Private - public mix in health care services – the Swedish experience

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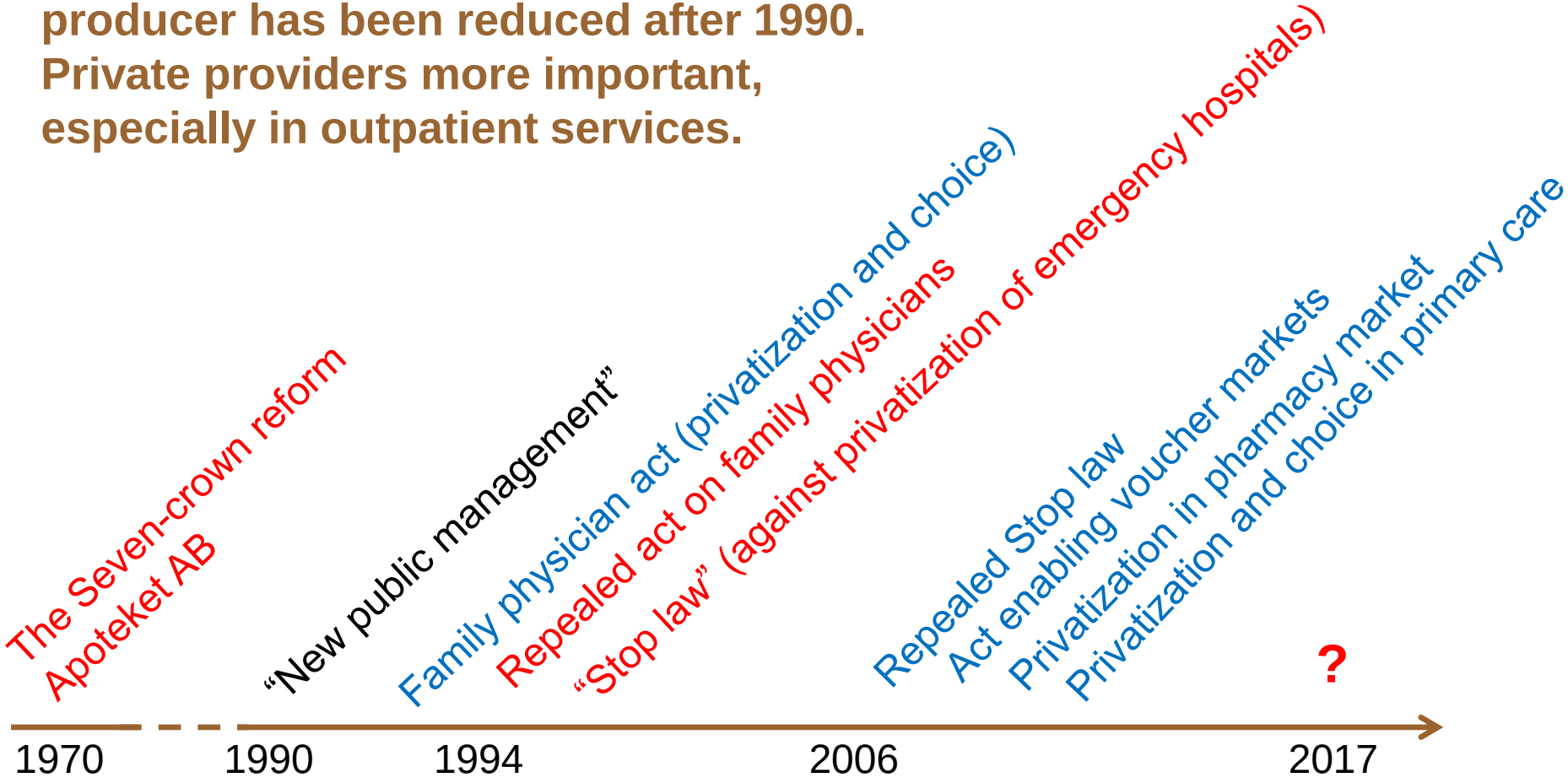
Several questions

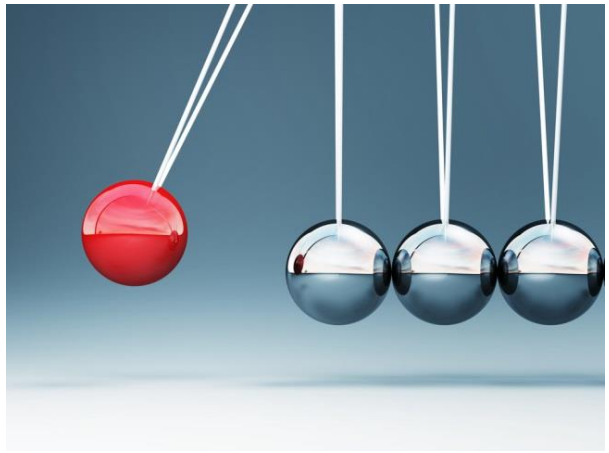
- Reforms from a political science perspective?
- Impact of privatization and competition, especially regarding equity and quality of care?
- Differences in behaviour and outcomes between for-profit and not-for-profit providers?
- Lessons for future policies and regulation?

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



”Red/green team” strikes back?

- Proposal to repeal act on choice in primary care (fall 2015)
  - No support in Parliament
- Regulation of voluntary private health insurance?
  - Priorities based on need only if providers have public contract
- Regulation of profits across private providers?
  - 7 percent on operating capital



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Perspective
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INTERNATIONAL HEALTH CARE SYSTEMS

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

Anders Anell, Ph.D.

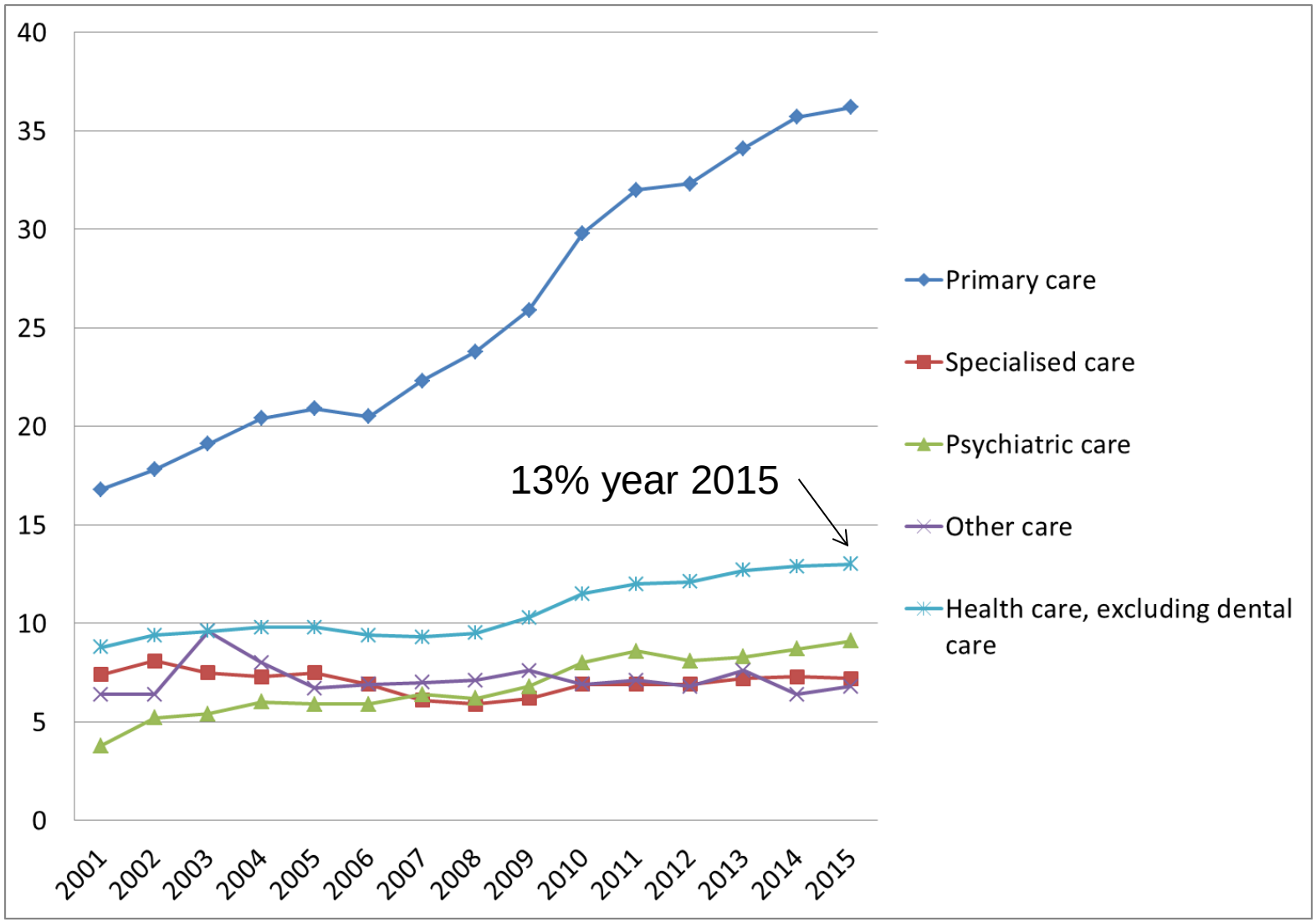
Decision making in Swedish health care is decentralized — 21 elected county councils own and operate almost all hospitals and a majority of primary care facilities, and most physicians are salaried employees of these institutions. There is universal access to high-quality medical services for all citizens at reasonable expenditure levels (see table and case histories). But the picture is more nuanced than those general facts might imply. 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.

An interactive graphic is available at NEJM.org

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 previously 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]

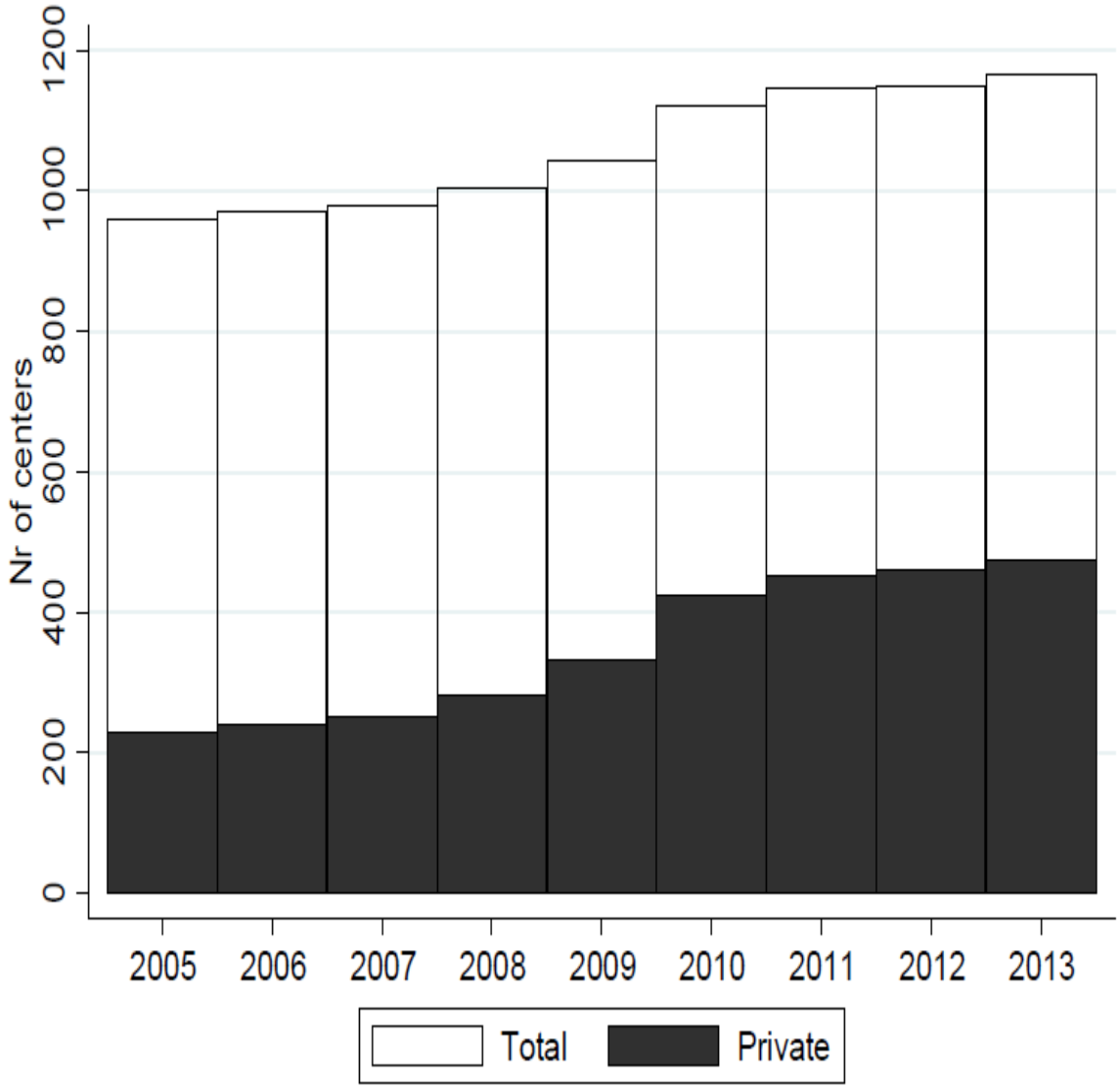
When it comes to health care, social services, and education, however, political opinions in Sweden have been more divided. The center-right government that was in place from 1992 to 1994 introduced changes that created opportunities for private providers of outpatient care. But these changes were reversed 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

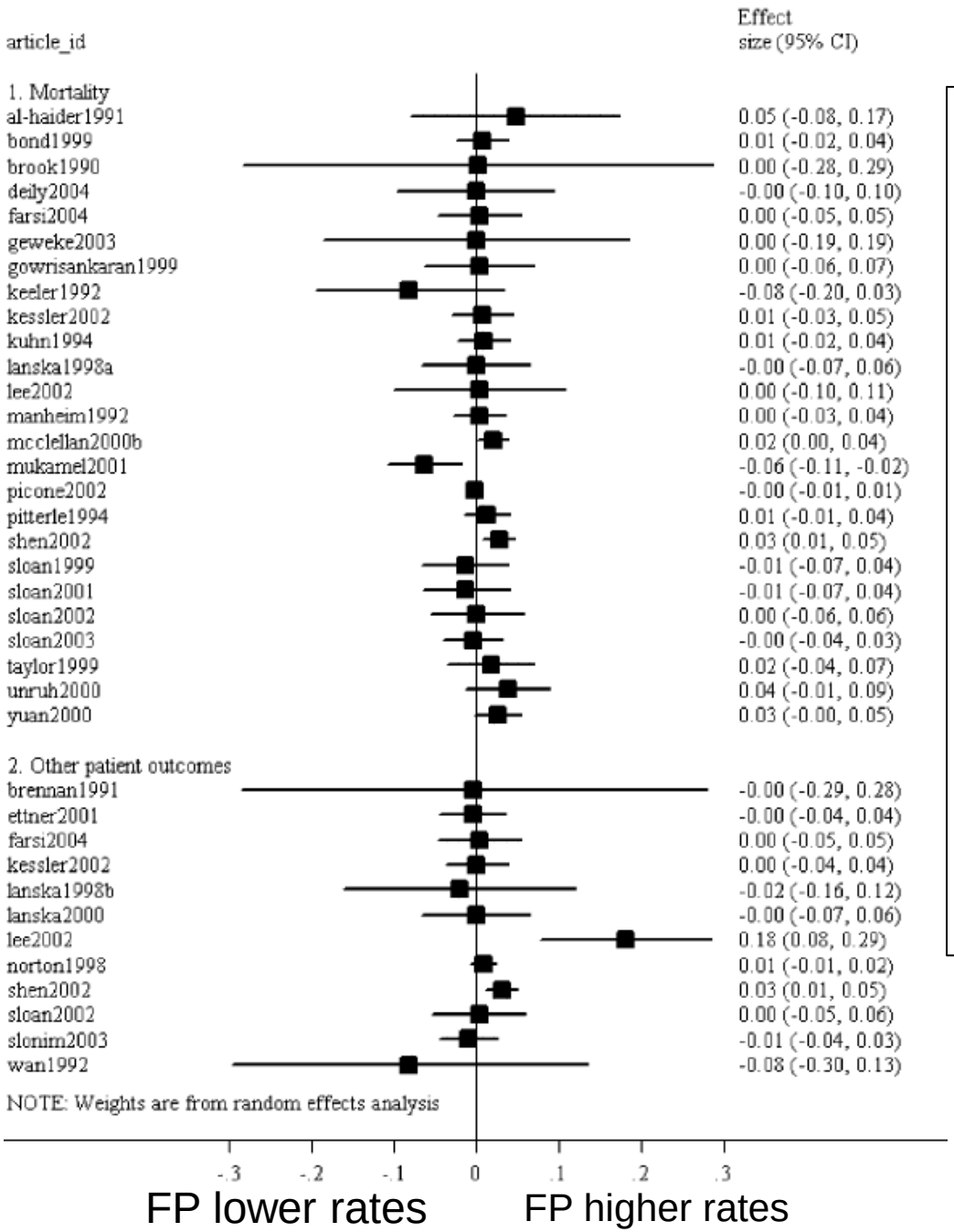
County councils payment to private providers 2001-2015 (proportion of net costs excl. prescription drugs).



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

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





Review of 31 original studies since 1990 (Eggleston et al. Health Econ 2008: 17).

Comparison of FP (for-profit private) with NFP (not-for-profit private) for acute, short-stay US hospitals.

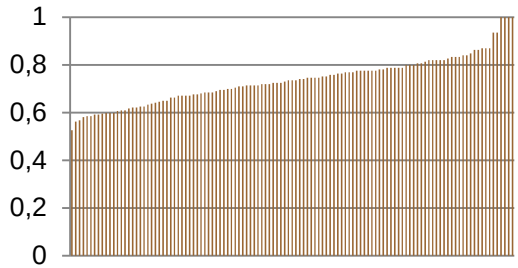
”*True effect of ownership appears to depend on institutional context, including differences across regions, markets, and over time*.” (s. 1345)

Studies about hospital conversions, Public/ NFP → FP (Joynt et al JAMA 2014; 312)

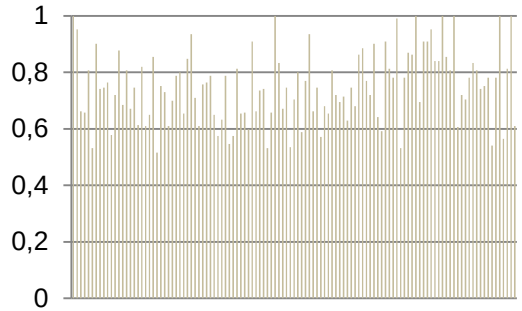
- Studies with data from the 1990s indicate higher profit margins, but also higher mortality
- Studies av 237 hospital conversions years 2003 – 2010 in comparison with control group
  - Higher profit margins
  - No difference in development of process quality or mortality
  - No difference in care to poor or minority patients

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:

- Large differences across practices

- No significant differences between private and public ownership

- No trade off between quantity and quality

- High medical and socioeconomic need reduces quantitative productivity

Glenngård AH, Anell A (2012) Produktivitet och patientnöjdhet i primärvården – En studie av Region Halland, Region Skåne och Västra Götalandsregionen. KEFU: Lund.

Two market principles – different outcomes to be expected

- LOU (Law on Public Tendering)
  - Competition *for* a market
  - Contracting out
  - Competition about price and quality
  - Limited choice and pluralism
- LOV (Law on choice system)
  - 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.

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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%.

Information, switching costs, and consumer choice: Evidence from two randomized field experiments in Swedish primary health care*

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November 2, 2016

"…. 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."

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

Arguments

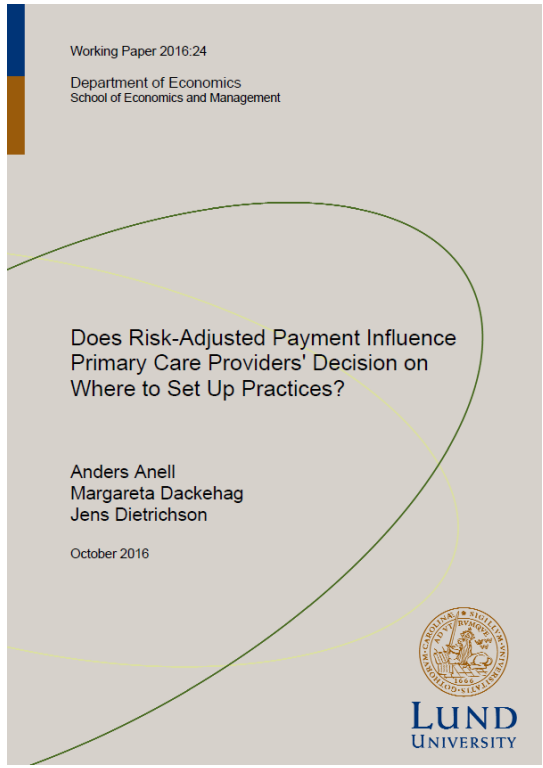
- Very good cost control
- Simple administration
- Practices may registrate patients with large needs without being financially punished
- Professional autonomy - possible to target patients with large needs; substitution between staff categories and type of contacts

In reality?

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

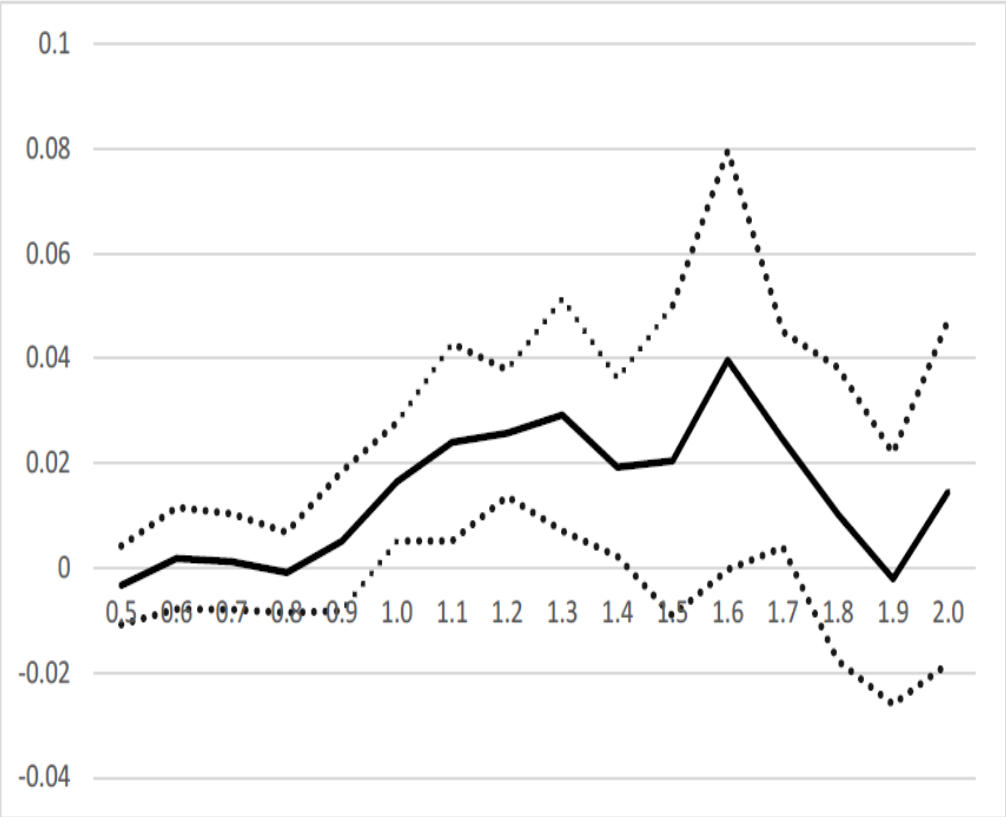
CNI-adjusted capitation and location of new private primary care practices

- 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



Heterogenous effect

- CNI-adjustment has a significant positive effect in small geographical areas (SAMS) with CNI values ranging from about 1.0 to about 1.8

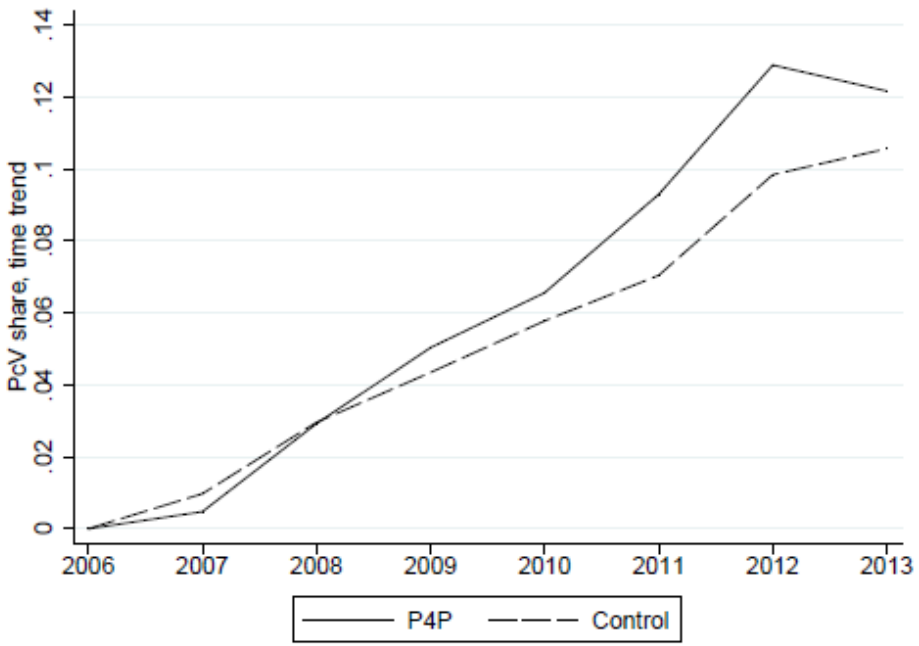


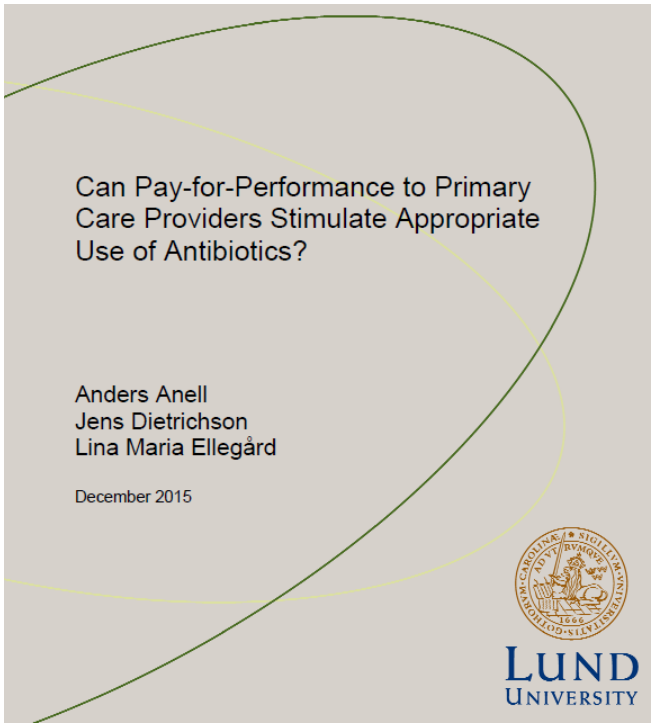
The solid line indicates the coefficients of interactions between CNI and indicators for intervals of CNI, ranging from 0.5-0.6 to ≥ 2.0 in intervals of 0.1. The dotted lines indicate the 95 percent confidence intervals.

Table 1: Prevalence of PcV P4P by year and county council

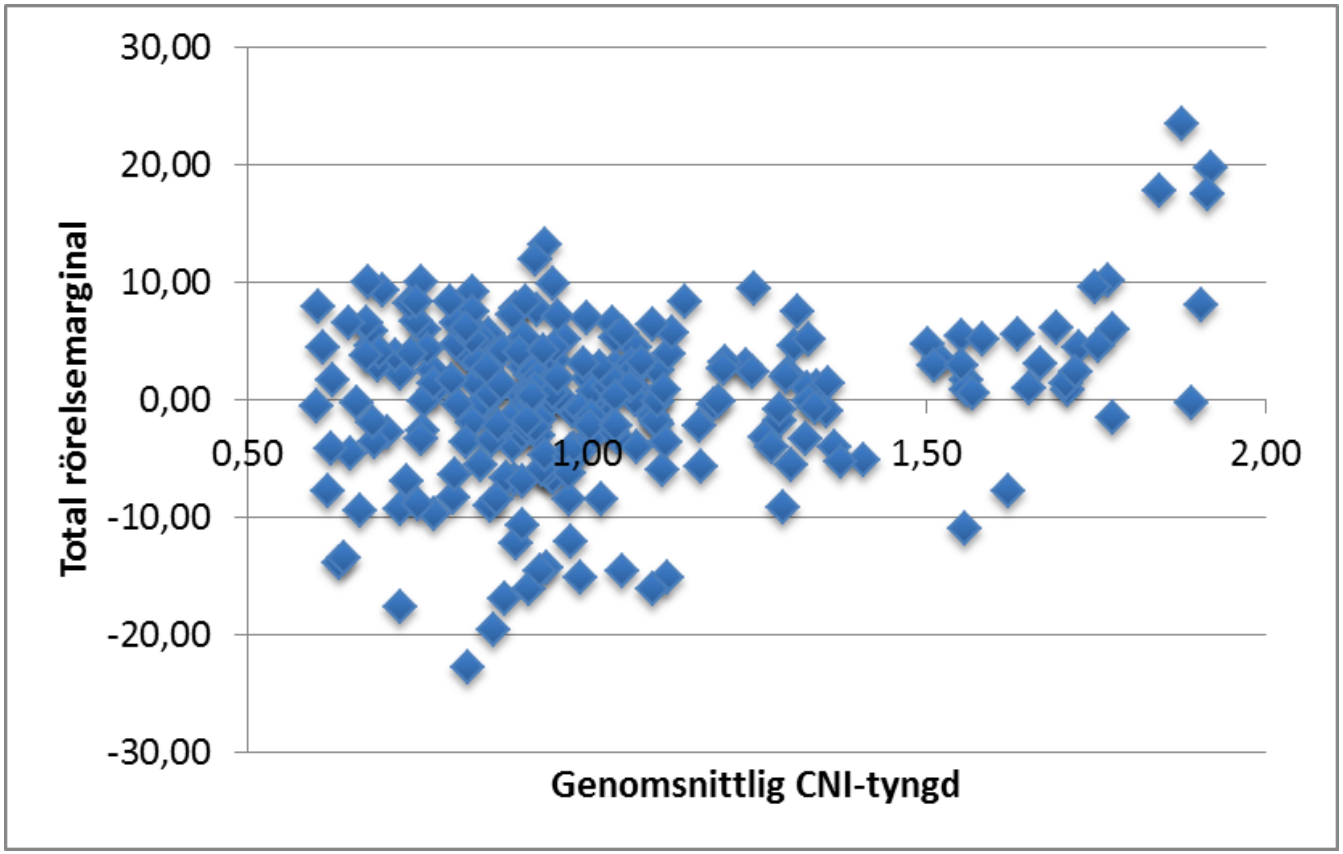
Year	Blekinge	Dalarna	Skåne	Västernorrland	Halland	Kronoberg	Stockholm (SLL)	Sörmland
2006								
2007								
2008								
2009			X					
2010	X	X	X	X				
2011	X	X	X	X	X		X	X
2012			X	X		X	X	X
2013				X		X	X	X

x = County council uses a P4P indicator related to the PcV share



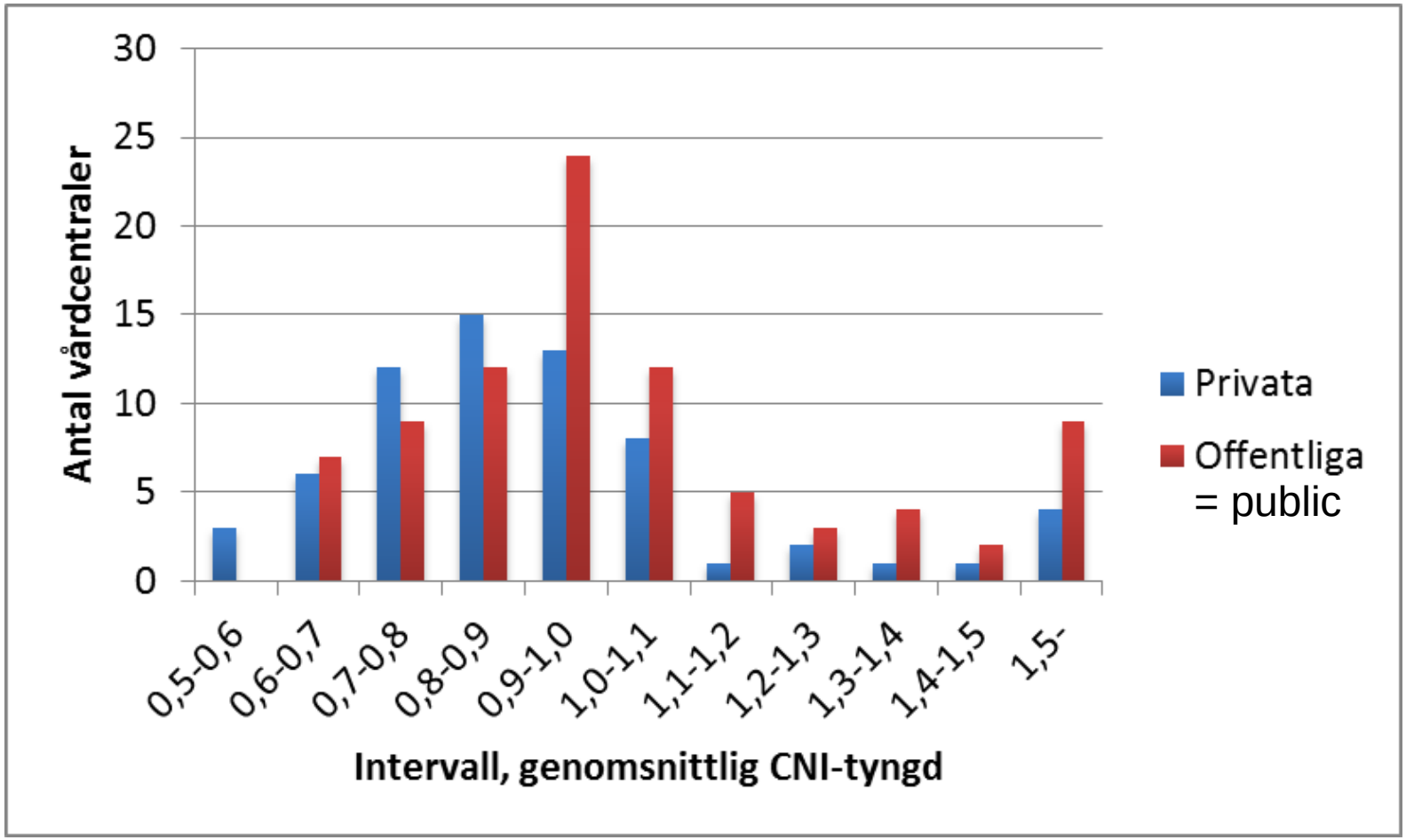


Surplus (% of revenues) and CNI for public practices in Region Skåne years 2012-2014.



Source: Anell A. (2016) Översyn av primärvårdens utveckling efter införande av Hälsoval Skåne. Kefu-rapport 2016:4.

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



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 anitiotics and bensodiazepines
- Less frequent folow ups of diabetes patients
- Increasing share of the population

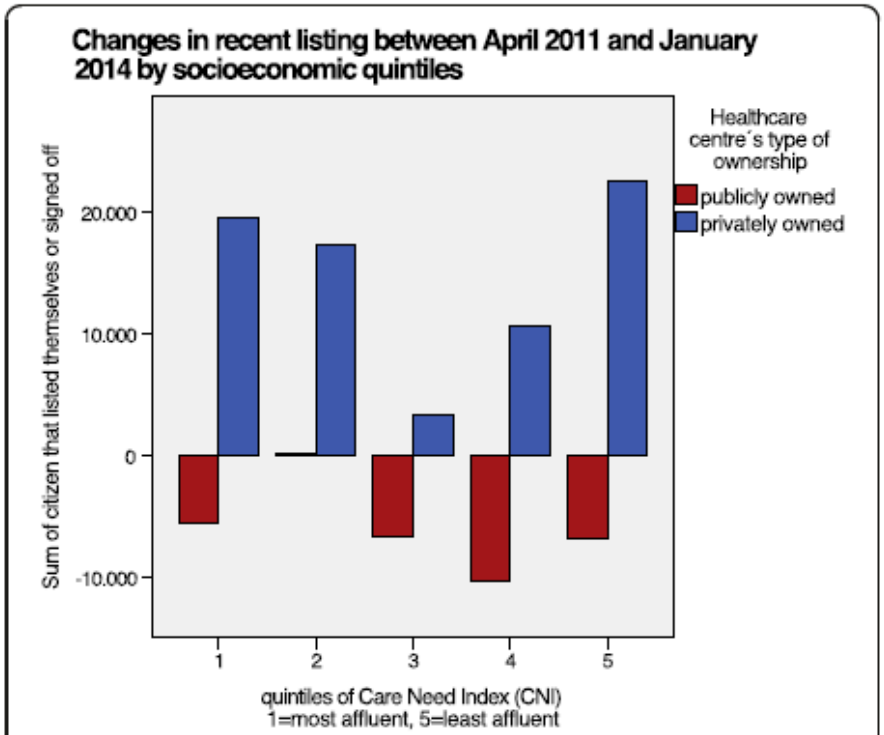


Fig. 2 Changes in recent listing between April 2011 and January 2014 by socioeconomic quintiles

Factors that influence patient satisfaction scores (Glenngård, Anell 2012, 2015)

Higher satisfaction

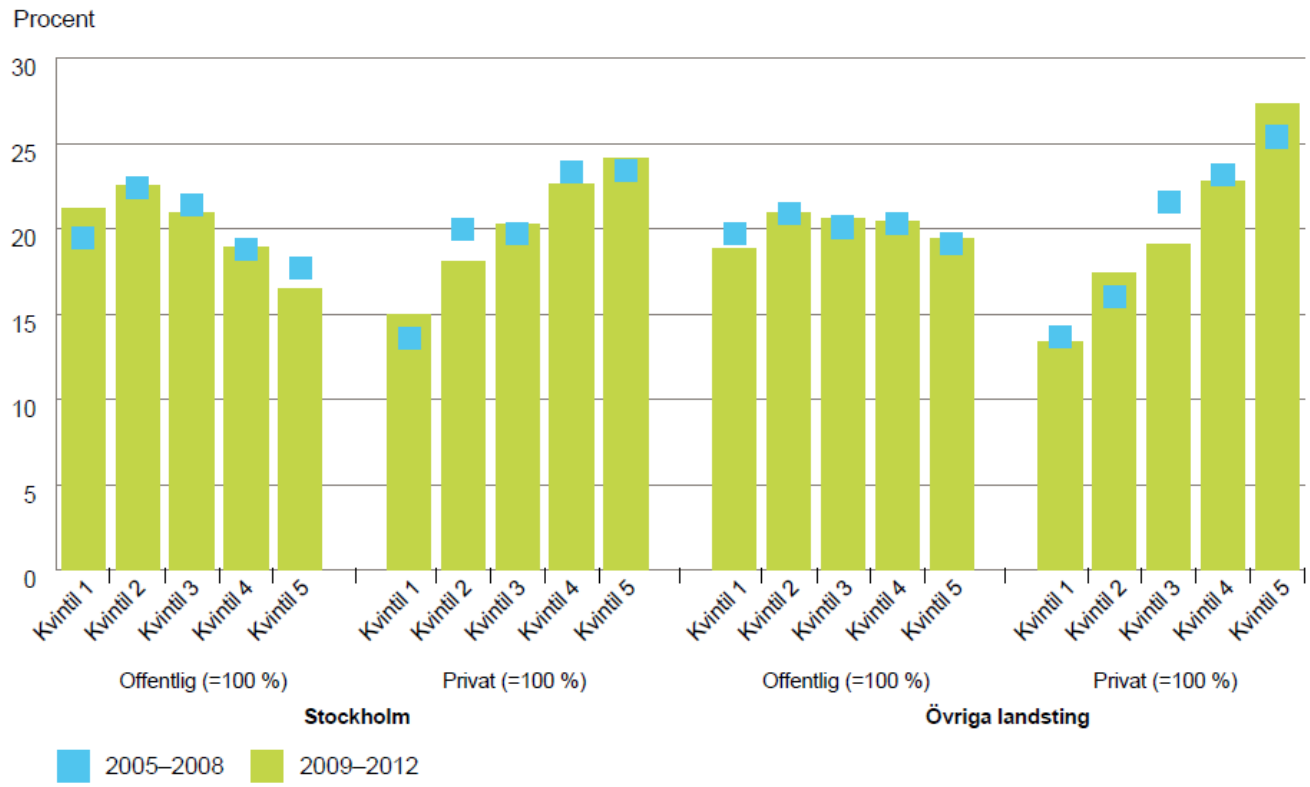
- Higher share of visits with doctors
- Higher medical needs (measured by ACG)
- Private ownership

Lower satisfaction

- Higher socioeconomic needs (measured by Care Need Index)
- Larger practices
- Larger cities

A higher share of high-income patients undergoing hip-replacements in private care (Vårdanalys 2014:1, p. 57)

Figur 23. Inkomstgrupp för de som opererats på offentlig respektive privatägd vårdgivare.



”…indications of lower quality in private care after adjustment for patient-mix…” (p. 13, translated from swedish)

Lessons for future policy and regulation

- Market principles and payment more important than ownership
- Socioeconomic gradient in private/public mix
  - But may be influenced by e.g. payment methods (socioeconomic adjustment)
- Several limitations in studies related to data
  - Parallel changes, long-term trends
  - Focus on physician contacts
  - Limited information about quality and value
- Improvement in data much needed
  1. To support choice by patients
  2. To support accountability towards payers (CE, equity)
  3. For improved research