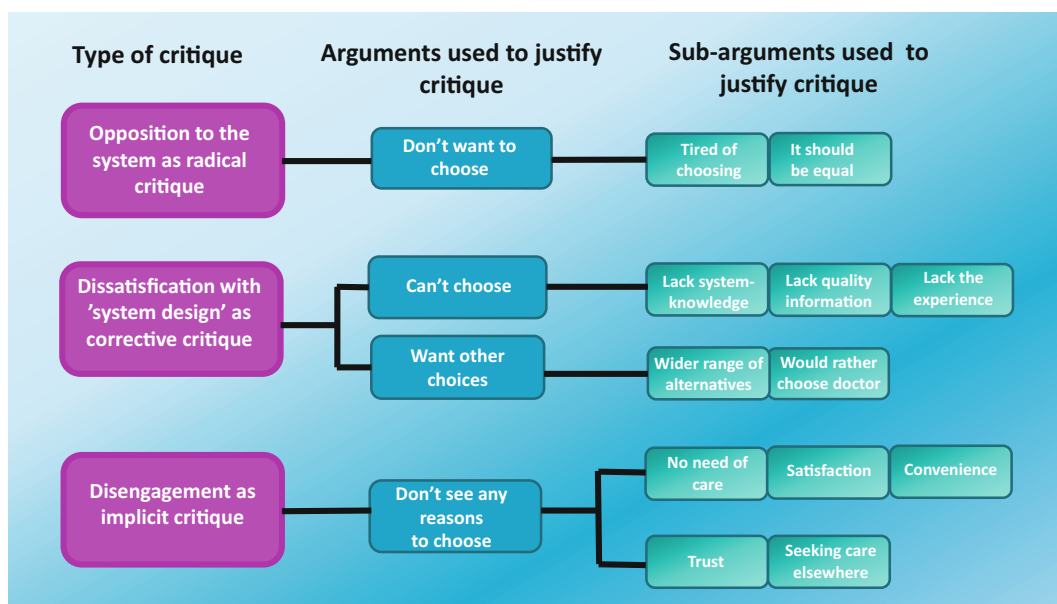


FIGURE 1 Arguments and sub-arguments used by respondents to justify different types of critique towards choice. [Colour figure can be viewed at wileyonlinelibrary.com]

Chiapello, 2018)—as patients did not criticise the underlying premises of a marketized primary health care system, but rather the implementation of *how* choice and competition in primary care was carried out. The fourth and final main argument ‘Don't see any reasons to choose’ was underpinned by several sub-arguments including the belief that convenience (e.g., choosing the geographically closest provider) was more important than opting for the best clinical quality, and satisfaction with one's current primary care provider. In line with the ideas of pragmatic sociology of critique, these arguments could be perceived as a justification of the exit critique, that is, implicitly criticising a system by trying to escape or circumvent its' established norms (Boltanski & Chiapello, 2018). However, another interpretation of the results is that patients ignored the expected rules of the social convention but still accepted its core foundations. In practice, patients believed they had made a choice of a primary care provider although not according to the expected premises, that is, by evaluating different providers on the basis of information about their services and clinical quality. Holmqvist (2020), suggests a revised type of the exit critique—‘disengagement as implicit critique’—which is argued to comprehend both the escape from socially sanctioned norms (e.g., not choosing a primary care provider at all), and the acceptance of established conventions but without conforming to the established procedures (e.g., making choices of a primary care provider on other criteria than expected).

The results also entail theoretical implications with respect to the microeconomic assumptions underlying the steering principles of choice of primary care provider, that is, the idea that patients will stimulate quality by means of active and informed choices (Le Grand, 2009). Although several patients in the study had made a choice of primary care provider, few based their decision on information which could guide their evaluation of the quality of the different providers. Consequently, it is questionable whether patients' choices constitute sufficiently strong signals to incentivise market competition on the basis of clinical quality.

From a policy-perspective study results may contribute to the future design of choice systems in primary care. While some patients expressed a reluctance towards choice per se, others seemed to be more interested in choosing if the design of the system would better meet their demands and expectations. The results indicate that the primary care health market—at least in the Swedish setting—has not materialised to the extent expected when introducing the choice reform in primary care. Results also call attention to the inequalities that might arise in a system which

relies heavily on patients' individual capacity to seek out care providers. Although most knew they could choose a primary care provider, there were patients who were unaware about this possibility or of how to practically exercise choice. Regional health authorities and providers themselves should therefore take further measures to ensure that all patients can use their right to choose in practice and to safeguard that all providers fulfil certain quality criteria irrespective of patients' choices. Finally, this study stresses the importance patients attach to choosing their own doctor. Some patients perceived that having access to the same doctor was more important than being able to choose a PHCC. Allowing choice of both a GP and PHCC could be a fruitful avenue in the further development of the design of choice systems in Swedish primary care.

6.1 | Methodological considerations

The study sample included respondents with various demographic and socioeconomic characteristics, which maximised the breath of perspectives on choosing a primary care provider. Furthermore, as all but one interview were performed digitally, this allowed for integrity in the interview situation, and consequently the possibility for respondents to feel more relaxed and able to disclose sensitive information on the study topic. Additionally, interviews were performed up to and beyond the point where data saturation was achieved. This resulted in a rich set of data consisting of more than 300 pages of transcribed interview material. Together, these prerequisites contributed to the ability to identify as many perspectives as possible on the role of active and informed consumers of primary health care services.

Nonetheless, it could not be excluded that the composition of the sample might have affected the types of and numbers of possible opinions on the studied phenomena. Also, the data collection technique, could have restricted the interviewer's possibility to observe face- or body expressions, potentially leading to the prevention of further probes and the investigation of additional justifications of respondents' disengagement from choice (see for instance Novick, 2008, concerning bias in telephone interviews).

7 | CONCLUSIONS

Great faith has been placed in patients being both capable and willing to actively choose a health care provider to stimulate competition between providers and thus foster increased quality and responsiveness of services.

The aim of this study was first to investigate if and how patients engaged in the role of being active and informed consumers of health care services in the setting of primary care. Second, it was investigated how they argued for their commitment, or lack of commitment, and how they negotiated with the expected role of being an active and informed consumer of primary care services. Overall results demonstrated that respondents did not engage in the active and informed choice. Main reasons to not engage in the active and informed choice were that patients saw no real reasons to choose, that they lacked necessary prerequisites to choose or that they did not want to choose to receive primary health care services of equal quality. Some of these arguments were in line with previous studies, while others appeared unique to the primary care setting. Overall, results indicated that patients tended to challenge the steering logic of patient choice by not aligning to expected conventions on how to perform the choice, that is, by neither actively considering different alternatives of primary care providers nor seeking information about clinical performance.

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CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

Author elects to not share data.

ETHICS STATEMENT

This study was approved by the Swedish Ethical Review Authority on 8 June 2020 (Dir.: 2020-01796).

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