

# Improving access and managing healthcare demand with walk-in clinic

## Convenient, but at what cost?

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### Abstract

**Purpose** – Poor access to healthcare and increasing demand for services represent a management dilemma how to balance between needs and costs. Scrutinising the concept of demand management and using a case study from Finnish primary care, the purpose of this paper is to examine the complexities of managing demand for health services.

**Design/methodology/approach** – Convenience has explained the popularity of walk-in clinics (WIC), making it an attractive demand management tool. By analysing the quantitative service utilisation data of frequent attenders at WIC, the paper exemplifies what enhanced access to care means for demand management of public welfare services.

**Findings** – High user rates and satisfaction indicate demand for this type of service; however, the establishment of WIC provided supplementary care for the high users of health services, most suffering chronic diseases.

**Research limitations/implications** – Better understanding of the structure of service demand is needed in order to develop a more coordinated service system and to manage demand for public welfare services.

**Practical implications** – The study demonstrates the importance of identifying service utilisation patterns in managing demand. Instead of single solutions, a wider system-level perspective is essential.

**Originality/value** – Managing demand and facilitating access are core primary care attributes but there is little evidence about the impact of demand management strategies. The paper ties together important healthcare management issues: how to control demand and improve the access? Moreover, few studies have examined the frequent attendance at WIC. This paper presents a practical illustration of demand management tool and indicates some demand management problems to be considered in healthcare management.

**Keywords** Finland, Access, Primary care, Demand management, Walk-in clinic

**Paper type** Research paper

### 1. Introduction

Due to the mismatch between evolving needs and scarce economic resources, the main impetus for reforming public welfare services seems to be similar: to make public services cost effectiveness and more responsive to citizen needs by increasing consumer choice (cf. Sanderson, 1996; Bolton, 2002; Krasnik and Paulsen, 2009). To balance the tensions between resource scarcity and citizen responsiveness, demand management has been considered as a one possible healthcare management strategy. It is premised on an assumption that patient empowerment and health promotion are the key issues to reduce inappropriate use and thus healthcare costs (Vickery and

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Lynch, 1995; Mohler and Harris, 1998). Nonetheless, as we argue, the adoption of those solutions may still be problematic in practice: how to curb demand on one hand and on the other respond to citizens' expectations for timely access to care?

Consequently, understanding the complexities related to managing demand and facilitating access to public services becomes essential. One solution introduced to this dilemma is the walk-in clinic (WIC) (walk-in centre, retail clinic, *terveyskioski*), which provides health counselling and treatments for minor illnesses. Located in shopping centres, WICs offer extensive opening hours and easy walk-in access. There is a longer tradition of WICs, especially in the USA and Britain, but in Finland, clinics are novel, local healthcare services provided by nurse practitioners free at the point of use and without the need for an appointment unlike in traditional community health centres. The initial purpose to establish WICs were to enhance accessibility, user satisfaction, promote health and redirect minor illnesses from health centre to WIC. However, WICs attracted a group of regularly visiting users (Kork *et al.*, 2015).

On the evidence of the Finnish WIC, we exemplify the ambiguity of such a demand management tool. The aim of this paper is to critically explore the complexities of healthcare demand management in local government. More specific research questions are the following:

- RQ1. How is demand management understood in health services research?
- RQ2. What does the walk-in access in one point local service system mean for service utilisation and demand management as a whole?
- RQ3. As only a small part of the population uses most healthcare resources, what do we know about the frequent attenders using the WIC and how is this information utilised in management?

Previous studies on demand management in health services have called for further research examining the effectiveness of demand management strategies by using multidimensional approaches (cf. Mohler and Harris, 1998; Mark and Shepherd, 2004; Brogan *et al.*, 2008; Jack and Powers, 2009; Fryer and Smellie, 2013). Instead of focusing on the success of a single management tool as such, we seek to understand the complexity of managing demand for health services by examining WICs from a public management perspective in the context of healthcare demand management. Although WICs have been studied since the early 2000s, the literature concerning the impact of WICs on other services has been relatively scarce and the evidence of the effects on demand has been mixed (cf. Mehrotra and Lave, 2012; Desborough *et al.*, 2012; Arain *et al.*, 2015). Research is therefore needed to explore WICs effectiveness within the framework of primary care demand management and accessibility, for instance, by scrutinising the reasons for repeat attendance at WICs (Maheswaran *et al.*, 2009). To demonstrate the (conflicting) outcomes of implementing a form of demand management strategy in local government, we explored frequent attenders and their usage of other services.

Accessibility has explained the popularity of WICs. Accordingly, the major objectives of WICs have been very similar in many countries: to improve access, cost efficiency and patient satisfaction (Salisbury and Munro, 2003; Mehrotra and Lave, 2012; Desborough *et al.*, 2012). The Finnish version of the WIC is built on the same idea, albeit the context and the practices are slightly different. WICs are part of the primary healthcare services organised by the municipality. By the support of the Finnish Innovation Fund (Sitra), the first WIC was piloted in 2009 in Ylöjärvi, a fast growing

small town with a stable economy and where the well-being and health of citizens are highly prioritised. As the proportion of children and elderly is estimated to rise creating the demand for welfare services, it was assumed that the early detection of diseases and walk-in access to care would increase citizen satisfaction to public services as well as help manage demand: diverting minor treatments from the community health centre to the WIC would allow general practices to focus on more complicated cases. A previous study (Kork *et al.*, 2015) has shown that patient volume and satisfaction with the WICs were high but urged evaluating the effectiveness of WICs more broadly, particularly whether they had increased the demand for services. On one hand WIC offers better access for citizens, but on the other hand it seems to increase the total number of municipal outpatient visits[1]. Moreover, the trend of the same regularly consulting patients indicate a long-term client relationship, which was an antithetical purpose for providing the facility (“quick and easy to drop by”). For these reasons, more specific data of the frequent attenders and their service utilisation are needed.

The paper is structured as follows: next we present the conceptualisations of demand management as theoretical and practical approaches in the healthcare literature. Then in Section 3, we illustrate the Finnish demand management policy in the local government context and its practical implications by characterising the frequent attenders and their service utilisation at Finnish WIC. In the discussion section, we reflect the results of case analysis to theoretical argumentations regarding healthcare demand management and highlight the problems of managing local demand.

## 2. Demand management in healthcare

Demographic changes, rising healthcare costs and increasing demand for welfare services put many governments under pressure to reform public services. Financial constraints force local authorities to find innovative ways to control cost and demand. Instead of cutting healthcare services, demand management is seen as a solution to healthcare cost reduction, quality improvement and managing demand fluctuations (Brogan *et al.*, 2008; Jack and Powers, 2009; Eitel *et al.*, 2010; Lee *et al.*, 2013). However, these compounded problems reflect the complex and dynamic nature of healthcare and thus call for examining interconnections of complex interventions (Zimmerman *et al.*, 1998; Clark, 2013).

### *Conceptualisation of demand management*

Demand management covers range of approaches. As a concept, demand management varies across academic disciplines and also reflects the cultural and political background of healthcare system. Healthcare demand management originated in the USA where it is connected to market perspective. To ensure appropriate requesting through price and availability it is often related to utilisation management (Mohler and Harris, 1998; Plebani *et al.*, 2014). In public health systems, for example in Britain, orientation has been in public policies aimed at improving service supply or access through reorganisation and demarketing of health services (Laing and Shroyama, 1995; Mark, 2005). Managing demand means not only limiting the utilisation, but to shape the demand so that the needs are matched (Pencheon, 1998).

Theoretically demand management refers to managing the balance between supply and demand. In economics it implies managing prices or supplied quantity, for instance in health economics discussion has concerned issues of allocating scarce healthcare resources. Controlling the demand for healthcare is considered problematic as there are

factors such as uncertainty, information asymmetry, externalities or market failure affecting supply and demand for health services (cf. Mooney, 2003). Some economists have argued that public policies often aim at managing the supply side, controlling the utilisation of healthcare services rather than managing demand or the patients' needs for services (Rice and Unruh, 2009; Ensor and Cooper, 2004; Mark *et al.*, 2000).

In local demand management the distinction of the terms "need" and "demand" becomes especially relevant. Limited resources means a dilemma for healthcare managers: how to respond to citizens' expectations with the available resources? According to Vickery and Lynch (1995) demand consists of four elements: morbidity, perceived need, patient preference and non-health motives, of which the perceived need and patient preference are considered the most potential elements of managing demand. But this requires understanding how the demand is initiated and to what desires public services should respond to (Sheaff *et al.*, 2002).

However, health services research is mostly interested in finding management strategies to ensure appropriate use of services and clinical resources. Demand management became a key development theme in the late 1990s when Vickery and Lynch (1995) framed the basic premises. They stated that the inappropriate use of medical care could be reduced through informed choice and self-care (Vickery and Lynch, 1995). In the first phases, the focus was more on the supply side – curtailing and controlling clinical activities; but subsequently patient choice, empowerment and participation were emphasised (Rogers *et al.*, 1998; Mark *et al.*, 2000). In healthcare management research, managing demand has meant controlling patient flows, supply chains and waste by utilising lean approach, queuing theories, simulation modelling and process mapping (cf. Towill and Christopher, 2005; Eitel *et al.*, 2010; Cheng *et al.*, 2015) whereas more business-oriented studies relying on marketing theory emphasise the identification of activities needed, e.g. for coordination, patient grouping or market segments (Rohrer and Culica, 1999; Klassen and Rohleder, 2001; Lillrank *et al.*, 2010).

All the perspectives above reflect the dictionary definition for demand management: "an approach to the allocation of scarce resources that is based on minimizing wastage, restricting supply, and educating people to use less of the resource and use it more carefully" (Park, 2007). Behind these educational and demarketing demand management strategies (Mark, 2005) is the economic rationale for the delivery of healthcare efficiency: if people were only better informed, they would use services appropriately. It is thus based on the assumption of consumers' ability to make rational choices about their health and services needed (Rice and Unruh, 2009). However, little is known about the impacts of such demand management strategies.

#### *Ways to manage demand*

Managing demand is often understood as deployment of various methods, models and strategies and are analysed mostly intervention based (Pawson *et al.*, 2014). The literature is mainly focused on pragmatic management techniques, clinical processes and organisational solutions lacking a coherent conceptual or theoretical framework. Making the conceptualisation more problematic, relatively little research has been conducted on the effectiveness of demand management strategies (Mark and Shepherd, 2004; Jack and Powers, 2009; Fryer and Smellie, 2013). Evaluation is focused on questions what works rather than how demand management strategies actually work. Many studies emphasise solving the specific capacity management issues, while some stress the multi-disciplinary view, shared decision making and whole system approach in managing demand (cf. Mark *et al.*, 2000; Brogan *et al.*, 2008; Mackenzie, 2011).

One of the few comprehensive literature reviews was taken by Jack and Powers (2009) who synthesised healthcare demand management and capacity management studies from 1986 to 2006. According to Jack and Powers (2009) the difference between techniques is the way they respond to the problem of demand. While capacity management concerns capability issues, such as the modelling of procedures, workforce, facilities and operation scheduling (Jack and Powers, 2009), demand management is considered a strategy for identifying the demand and optimising the timing or setting of care (Klassen and Rohleder, 2001). Studies explore health maintenance organisations, organisational integration or multi-hospital systems (Jack and Powers, 2009). Nevertheless, the distinction between approaches is blurred. Tools for managing demand (e.g. utilisation reviews, clinical guidelines, prior approval and referral procedures) may also be utilised in tactical issues of capacity management such as controlling laboratory test utilisation, hospital admissions or number of beds (Brogan *et al.*, 2008; Jack and Powers, 2009). Both approaches claim to ensure appropriate use of resources, only the perspective may be slightly different.

It seems that many studies in health services research assume demand management as an instrumental managerial tool (cf. Mort, 1998; Brogan *et al.*, 2008; Fryer and Smellie, 2013) that can be applied similarly anywhere resolving the problems of healthcare: it leads to the better integration and coordination of care, a more efficient and equitable healthcare system and increased patient choice and participation. But what is often missing is the whole system understanding that the development of healthcare services requires complex interventions, there are no universal panaceas for “wicked” healthcare problems (Rittel and Webber, 1973; Pawson *et al.*, 2014). The critics see demand management as a policy arguing that the true motive for managing demand is cost constraint and all the rest is rhetoric. The financial incentives are over-emphasised, and the purpose of self-care and user empowerment is only to reduce service utilisation and to reshape services so that they respond to what policy makers or managers desire to finance (Mohler and Harris, 1998; Sheaff *et al.*, 2002; Mackenzie, 2011; Carlisle, 2007).

#### *Policy perspective*

To understand complexities of managing demand for health services it is necessary pay attention to interrelationships of various demand management strategies. Mark *et al.* (2000) compared healthcare demand management strategies in Britain and in the USA. The American healthcare system is market-oriented, and even the term “demand management” has been trademarked for business purposes (Mark *et al.*, 2000): it is about getting the right and timely treatment in the right place for the right price. Demand management strategies strive to regulate service utilisation and costs. In the USA these interventions may be referred to rationing by exclusion of specific services or treatments from insurance coverage, but in Britain rationing at the supply-demand interface (“the gatekeeping”) is traditionally left to the medical profession possessing power to define population needs and hence control demand although supply of services is regulated by the state (Klein, 1998; Salter, 1998).

Furthermore, demand management strategies are connected to public policies advocating competition, market mechanisms and consumer choice in delivering healthcare (Enthoven, 1993; Bryant, 2007). For instance, managed care is seen as a way to improve cost efficiency by reducing overutilisation and waste in the system as well as sharing the risk and responsibility between insurance companies, physicians and hospitals (Mort, 1998; Scott *et al.*, 2000; Rice and Unruh, 2009). Similar demand

management strategies are employed in the countries with publicly funded healthcare albeit the normative emphasis is on citizen equity and shared responsibility (Laing and Shiroyama, 1995; Mark *et al.*, 2000). To enhance client choice and competition among providers, strategies reflect the new public management ideas where demand management interventions were introduced as part of the national healthcare policies to improve the efficiency and the quality of public services (Rogers *et al.*, 1998). Purchasing agencies were then given the responsibility of the needs assessment and resource allocation (Klein, 1998). For optimising appropriate care, demand management was developed as a process of “identifying where, how, why and by whom demand for healthcare is made” (Pencheon, 1998).

One intention is thus to better understand the demand – why people use services, when and for what reasons – and finding alternative ways of responding to need (Rogers *et al.*, 1998). Another underlying motive is to identify those services that must be publicly provided (Mark *et al.*, 2000). Although the approach resembles managed care in the USA, the emphasis is yet on developing partnerships, organisational integration and cooperation. That is, healthcare policies promote a more graduated care system by reorganising care facilities, location and service mix (Pencheon, 1998) and by underlining the role of primary care, evidence-based medicine and disease prevention (Mackenzie, 2011). For instance, initiatives like telephone advice service, walk-in centres and minor injuries units were launched as part of the demand management scheme of the NHS.

### 3. WIC as demand management instrument in Finland

A key challenge for Finnish health policy is how to manage financial difficulties related to the ageing of the population, increasing demographic dependency ratio and demand for welfare services. Due to long-term sustainability gap in public finance, the Finnish government is currently reforming the structure of social welfare and healthcare services. The reform seeks solutions to balance the growing demand for services and the shortage of the resources. Demand management has become an important instrument for these reform objectives.

In Finland, the ways to manage demand are dispersed due to decentralised decision making. Local governments are responsible for providing public services, meaning that municipalities have extensive autonomy in organising the healthcare services and hence managing demand would require rather local solutions. The adoption of demand management policies varies between municipalities and depends on the competence and reformist attitudes of local authorities. The present healthcare system is fragmented, causing problems of service accessibility and equality. There are disparities between municipalities in the availability, in the scope of services and at the service level. As Finland is a sparsely populated country, in managing service delivery and local demand the demographic and geographical aspects need to be considered too. There is a great local variation in healthcare resource allocation. This is because there is no direct governmental steering of resources (Vuorenkoski *et al.*, 2008, pp. 65-66).

At the health policy level, health in all policies has been a priority and the new legislation such as Public Health Act 2010 imposes municipalities to promote health and cooperate with service providers (Melkas, 2013). The national development programmes and plans (e.g. Finnish Government, 2015; Kaste, 2012; Mieli, 2011) encourage municipalities to develop intersectoral collaboration and seamless service chains, one-stop-shops and low-threshold services. The proposed actions include improving outpatient services, early identification of problems, service voucher system and the use of health technology, care guidelines and service plans.

In order to manage demand the government has highlighted preventative services based on customer needs: "An emphasis will be placed on early support, preventive methods and effective customer-oriented service chains across administrative boundaries" (Finnish Government, 2015, p. 21). This is achieved by implementing best practices, reinforcing self-care, informal care and home care for older people and promoting citizens' greater choice and responsibility for their own health (Finnish Government, 2015, pp. 21-22).

From the perspective of the patient, long waiting times and access to primary care are considered major problems. In 2005, the government set the maximum waiting times for health services (Vuorenkoski *et al.*, 2008). This had implications for municipalities since public primary healthcare services are mostly provided at the municipal health centres. A needs assessment should be conducted either on the phone or at the appointment within three days. In practice, nurses now act as gate-keepers to the physician appointment (Vuorenkoski *et al.*, 2008) and a needs assessment has turned into an efficient demand management tool instead of facilitating citizens' access to care. In nonurgent specialised care the guidelines and scoring systems are used to limit the statutory care guarantee.

At the system level, the dominant problem of public healthcare services relates to the socioeconomic inequalities in utilisation. Attention is paid to the procedures that facilitate access to care and ensure that patients are directed to the appropriate place for care according their need. This is assumed to require a functionally integrated service system (Mieli, 2011). Moreover, the minor section (10 per cent) of population is using the majority (80 per cent) of social and healthcare resources (MSAH, 2015). This risk group has been the focus of recent policy.

#### *Complex frequent attendance*

Managing demand is based on idea of reducing overutilisation and educating people to use healthcare resources appropriately. Therefore, the high use of health services can be considered as a demand management problem where only a small group of patients, called frequent attenders, use a substantial proportion of primary care resources, making 30-50 per cent of all contacts (Vedsted and Christensen, 2005). Frequent attendance might be interpreted as inappropriate use of resources by increasing the workload and costs of healthcare (Smits *et al.*, 2013). Besides having physical, mental or social problems, frequent attenders are usually high users of other services, too (Neal *et al.*, 2001; Byrne *et al.*, 2003). The definitions vary across the studies. Frequent attendance is either perceived by absolute numeric definitions (ranging from two to 24 contacts) or by percentiles (range 3-25 per cent) (Vedsted and Christensen, 2005). Given that frequent attenders contribute high expenditures, the medical problems alone still do not explain their high use of services (Smits *et al.*, 2013). Even though activity may be practice driven, e.g. diseases that require regular monitoring, it may be persistent patient-created demand (Foster *et al.*, 2006). With this in mind, we were interested to study frequent attenders at WIC and their service utilisation to understand how demand management intervention works.

Improving access to and managing demand for healthcare have been issues on the political agenda and also are primary goals of WICs. Few studies have previously examined frequent attendance at WICs in the context of primary care access (e.g. Maheswaran *et al.*, 2009). In this paper, demand management is understood as management of complex healthcare interventions by scrutinising what constitutes the demand for WIC and how this evidence could be deployed in managing and developing

public services. As outlined by Brogan *et al.* (2008), managing demand consists of analysing both the costs and the thresholds of care by using a systems approach. This means the evaluation of activities, including needs and demand. Given that demand management can be applied at different levels, here our standpoint is particularly on whole system perspective, although we illustrate the outcomes of managing demand on the organisational level.

### *Data and methods*

Demand management has been studied at different empirical extents. The literature includes qualitative case studies, literature reviews as well as quantitative studies using patient registers, surveys and time series. In this paper, we use a case study of the Finnish WICs to exemplify what enhanced access in one point of service system means for management of local demand. We examine the demand structure of the WIC: what constitutes the demand and whether the WIC offer supplementary service.

The high use of services has a complex nature that increases healthcare costs. As previously noted, we chose frequent attendance to represent a demand management issue. Since there is no universal definition of frequent attendance (Vedsted and Christensen, 2005), we examined the frequent consulters with ten or more yearly contacts with a WIC in the town of Ylöjärvi in 2011 or 2012. To explore the patterns of health service utilisation, we analysed the characteristics of frequent attenders by using the administrative data from electronic patient records. The local administrator of the medical information system conducted the collection of the anonymised data of the frequent attenders at WIC including home visits and contacts with other care units. The printed records were sent to the researcher via post. The information of the visits contained the date of birth and gender of the patient as well as the date, setting, urgency and nature of the contact. To ensure patient privacy, the system administrator replaced the social security numbers with specifying research code numbers. The study was approved by the executive group of municipal welfare services in Ylöjärvi (12 November 2012) and the Ethics Committee of the Tampere region (University of Tampere 28 January 2013).

In the records, the reasons for the visits were classified according to the International Classification of Primary Care, 2nd Edition (ICPC-2) or the International Classification of Diseases, 10th Revision (ICD-10). Medical procedures were encoded under the Finnish primary care classification for outpatient activities and follow-up treatments (SPAT). The research data were recorded and analysed with SPSS Statistics 20.

### *Results of the study*

During the study period (48 months, 2011-2012), 107 frequent attenders ( $\geq 10$  contacts/year) at WIC represented 2 per cent of all the users but they accounted for 16 per cent of all contacts. Furthermore, 24 (42 per cent) of 57 frequent attenders in 2011 continued their frequent consulting in the second year.

Frequent attenders were typically elderly people over 60-year old (median 68 years, range 14-86 years), and the majority were male (54 per cent). In addition, these frequent consulters at WIC proved to be high utilisers of other healthcare services too (Table I), such as at general practices or out-of-hours services, having on average 25 visits per year to municipal health services (contact visits ranging between 10 and 58).

In primary healthcare some morbidities, such as mental, endocrine and circulatory disorders, are considered prevalent among frequent attenders (Foster *et al.*, 2006).



As the diagnoses were found only in 53 per cent of the cases and those were encoded to the system by using either ICPC-2 or ICD-10 codes, we decided to combine the reasons for an encounter into more general categories (Table II). Consequently, the frequent attenders at WIC used all health services mostly for problems related to circulatory, musculoskeletal or general and unspecified symptoms.

From the very beginning the WIC was integrated into the local healthcare system as some of the treatments, like blood pressure measurements, stitches and ear wax removal, were diverted from the local health centre to a WIC. The most typical reasons to visit WICs have been health counselling and measurements (Kork *et al.*, 2015). For frequent attenders, however, the reason more often related to the treatment of a previously diagnosed problem. In comparison with other patients at WIC, the focus of activity was thus primarily on treatments rather than the prevention of illnesses (Table III). On the basis of SPAT codes, injections and guidance related to disease management were most common procedures, and 7 per cent of the cases were requested to revisit a WIC or GP. Most importantly, only 11 per cent (12 users) of the frequent attenders used WIC exclusively, whereas 41 per cent (44) proved to be high users also of out-of-hours services (4-18 visits yearly), mostly for rheumatoid arthritis, chronic skin ulcer and type 2 diabetes.

These results present one picture of the frequent attenders' service utilisation patterns indicating that improving access in one part of the care system may have unintended consequences for managing the local demand for health services. In the following sections we reflect on these outcomes in the framework of healthcare management.

**Table I.**  
Service utilisation of frequent attenders at WIC 2011-2012

Care unit	% of contacts	Contacts <i>n</i> = 3,303
Walk-in clinic	60.3	1,991
Health centre (GP/NP)	17.3	570
Out-of-hours services	13.9	459
Home nursing	2.8	93
Mental health services	1.9	64
Diabetes nurse	1.4	47
Physiotherapy	1.2	41
Other	1.2	38

**Table II.**  
Frequent attenders' reasons for encounters in all practices 2011-2012 (ICPC and ICD codes combined)

Category (ICPC-2, ICD-10)	% of contacts	<i>n</i> = 1,741
Circulatory	29.8	518
Musculoskeletal	22.1	384
General and unspecified	11.7	203
Endocrine, metabolic and nutritional	9.1	159
Skin	7.7	134
Psychological and social problems	5.5	95
Blood and blood-forming organs	4.0	69
Ear	2.6	45
Respiratory	2.2	38
Genitourinary	1.3	22
Digestive	1.0	18
Neurological	0.7	12
Other (individual findings)	2.5	44

#### 4. Discussion

Problems of responsiveness, uncoordinated processes and inappropriate requesting compounded by financial austerity are common motives to implement various demand management strategies. The mutual aim of such initiatives is on the one hand to control costs and service utilisation and on the other hand to encourage activity and collaboration (Mohler and Harris, 1998; Bryant, 2007). In practice, these key objectives, cost containment and customer responsiveness, may conflict and create new problems.

Easy access and convenience have made Finnish WICs popular among citizens and hence an attractive demand management tool for healthcare administrators. Despite the image and general outcomes being positive, our empirical evidence demonstrate the complex interrelationships of managing demand. At least three kinds of demand management aspects can be considered, namely acquiring adequate knowledge in diverting demand, defining the focus for the activity taken and identifying the service utilisation and setting where facilitating access would be most beneficial.

##### *Complexity of diverting demand*

Appropriate use of resources is one of the main principles of demand management (cf. Vickery and Lynch, 1995; Pencheon, 1998). Our data show that a small minority of the users, i.e. frequent attenders at WIC accounted for 16 per cent of all visits and that a WIC was used to complement rather than substitute for their primary care. That is, the availability of a WIC increased service demand by creating an extra setting for the high utilisers of health services. The literature has shown that frequent attendance in primary care is associated with age and gender, being typically elderly females (Vedsted and Christensen, 2005; Smits *et al.*, 2013), and this also applies to Finnish primary care (Jyväskylä *et al.*, 2001; Koskela *et al.*, 2010). However, the most frequent attenders at a WIC were elderly male. On the one hand, engaging men is significant for public health and early disease detection. On the other hand, these men tend to have chronic diseases and high use of out-of-hours services implying inappropriate use of services. Similar to the easy access at a WIC, the utilisation of out-of-hours services also arises from convenience and walk-in access but may lead to misuse of emergency services. As demonstrated by Hansagi *et al.* (2001) and Byrne *et al.* (2003), the high users of emergency departments are also high users of all care and often have psychosocial problems and increased morbidity. These findings correspond to frequent attenders at WIC. From the demand management and resource allocation perspective, this kind of service usage raises questions as to whether a WIC is an appropriate setting for frequent attenders giving the psychosocial support needed and controlling chronic diseases, or should these needs be met primarily elsewhere in the system? It appeared that the redirection of

Reason for encounter (ICPC-2)	Frequent attenders, contacts n = 1,010		All users, contacts n = 4,470	
	%		%	
Elevated blood pressure/hypertension (K85-87)	25.2	255	24.6	1,098
Rheumatoid/seropositive arthritis (L88)	20.1	203	4.6	207
Health maintenance/prevention (A98)	12.8	129	44.8	2,003
Endocrine/metab./nutrit. disease/type 2 diabetes (T99, T90)	3.3	33	1.5	65
Psychological problem (P70-99)	1.7	17	0.4	19
Other	36.9	373	24.1	1,078

**Table III.**  
Most common  
reasons for  
encounters in WIC  
among frequent  
attenders and all  
users 2011-2012

demand was made without the preliminary knowledge of the actual service users and their needs. The outcome has relevance to the accessibility and managing demand as a whole: what kind of access barriers exist inside the service system and how high must the thresholds be? Moreover, it is important to consider what implications this better access to one unit means for other services.

*Focus for activity*

Demand management strategies emphasise the activities targeted at primary care, health promotion and integrated services (Mark and Shepherd, 2004; Mackenzie, 2011). Conversely, frequent attendance is usually associated with chronic diseases, multi-problems or somatisation (Vedsted and Christensen, 2005; Jyväsjarvi *et al.*, 2001; Norton *et al.*, 2012). The frequent attenders used WIC mostly for monitoring their chronic diseases, i.e. having injections for rheumatoid arthritis or blood pressure measured. Apart from the fact that frequent attenders use a considerable proportion of healthcare resources, it has been estimated that over one-third continue to be persistent high users of services (Vedsted and Christensen, 2005). These findings are similar to WIC as 42 per cent were persistent frequent attenders. Although frequent consulters may be considered as “problem patients” who increase the workload and use services inappropriately, these patients may as well indicate malfunctioning chronic disease management or unmet patient needs (Malone, 1996; Foster *et al.*, 2006; Norton *et al.*, 2012; Lee *et al.*, 2013). In the case of the WIC, the emphasis was put on primary prevention despite chronic diseases being prevalent. However, activities aimed at prevention may turn out to be the management of chronic diseases (albeit this depends how the preventive action is defined). Moving the focus from cure to prevention may denote demand management that only aim to curb demand by stipulating users on self-management. This development has recently taken place at WICs, too. It remains to be seen whether this is an appropriate or successful way to manage local demand. It is therefore legitimate to ask how much of WIC capacity can be allocated, for instance, to treatments or chronic care management without compromising the principles of easy access and health promotion.

*Scrutinising service utilisation more extensively*

WICs may be one way to offer support, guidance and preventive services, but a more effective demand management strategy would require multi-professional cooperation and a wider perspective of access barriers. Of concern has been how demand management tools impact on the utilisation behaviour of patients, organisation or delivery of other services (cf. Mark *et al.*, 2000). To ensure the right timing and setting of care, the big picture of the system and its users is needed. To identify users' demands or utilisation patterns is an ambitious mission. It is uncertain whether there is available adequate information and if so, whether it is at all utilised in management or decision making (Sheaff *et al.*, 2002). Instead of focusing on one single intervention, attention should be paid on the larger pattern of service utilisation. Therefore, identifying frequent attendance is essential in managing demand: who are the patients using most of the resources and for what reason?

In our case, implementing demand management strategy was considered an easy solution to complex issues. Local authorities seemed to pursue distinct objectives simultaneously: encouraging demand for health services while pursuing economic efficiency. At the same time they strive for facilitating access, reducing waiting times as

well as improving organisational performance and the cost effectiveness of care. However, to solve these compounded problems of service delivery a more holistic approach is needed where not only financial but also social and environmental aspects are taken into account (Mackenzie, 2011). So far, the strong emphasis on pragmatism has guided the management and development of healthcare. Technocrats have relied on the ideal of economic rationality solving the practical aims of rational policies – that is, providing a technical fix to the problem of scarce resources without considering bureaucratic or political pressures (Porter, 2008). In reality, these “novel” strategies (such as managing demand) contain very little new science although they are often promoted as something new. It seems that the pursuit of an efficient healthcare delivery discussion has focused on methods rather than on the teleological arguments of rationing healthcare resources (Klein, 2005). This also applies to demand management strategies.

## 5. Conclusion

Easy access to primary care is convenient from the clients’ point of view. However, from the perspective of demand management, it is more problematic if increased demand is the consequence of facilitating the access. As our study demonstrates, WIC offers supplementary rather than substitutive care for frequent users of healthcare services. In managing demand it is thus important to understand the demand more precisely by identifying the high users of services, their preferences and their utilisation patterns. More systematic demand management would thus include surveying the barriers for access and better management of chronic diseases. There is no single demand management tool for solving the dilemma of healthcare provision – resource scarcity and citizen needs. Instead of a linearly developed theoretical concept or coherent discussion, demand management in healthcare service management is more an unsystematic collection of pragmatic solutions to the prevailing health policy issues of the time.

## Note

1. The outpatient medical visits in primary healthcare include the patient visits to practitioners other than physicians. Outpatient care is a service provided by the municipality to treat the health problems without or by appointment, such as the monitoring of chronic illnesses. (Sotkanet Indicator Bank, National Institute for Health and Welfare).

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