

Choice and privatization in Swedish primary care – experiences and outcomes

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”Vårdval” reform implemented 2007-2010

- National regulation in 2010 (voluntary in 2007-2009)
- Differences across the 21 county councils
 - Responsibility for practices (wide/narrow)
 - Payments systems (capitation important)
 - Financial responsibility (prescription drugs in many CC)
 - Geographical and demographical conditions
- Differences compared to other countries
 - ”Free” establishment of private providers (mixed owners)
 - Unlimited options for individuals to change practice
 - Limited possibility for practice to refuse registration
 - Registration by practice (rather than GP)

Two market principles – different outcomes to be expected

- LOU (Law on Public Tendering) 1990s-
 - Competition *for* a market
 - Contracting out
 - Competition about price and quality
 - Limited choice and pluralism
- LOV (Law on choice system) 2010-
 - Competition *on* a market
 - Voucher principle
 - Competition about quality (fixed payment)
 - More choice and pluralism

Source: Bergman M (2013) Upphandling och kundval av välfärdstjänster – en teoribakgrund. www.uppdragvalfard.se.

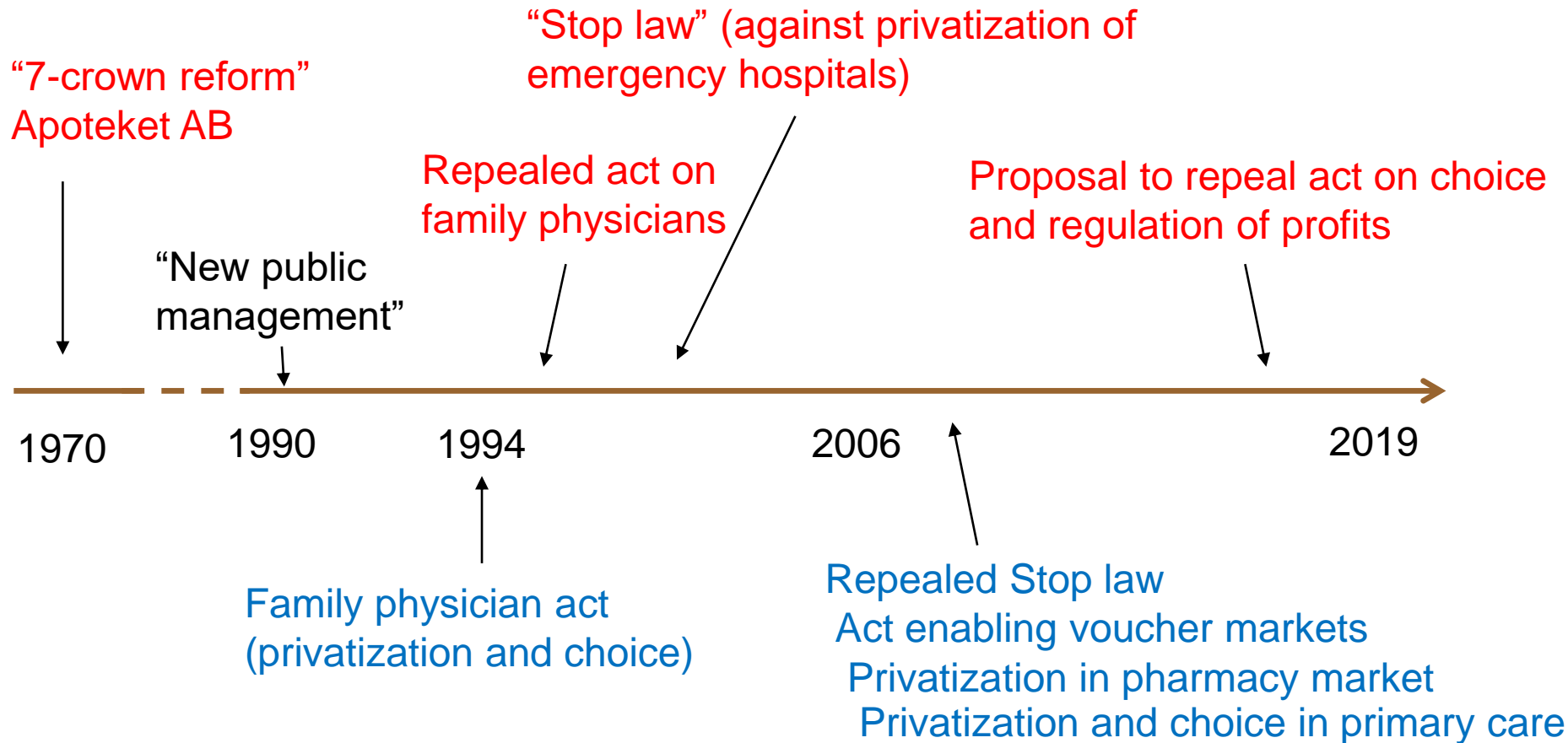
Why choice and privatization?

- A majority of individuals like choice (when asked)
- Choice may (theoretically) improve quality of care
 - Better match between individual needs/preferences and practices
 - Competition incentivize practices to improve quality of care (access and other aspects)

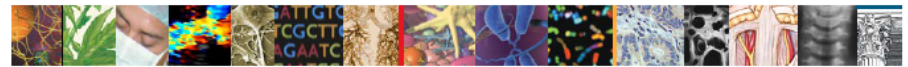
Several questions

- Reforms from a political science perspective?
- Impact of choice and privatization?
 - Savings, productivity
 - Quality, Equity
 - Differences between public and private practices

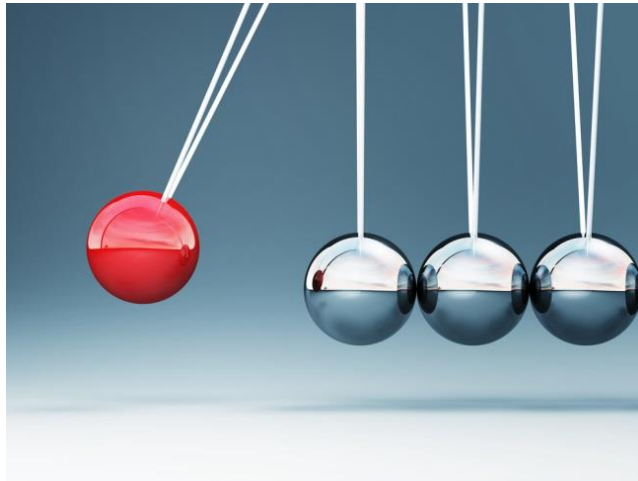
The role of the public sector as a service producer has been reduced after 1990. Private providers more important, especially in outpatient services.



And next?



The NEW ENGLAND JOURNAL of MEDICINE



Perspective
JANUARY 1, 2015

INTERNATIONAL HEALTH CARE SYSTEMS

The Public–Private Pendulum — Patient Choice and Equity in Sweden

Anders Anell, Ph.D.

New government with liberal support → support for choice and privatization will continue (for now...)

Decision making in Swedish health care is decentralized — 21 elected county councils own and operate almost all hospitals and a majority of primary care facilities, and most physicians are salaried em-

ployees of these institutions. There is universal access to high-quality medical services for all citizens at reasonable expenditure levels (see table and case histories). But the picture is more nuanced than those general facts might imply.

 An interactive graphic is available at NEJM.org

Waiting times for consultations and treatment and lack of patient-centeredness are persistent problems, and services are not always distributed equitably, to name a few common concerns.¹ The types of organizational reforms undertaken to address such problems depend

in part on the ideologies of both the national and local governments — a factor that has been most evident in recent policies related to patient choice and the private provision of care.

The current Swedish health care system is largely the product of past national governments led by the Social Democrats, which strongly emphasized equity and reliance on the public sector. Since 1990, however, both center-right and center-left governments have turned to competition and consumer choice as ways to increase efficiency in areas previ-

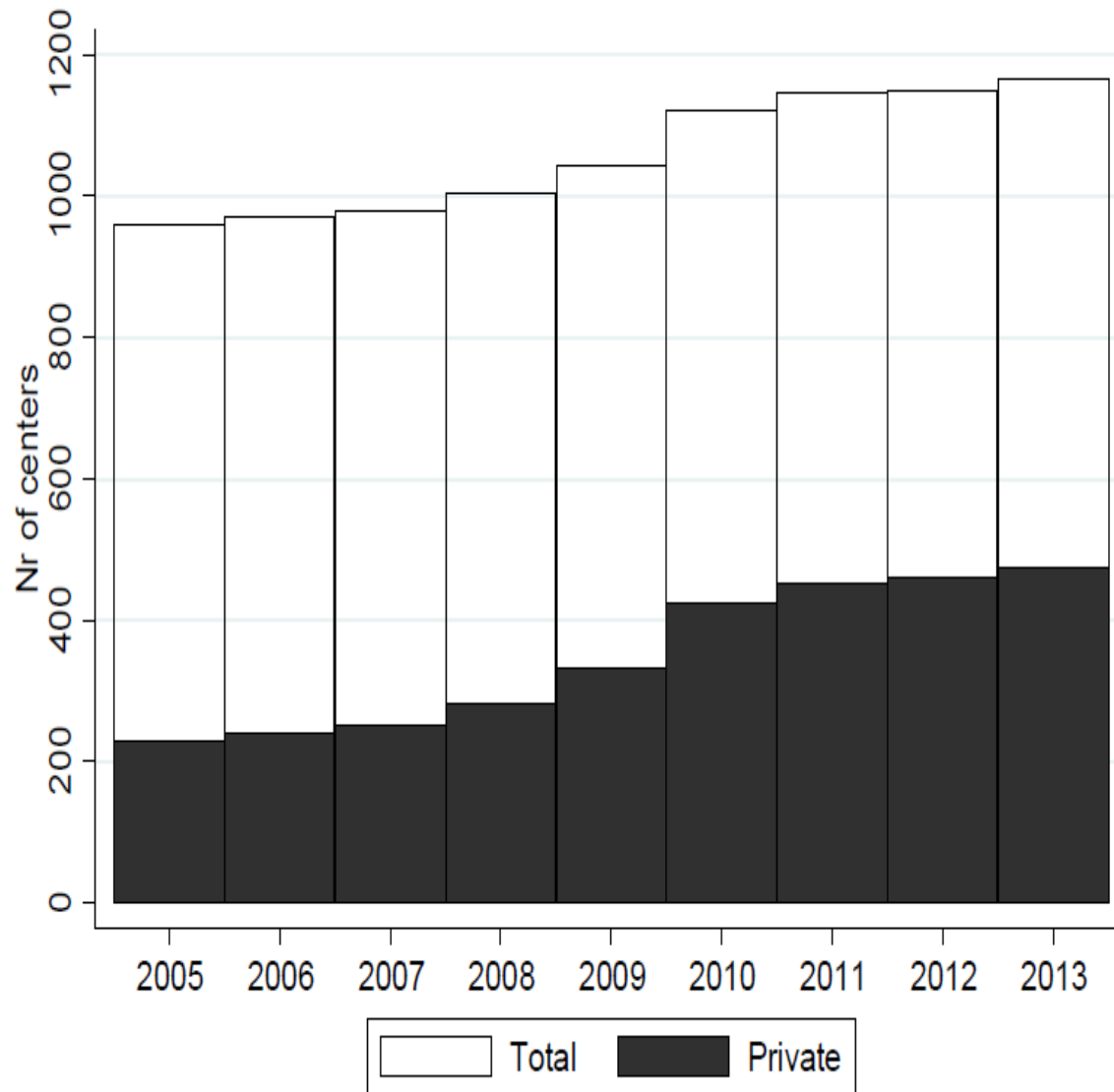
ously dominated by public monopolies. Together with tax-policy reforms and liberal labor-immigration policies, these changes have substantially transformed the Swedish economy over the past 25 years.²

When it comes to health care, social services, and education, however, political opinions in Sweden have been more divided. The center-right government that was in place from 1992 to 1994 introduced changes that created opportunities for private providers of outpatient care. But these changes were reversed by a later government led by the Social Democrats, which also introduced a so-called stop law in 2000 to prevent county councils from contracting out the operation of emergency hospitals to private

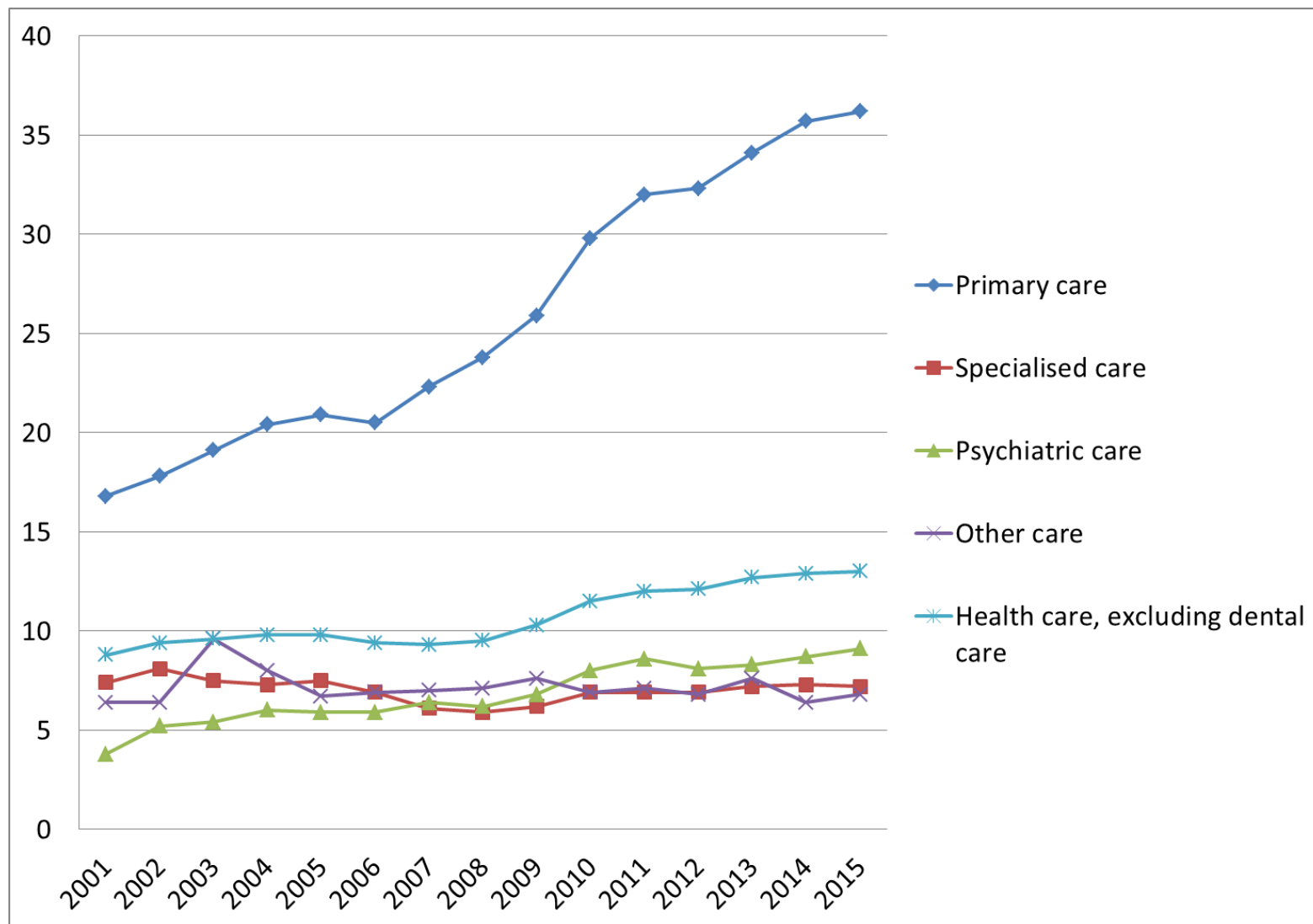
Impact of choice and privatization?

- Increase in the number of private health centers (populated areas)
 - Small bias towards more new practices in favourable socioeconomic geographical areas
- Large differences between CC when it comes to development of visits
 - Mixed evidence regarding impact on equity (distribution of visits)
- Small positive impact on proportion of patients that recommends their practice to others in areas with greater competition
 - Short term increase in prescription of antibiotics in areas with greater competition

Figure 1. *Number of primary care centers 2005-2013*



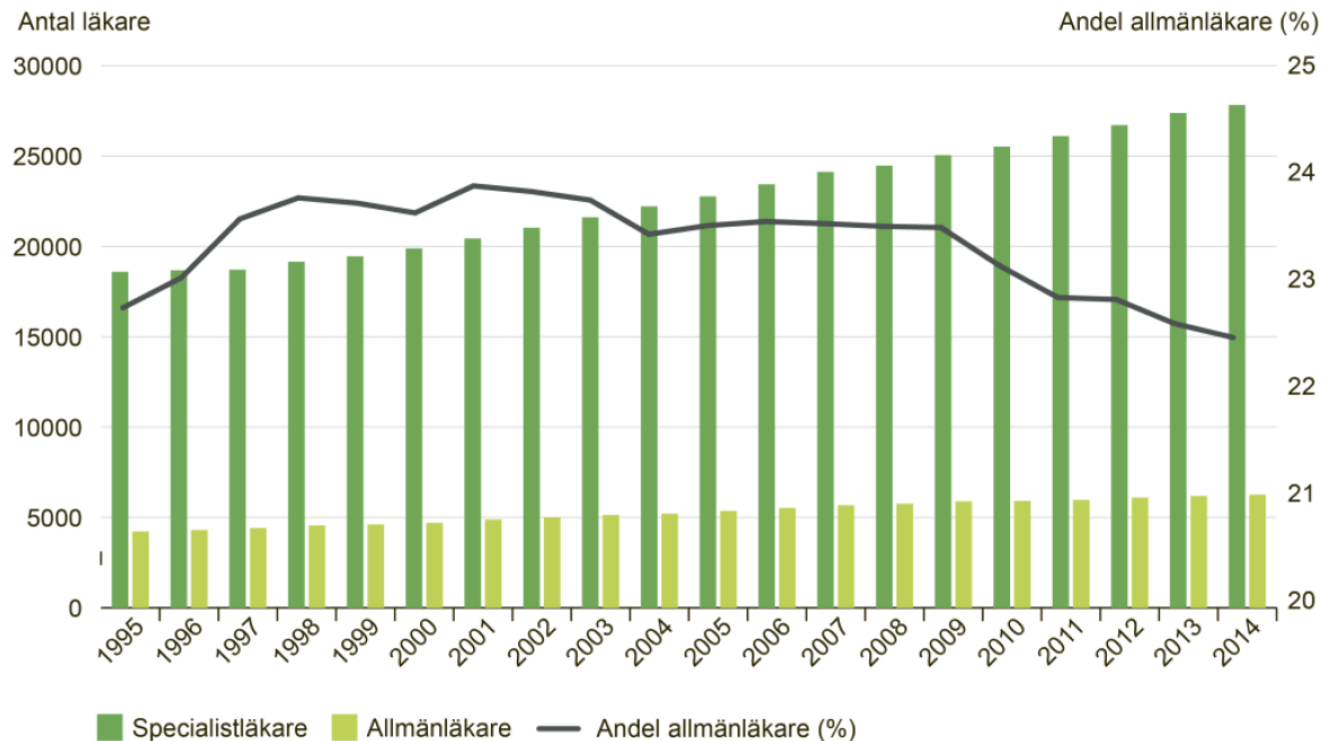
Increase in county councils payment to private providers



Source: SALAR, Financial reports, table E31 different years.

More practices, BUT the number of GPs ("allmänläkare") is the same → reduced share of total number of physicians!

Figur 2. Fördelning allmänläkare och övriga specialister, Sverige 1995–2014.

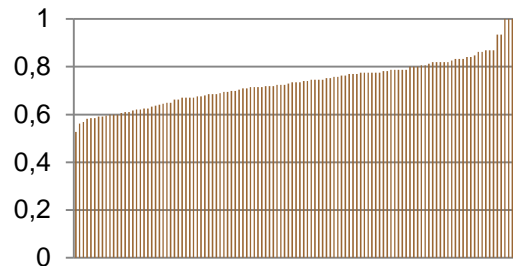


Källa: Socialstyrelsens statistikdatabas.

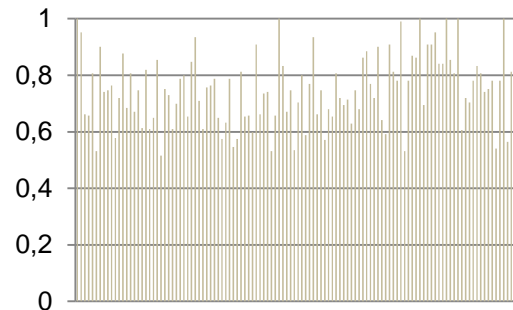
Vårdanalys PM 2017:4

Productivity (DEA) for primary care practices in Region Skåne (year 2010)

Quantity (resources – visits)



Quality (resources – patient satisfaction)



Analysis of data from three county councils year 2010:

- Large differences across practices
- No significant differences between private and public ownership
- No trade off between quantity and quality

Patient satisfaction higher in private practices in later studies (but small difference when adjusted for case-mix)

Glenngård (2013) Health Policy 111: 157-165; Glenngård (2012) Health Econ. Policy and Law; Glenngård AH, Anell A. (2017) SAGE Open Medicine Volume 5: 1–8.

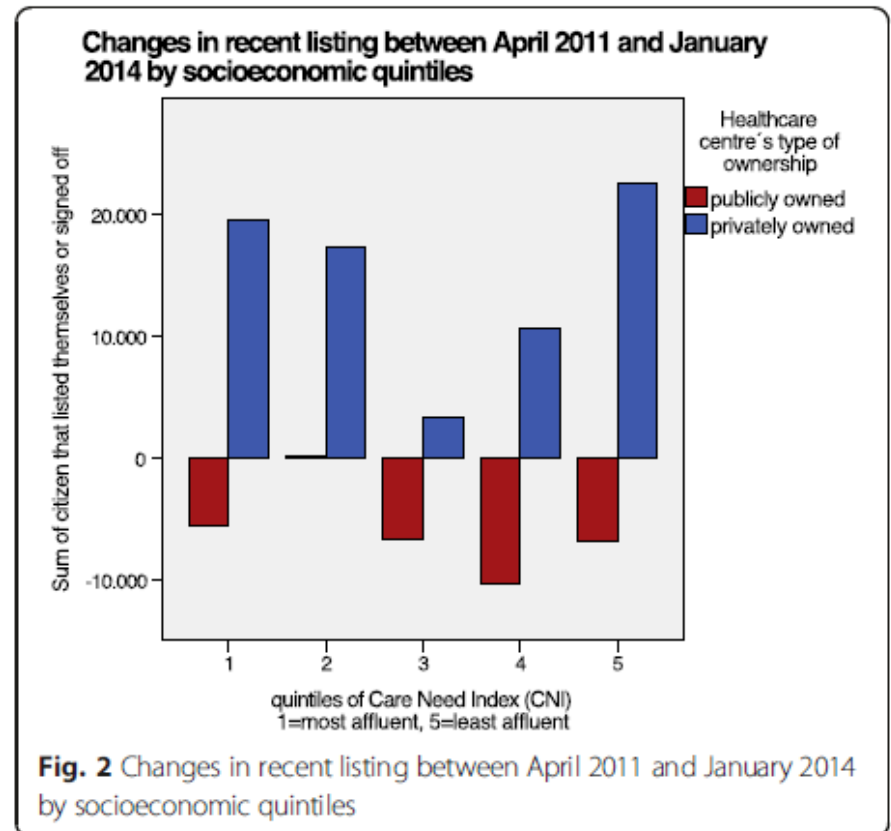
Several studies about impact on equity (examples)

- Vårdanalys (2013)
 - Larger increase in number of physician contacts for population at large compared to patients with large needs ((Stockholm, VGR, ÖG)
- Beckman, Anell (2012, 2013)
 - General increase in number of physician contacts and propability of at least one contact per year. Larger increase for patients 65+ with income above median. (Regions Skåne)
- Rehnberg, Dahlgren, Svereus m fl (2013, 2014)
 - Larger increase among elderly and for individuals with lower education. Smaller increase among people with lower income. (Stockholm)
- Holmberg, Ekström (2014)
 - No indications of crowding-out based on age, education, sex or ethnicity. (Kronoberg)
- Agerholm et al (2015)
 - Smaller increase in number of physician visits among patients with poorer self-reported health, in particular in socially deprived areas. (Stockholm)
- Vårdanalys (2015)
 - Individuals with lower education and lower income use primary care more both before and after choice reform. Individuals with higher education, income and health prefeer private practices. (Stockholm, VGR, ÖG)

Differences between private and public practices in VGR (Maun A, et al. BMC Health Services Research 2015; 15:417)

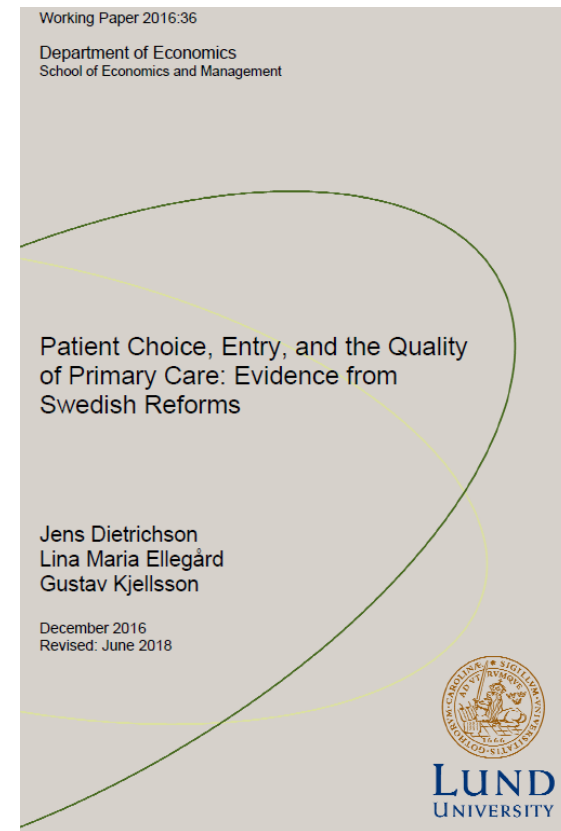
Private

- Smaller size
- More in urban areas
- More working age
- Higher patient satisfaction
- More use of antibiotics and benzodiazepines
- Less frequent follow ups of diabetes patients
- Increasing share of the population



Some studies focusing impact on quality

- Short term increase in antibiotics prescription in areas with more intense competition (Fogelberg 2014, IFN Working Paper No. 949)
- Positive but small effect on share of patients that would recommend their health center to others (Dietrichson et al 2016)
 - No significant effect on other indicators (3 PREEMs; avoidable hospitalizations)



So why did quality not improve more?

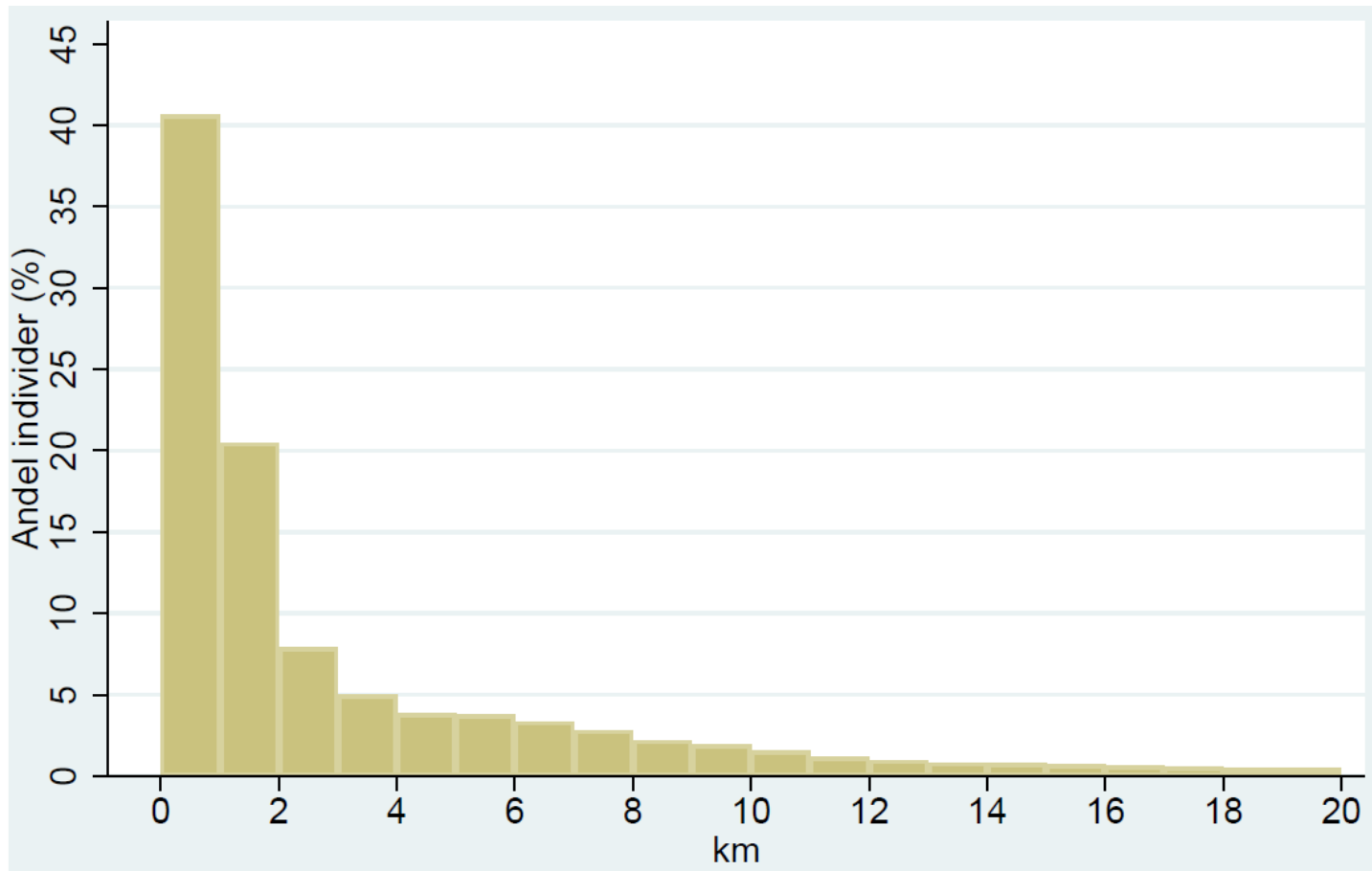
- Possible problems at the supply side
 - No increase in number of GPs
 - Payment systems (focus on capitation)
 - Counteracting incentives (“management” in CC)
- Possible problems at the demand side
 - Do people care about choice in practice?
 - Limited variation in quality between health centers?
 - Limited access to information about variation in quality?
 - Other “switching costs”?

DOES QUALITY AFFECT PATIENTS' CHOICE OF DOCTOR? EVIDENCE FROM ENGLAND*

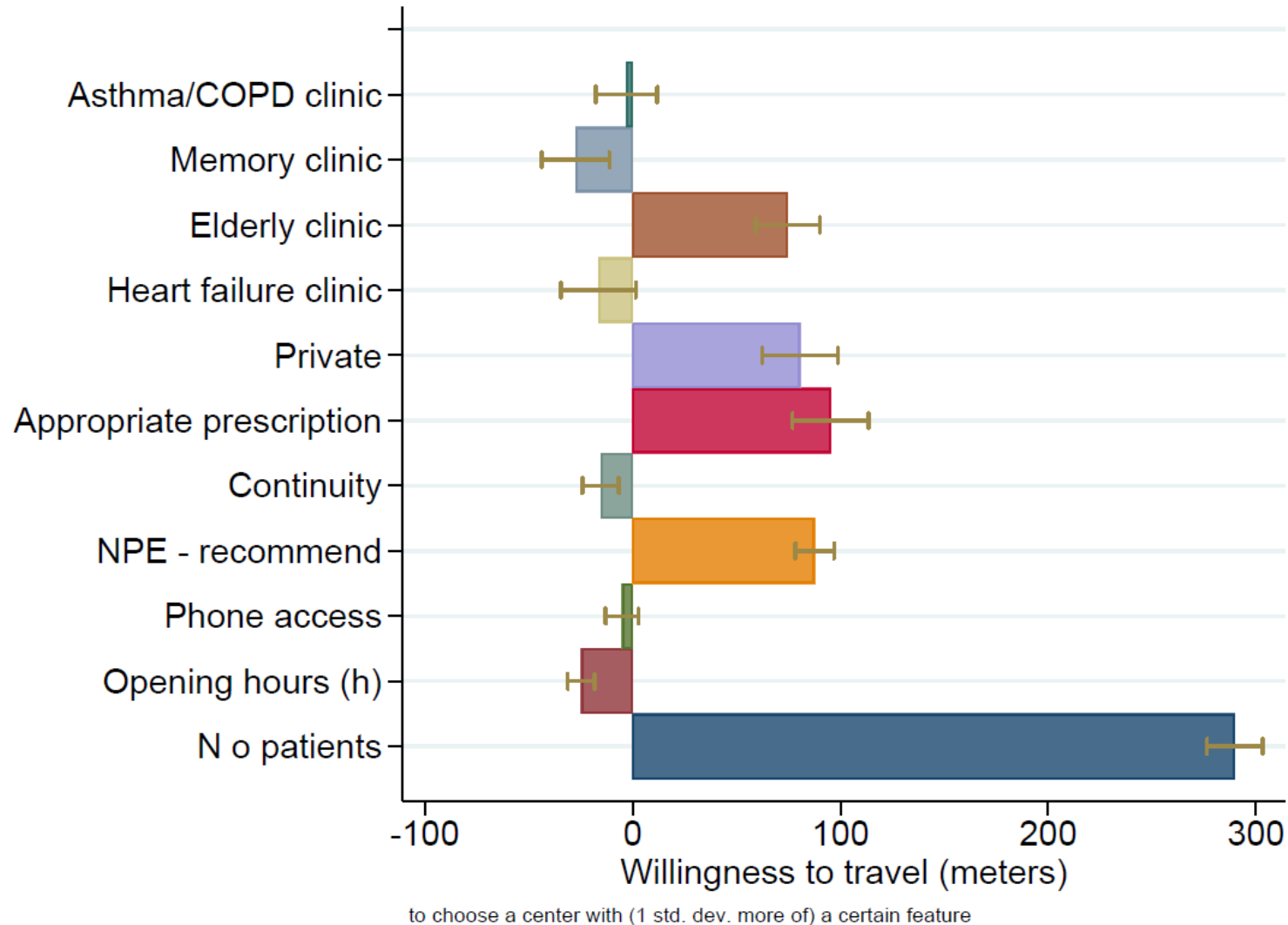
Rita Santos, Hugh Gravelle and Carol Propper

Reforms giving users of public services choice of provider aim to improve quality. But such reforms will work only if quality affects choice of provider. We test this crucial prerequisite in the English health care market by examining the choice of 3.4 million individuals of family doctor. Family doctor practices provide primary care and control access to non-emergency hospital care, the quality of their clinical care is measured and published and care is free. In this setting, clinical quality should affect choice. We find that a 1 standard deviation increase in clinical quality would increase practice size by around 17%.

Tendency to "chose" a nearby health center (data from Region Skåne year 2015)



Willingness to trade-off distance against other qualities limited (data from year 2015)



Two randomized field experiments (year 2015)

“.... experiments show that comparative information and reduced switching costs significantly increase the propensity to switch provider.

The effects are larger for new residents, and for individuals with alternative providers reasonably close by their homes (urban areas).”



Fixed risk-adjusted payment to swedish primary care – arguments and experiences

Arguments

- Very good cost control
- Simple administration
- Practices may register patients with higher needs without being financially punished
- Professional autonomy - possible to target patients with higher needs; substitution between staff categories and type of contacts

In reality?

- Access and productivity?
- Skimping on quality?
- Impact on location of private practices?
- Impact on actual services to patients with higher needs?
- Innovations related to substitution (use of staff, type of contacts)?

CNI-adjusted capitation and location of new private primary care practices

- CNI-adjusted payment increase the number of new private providers in areas with high CNI ($> 1,0$) compared to areas with low CNI ($< 1,0$).
- CNI-adjusted payment do not increase the total number of new private providers
- CNI-adjusted payment influence the distribution (from low to high CNI) rather than total number of new private providers

Anell et al. *BMC Health Services Research* (2018) 18:179
<https://doi.org/10.1186/s12913-018-2983-3>

BMC Health Services Research

RESEARCH ARTICLE

Open Access

Does risk-adjusted payment influence primary care providers' decision on where to set up practices?



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Abstract

Background: Providing equal access to health care is an important objective in most health care systems. It is especially pertinent in systems like the Swedish primary care market, where private providers are free to establish themselves in any part of the country. To improve equity in access to care, 15 out of 21 county councils in Sweden have implemented risk-adjusted capitation based on the Care Need Index, which increases capitation to primary care centers with a large share of patients with unfavorable socioeconomic and demographic characteristics. Our aim is to estimate the effects of using care-need adjusted capitation on the supply of private primary care centers.

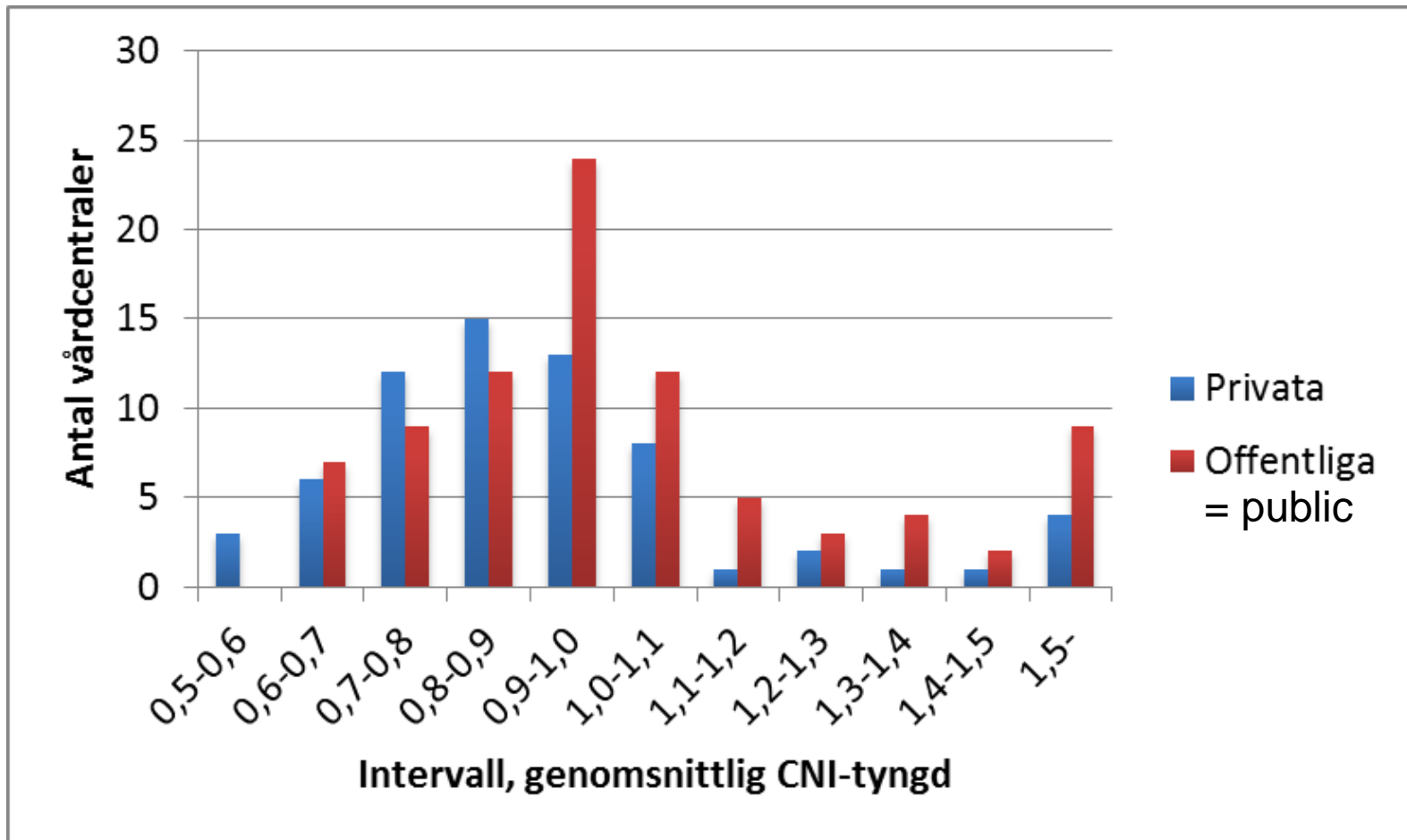
Method: We use a dataset that combines information on all primary care centers in Sweden during 2005–2013, the payment system and other conditions for establishing new primary care centers used in the county councils, and demographic, geographic, and socioeconomic variables for low-level geographic areas. To estimate the effects of care-need adjusted capitation, we use difference-in-differences models, contrasting the development over time between areas with and without risk-adjusted capitation, and with high and low Care Need Index values.

Results: Risk-adjusted capitation significantly increases the number of private primary care centers in areas with relatively high Care Need Index values. The adjustment results in a changed distribution of private centers within county councils; the total number of private centers does not increase in county councils using care-need adjusted capitation. The effects are furthermore increasing over the first three years after the implementation of such capitation, and concentrated to the lower and middle range of the group of areas with high index values.

Conclusions: Risk-adjusted capitation based on the Care Need Index increases the supply of private primary care centers in areas with unfavorable socioeconomic and demographic characteristics. More generally, this result indicates that risk-adjusted capitation can significantly affect private providers' establishment decisions.

Keywords: Primary health care, Establishment, Equal access, Private provision, Risk-adjusted capitation, Sweden

Distribution of ownership across practices with different CNI still vary (Region Skåne year 2015)



Some conclusions and lessons

- More private practices, but same number of GPs.....
 - The need to prioritize primary care resources is emphasized in the debate, but not in action
- Limitations in study findings of productivity and equity related to available data
 - Focus on physician and nurse visits
 - No information about length and quality of contacts
 - Parallell changes (triage, task-shifting)
- Socioeconomic gradient in public/private mix
 - Can be influenced by risk-adjusted payment
- Possible to support choices with improved information and reduced "switching costs"
 - Shortage of GPs still important barrier on the provider side