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Review

Competition and integration in Swedish health care

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ABSTRACT

Despite of an insignificant track record of quasi-market models in Sweden, new models of this kind have recently been introduced in health care; commonly referred to as “choice of care”. This time citizens act as purchasers; choosing the primary care centre or family physician they want to be treated by, which, in turn, generates a capitation payment to the chosen unit. Policy makers believe that such systems will be self-remedial, that is, as a result of competition the strong providers survive while unprofitable ones will be eliminated. Because of negative consequences of the fragmented health care delivery, policy makers at the same time also promote different forms of integrated health care arrangements. One example is “local health care”, which could be described as an upgraded community-oriented primary care, supported by adaptable hospital services, fitting the needs of a local population. This article reviews if it is possible to combine this kind of integrated care system with a competition driven model of governance, or if they are incompatible. The findings indicate that some choice of care schemes could hamper the development of integration in local health care. However, geographical monopolies like local health care, enclosed in a non-competitive context, lack the stimulus of competition that possibly improves performance. Thus, it could be argued that if choice of care and local health care should be combined, patients ought to choose between integrated health care arrangements and not among individual health professionals.

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Contents

1. Introduction	00
2. The Swedish health policy initiatives in brief	00
2.1. Choice of care	00
2.2. Local health care	00
3. Difficulties and possibilities in combining patient choice with integration	00
3.1. Patient choice in Beveridge-type of health care systems	00
3.2. A review of the Swedish situation	00
3.2.1. Closeness between organisations and between professions	00
3.2.2. Closeness in distance and time	00
3.2.3. Closeness in shape of interpersonal connections	00
4. Concluding remarks	00
References	00

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1. Introduction

Sweden has a Beveridge-type of health care system with two main clusters of public providers: 21 county councils/regions¹ and 290 municipalities, which levy taxes in order to finance their work. The county councils are responsible for all health care except for nursing homes and other forms of housing for older people with somatic and psychiatric long-term diseases as well as for mentally retarded patients, which is the responsibility of the municipalities.

During last decades new principles of governing as well as of organising have been implemented in Swedish health care. For instance, in the end of the 1980s purchaser–provider models were introduced in Swedish health care as a remedy for experienced service inefficiency. Politicians took up a new role as purchasers in new-established political committees, whereas provider operations were depoliticized and managed more strictly from professional principles, including some examples of hospitals transformed to limited companies with the county council as sole shareholder. Furthermore, in some places internal markets were launched, which implied that the health care providers had to purchase services from laboratories and other types service units [1].

These quasi-market models had a strong foothold especially during the 1990s. At that time 13 of the 21 county councils used a purchaser–provider split to govern health care, which also included some attempts at involving primary care on the purchaser side giving expert support to the commissioning process [2,3]. In spite of some county councils still manage their health care according to the purchaser–provider split, most of the marketisation of governance has faded away from the Swedish health care scene [4]; chiefly due to lack of evidence that the purchaser–provider split increases efficiency in health care [5,6]. Today improved political democracy, provided by the split, seems to be the rationale for the continuance of these models.

Despite of the insignificant impact of previous marketisation [4], a new quasi-market model has been introduced during the last years. This time citizens act as purchasers when choosing the primary care centre they want to be treated by, which, in turn, generates a capitation payment to the chosen unit. The emphasis on patient choice could be regarded as a reaction against this component being more or less neglected in earlier policies [7]. These new models are commonly referred to as “choice of care”. Policy makers believe that such systems will be self-remedial, that is, as a result of competition strong providers survive while unprofitable ones will be eliminated. For this purpose, competition between public and private providers is facilitated by the act on free choice systems from 1 January 2009 [8].

Moreover, the development of the Swedish health care system has lead to an increased differentiation of roles,

tasks and responsibilities. There are three main forces behind this development: decentralisation, specialisation and professionalization. The outcome of this development can on one hand be regarded as a success story. Decentralisation of responsibilities and authorities to lower hierarchical levels is commonly regarded as a successful condition to rationalise the activities. Clinical specialisation has undoubtedly promoted the health of populations. Furthermore, the principle of a professional organisation of management is today deeply embedded in the organisation of health care.

On the other hand, there is also a flipside of this demandable development. All three driving forces, individually and together, have contributed to a state of differentiation with manifold negative consequences for the health care system as a whole [9]. This is often described as fragmentation, which can be defined as a state of differentiation without the integration that is required to achieve a unity of effort [10]. Furthermore, it can be divided into organisational fragmentation, which makes it difficult to manage and organise between organisational units; clinical fragmentation, which is primarily a result of the specialisation in health care and its disintegrative logic; and cultural fragmentation, which makes it difficult to develop and share common values among health care professionals [9].

Because of this fragmentation policy makers promote different forms of integrated health care arrangements. One example is “local health care”. This term is not a literal translation of the Swedish word *närsjukvård*; which would be “close health care”. Furthermore, local health care could be described as an upgraded community-oriented primary care, supported by adaptable hospital services. The creators of local health care strive to develop an integrated system fitting the needs of a local population. This means that the content and organisation of local health care may differ from one area to another [11].

Following Hood [12], quasi-market models tend to fragment the provision of services. As been shown, local health care is founded on integration of different providers. Thus, are these two policy actions compatible with each other? The aim of this study is accordingly to further explore choice of care and local health care, and also review if it is possible to combine a competition driven concept with locally tailor-made integrated care, or if these policy concepts are incompatible.

2. The Swedish health policy initiatives in brief

2.1. Choice of care

The County Council of Halland implemented a choice of care scheme in 2007. This model implies that providers who want to be engaged in primary care must apply for accreditation. Among other things, demands are made on competence, quality systems, and clinical guidelines as well as on financial stability. It is possible for both private and public providers to be accredited. Any unit selected is paid a health care subsidy, the size of which varies with the patient's age, and, in addition, the patients pay a heavily subsidized fee-for service.

¹ In some cases two or more county councils have merged into a “region”, which has the same responsibility for health care as an individual county council. The term “county council” is used synonymous with “region” in the following text.

The primary care centre thus gets an objective related capitation fee based on the number of listed individuals and their age distribution. The objectives to be fulfilled are first of all about accessibility and assignment coverage. Deductions from the subsidy are made if not all of the objectives are fully met. Furthermore, within the framework of the Health and Medical Services Act, the units have considerable freedom to organise their services to meet the needs of their listed patients in the best possible way [13].

The model of Halland was to some extent inspired by the school voucher reform in 1992/93 at primary and secondary school level, enabling free choice among public and independent schools, that is, introducing a competitive school market [14], and also by voucher schemes in elderly care used in altogether about 50 Swedish municipalities [15].

When the County Council of Halland launched their choice of care scheme it caught a lot of attention among the other county councils in Sweden, which, have by the end of 2009 inspired seven other county councils to develop and implement choice of care. Moreover, in 2010 seven more county councils plan to put their schemes into practice. At that time Sweden will thus have 15 county councils with choice of care. Though, it is not a case of having one common model being applied in all places. Following Anell [16], there are considerable differences between the choice of care schemes in different county councils with respect to provider requirements and assignment as well as to the size of the health care subsidy. For instance, choice of care in Stockholm has a relative small capitation fee; about 40% of the yearly proceeds. Remaining part is reimbursements in proportion to the number of patient visits, which, in turn, could imply prioritisation of short and uncomplicated visits. In the other seven county councils is it the other way around; 80–90% of the yearly proceeds derive from the capitation fee.

All county councils with implemented choice of care schemes have non-socialist majorities. In addition, the non-socialist majority in the Swedish Parliament have decided that all Swedes shall be able to choose primary care in 2010. The aim of this reform is to increase freedom of choice for the patients and facilitate for new providers to establish themselves in publicly financed primary care [17]. Thus, choice of care could be regarded as political tool to once again expose Swedish health care to competition.

2.2. Local health care

The first examples of local health care emerged in the beginning of this millennium. In 2005 two out of three Swedish county councils had implemented local health care, or planned to do so [18]. A recalculation on basis of number of inhabitants shows that 80% of the Swedes are, or will be, comprised by local health care [19].

Following the introduction, local health care could be described as integrated system of health care providers from municipalities, primary care and selected part of hospital services, adapted to the needs of a local population. Thus, there is no single model of local health care to be applied everywhere, nor is there an agreed common def-

inition of this concept [18]. Nevertheless, some common characteristics can be distinguished.

Local health care has a main orientation towards diseases of frequent occurrence and needs among major population groups, such as families with children, older people, and patients with chronic diseases. Local health care is also supposed to be the base of a county health care system, and, moreover, include about 75% of all county health care [18]. Having the literal meaning of the Swedish term in mind, this could imply *closeness*:

- *between organisations and between professions*; interorganisational and interprofessional collaboration between providers of local health care.
- *in distance and time*; accessible services for the patients.
- *in shape of interpersonal connections*; continuative contacts between patients and health care staff [20].

It is unusual to find a high degree of organisational cohesiveness in local health care. Only a few county councils have thus chosen to merge resources into new organisations of local health care. This provision is instead usually linked together through collaborative clinical networks including hospitals, primary care and municipalities [18]. Creating such health care systems does seldom imply large changes in organisations, resources or competences. Instead it is about new ways of connecting resources to achieve a working whole [21,22], which, as in the case of West Gästrikland Local Health Care, could include primary health care, health prevention, rehabilitation, dental care, residential care, elderly care and outpatient hospital care [11]. Several commentators stress the importance of adequate professional as well as financial incentives to promote this kind of integrated care concepts, and not only relying on the good will of the providers involved [23–27]. Though, such motivating conditions seem not be favoured by Swedish policy makers. Accordingly, there is a risk local health care policies get limply as they are generally not fostered by stimulus to bridge fragmentation of the health care delivery.

Following the taxonomy of Chauvette [28], local health care could be classified as an integrated community model, whereas the classical Swedish primary care is more of a non-integrated community model. Both Swedish models have thus a community-oriented approach in contrast to some other countries with predominantly professionally founded primary care (see Fig. 1). Such approach could in turn be subdivided into a professional contact model, which involves physicians operating their own practices on a fee-for service basis, and a professional coordination

Professional approach		Community-oriented approach	
Professional contact model	Professional co-ordination model	Integrated community model	Non-integrated community model
Occurs in: USA, Canada, Germany	Occurs in: UK, Denmark, Norway	Local health care	Classic Swedish primary care

Fig. 1. Local health care in comparison with other primary care models (adapted from Chauvette [28]).

model. The purpose of the latter model is to provide continuous service to patients registered with for instance family physicians.

The national Family Physician reform in 1994 is worth mentioning in this connection. Inspired by corresponding systems in for instance Denmark and UK, Swedes were able to register with an optional family physician. This procedure implied that community responsibilities were removed from general practitioners. Furthermore, this reform was to some extent in conflict with the purchaser–provider logic; since patients not always choose the local family physicians contracted by the purchasers [29]. This is one reason why this reform was short-lived; next year primary care was back to the traditional community-oriented approach [30].

3. Difficulties and possibilities in combining patient choice with integration

3.1. Patient choice in Beveridge-type of health care systems

In general, patient choice could be perceived as something positive in its own right, since such a condition is believed to increase the responsiveness in health care services to wishes and demands of the patients. It is also in line with the development of empowering the patients [31]. Several international studies have though concluded that patients, incorporated in Beveridge-type of health care systems, show relatively little enthusiasm in choosing health care providers, except when they perceive services as unsatisfactory, for example, unacceptable long waiting for specific treatments. Instead, other issues, like for instance involvement in treatment decisions, appear to be of more importance for the patients [32,33]. That is, patient choice schemes up to now seem not to include the sort of choices valued by most patients. Though, young, mobile, prosperous and well educated patients are usually more in favour of exercising choice of health care providers, while other groups are more conservative; often preferring their established provider contacts [34].

These findings from international research are supported by similar results with origin in a Swedish context. Following Hjelmgren and Anell [35], influence over the care received is highly valued by the patients in primary care. Moreover, only a small proportion of patients in Stockholm have used the opportunity to change their choice of care, and, furthermore, if this happens, the patient seldom chooses a provider outside their town district or local area [36]. In addition, Rosén et al. [37] conclude that relatively young and urban patients are more anxious to be able to choose their primary health care provider in comparison with other patient groups.

Most Beveridge-type of systems with patient choice could therefore not be regarded as a traditional consumer markets, characterised by a high degree of exchangeability of providers. Instead, human geographical closeness and continuity of care seem to be prioritised by most of the patients.

Table 1

Forms of patient allocation in 2009 according to type of primary care.

	Local health care	Traditional primary care
Choice of care	6	2
Conventional patient allocation	4	9

3.2. A review of the Swedish situation

Swedish patients appear to have a conservative attitude towards possibilities to exercise choice of health care providers [37–39]. Political reforms of this kind seem accordingly to have limited impact on the allocation of health care resources. But what about the performance in local health care? Is it possible to fulfil the three closeness mottos of this concept at the same time as choice of care is an option?

It could be useful to start with the overall picture in Table 1, which shows that in 2009 six out of the eight county councils with choice of care try to combine this with local health care. Two county councils accordingly combine choice of care with traditional primary care. The table also shows that it less common to combine conventional patient allocation with local health care, and, furthermore, that nine of the county councils had not implemented either of the two policy concepts.

There are discrepancies in what patients actually choose between. This is not only related to the different types of primary care. There are also differences between county councils that provide local health care. In Halland County Council the patients choose among different local health care arrangements. Whereas patients in Stockholm County Council register for a specific general practitioner and primarily not a local health care system [16]. This later procedure is equivalent to the core principles of the Family Physician reform in the 1990s.

There are no limits on the number of listed patients at each primary care centre, and they cannot refuse patients who want to choose their unit. In Stockholm County Council this is accompanied by a queue system for those waiting for their turn to be listed. Moreover, in for instance the county councils of Halland and Västmanland the inhabitants must choose a primary care centre. Passive listings, founded on the individuals' previous visits to primary care, are performed of those not making an active choice. Stockholm County Council on the other hand has only active listing of patients. Furthermore, in all county councils the citizens are allowed to change their choice during current year. Halland County Council permits four changes of primary care units per year, while in remaining county councils the number of changes during one year is unlimited [16].

3.2.1. Closeness between organisations and between professions

Choice of care according to the approach of Stockholm County Council will make the creation of local health care complicated. Choosing only one part, the family physician, of an integrated arrangement, implies risk of fragmentation rather than maintenance of a working whole [40].

Especially in the cure and care of patients with complex conditions, local health care networks thus also need to collaborate with external health care organisations and professionals for the best of these patients, which hardly promote allocative efficiency in local health care. This state is achieved with an optimal level and mix of health care resources [41]. At worst, popular family physicians have to cooperate with several local health care networks, which involve increased transaction costs as well as practical obstacles to the creation of interprofessional collaboration. This situation aggravates if patients change their choice several times per year.

On the other hand, if the citizens choose a local health care network instead of a specific family physician, like in Halland, competitions of this kind seems not to have contra productive effects on achieving closeness between organisations and professions in local health care [40,42]. That is, circumstances similar to the school voucher scheme with free choice among public and independent schools, but not among individual teachers.

3.2.2. Closeness in distance and time

Patients with high mobility, i.e., having access to a car, lacking movement disabilities, etc, most likely have wider references of closeness in distance than those with limited mobility, which in turn mean that mobile patients could choose among a number of local health care options and still find it close from a transportation stand point. In addition, due to choice of care the number of local health care providers has increased; in the County Council of Halland by 15% [13] and in the County Council of Stockholm by 11% [43], which enhances the possibilities for mobile patients to find an accessible alternative. Moreover, all types of choice of care schemes seem to stimulate local health care to shorten the waiting times [44], which is generally appreciated by patients receiving this kind of health care service [35].

On the other hand, elderly patients, one of main targets groups of local health care, have in general decreased their mobility over the years. For these patients a short distance to local health care will thereby be of vast importance if the motto closeness in distance is to be fulfilled. Accordingly, this implies that choice of care, from this perspective, seem to be irrelevant for local health care patients with decreased mobility.

Furthermore, if mobile patients chose local health care where it is regarded as accessible, they actively contribute to realize the target of closeness in time. Though, immobile elderly and chronically ill have not the same opportunity. These groups of patients are thereby not able to minimise their waiting time in the same way as mobile patients, which, in turn, imply an insufficient matching as well as an inequality provision of local health care to the population [31]. This situation also counts for occasional visits to other providers of local health care, due to for instance temporary perceived inaccessibility in the initially chosen local health care. It is possible in most of the county councils to be disloyal in this way, and there is a reallocation of the capitation fee to compensate for the extra production [16].

3.2.3. Closeness in shape of interpersonal connections

Patients with regular needs to visit local health care, for instance older people and chronically ill, prefer care provider continuity to make this as convenient as possible [35,37]. As a consequence, this group of patients are not likely to frequently change their choice of local health care provision and thereby make it difficult to maintain good interpersonal connections. On the other hand, choice of care makes it possible for patients to select among local health care providers until they find for instance a physician who describes the specific drugs a patient desires or is willing to put the patient on the sick list. These patients are not faithful to their choice. Instead they chose the option most suitable for the time being. A choice of care scheme allowing patients to change their choice several times a year thereby facilitate for these “patient vagabonds” to be active, which is a problem that the County Council of Västmanland has become aware of [45].

4. Concluding remarks

Regardless of the emerge of different Swedish choice of care schemes, this policy concept seems on the whole to strengthen the position of patients within health care; acting as principals accompanied with payments linked to their choice of health care provider. Though, this review indicates that some choice of care schemes could hamper the development of local health care with respect to the fulfilment of the three mottos: *closeness between organisations and between professions, closeness in distance and time, and closeness in shape of interpersonal connections*. First, quasi-market models generally make it difficult to integrate a differentiated health care provision. Thus, choice of care scarcely injects conditions which promote the development and sustainability of local health care. At best, following the theory of Health Care System Ecology, there is a state of commensalism. That is, when local health care is unaffected by the launch of choice of care. Though, at worse, when choice of care has a negative impact on interorganisational and interprofessional collaboration between providers of local health care, a state of amensalism evolves [20]. However, geographical monopolies, like local health care enclosed in a non-competitive context, will lack the stimulus of competition that possibly improves performance. Thus, it could be argued that if choice of care and local health care should be combined, patients ought to choose between networks of integrated health care and not among individual health professionals.

Moreover, if citizens chose local health care outside their residential area, they are taken away from their health context, which mean intersectoral collaboration about health promotion and health prevention are obstructed.

Second, all choice of care schemes includes incentives to get enough listed patients to defray the expenses with proceeds from capitation subsidies and activity based reimbursements. The feature of competition is according to this mainly a question of having accessible services for the patients, which in turn induce the health care providers to facilitate a provision adapted in most parts for short and uncomplicated visits. Target groups of local health care, such as heavy-care patients among elderly and chronics,

are not equally interesting from a financial standpoint; especially in schemes with a high proportion of flexible reimbursements. For these patient groups choice of care could thus cause deteriorated access to local health care. This situation is often reinforced due to a general low mobility among patients in this group, which make it difficult to change their choice even if the waiting time is shorter to other local health care networks.

Third, continuity of care is about the establishment of close interpersonal connections. With a choice of care scheme, discontinuity will evolve when patients frequently change their choice of care. Continuative contacts between patients and health care staff in local care are thus very much dependent on if the patient for some reason or other frequently exercises choice or not. On the other hand, target groups of local health care; elderly, chronically ill, etc., seem to be less eager change an established contact. Thus, if local health care sufficiently fulfils the basic needs of these groups; it will also be able to maintain interpersonal connections between the health care staff and most of the patients.

Moreover, these three remarks seem also to be applicable to other settings with patient choice in combination with a locally tailor-made integrated care.

To conclude, although Swedish policy makers promote both choice of care and local health care; it seems like more faith is placed in competition than in integration. More emphasis has to be placed on incentives to develop local health care into the integrated networks they are designed to be. The two policy initiatives will thereby have more equal conditions and possibly also develop a mutualistic relation, that is, a state where both concepts derive decisive benefits.

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