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**Working Party No. 2 on Competition and Regulation****Designing publicly funded healthcare markets – Note by Sweden**

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More documents related to this discussion can be found at

<http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm>

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## Sweden

### 1. Introduction

1. The responsibility for the healthcare system in Sweden is shared between the state, the 20 county councils and regions<sup>1</sup>, and the 290 municipalities<sup>2</sup>. The role of the government is to establish principles and guidelines and to set the political agenda for healthcare. The government should also create conditions for equal care. The country's municipalities and county councils are responsible for providing a significant proportion of all public services, including healthcare. The county councils organize public primary and specialised care (including hospital care). The municipalities are responsible for care of the elderly, for people with physical or mental disabilities, for services for people released from hospital care and for school healthcare.

#### 1.1. Public funding of healthcare

2. The Swedish healthcare system is primarily funded by taxes.<sup>3</sup> Municipalities and county councils have a considerable degree of autonomy and have independent powers of taxation. Local self-government and the right to levy taxes are stipulated in the Instrument of Government, one of the four pillars of the Swedish Constitution. The rate of the county or municipality income tax is revised annually and in the local administrations' budget it is decided how money should be spent.<sup>4</sup>

3. In addition to a county tax, adult patients<sup>5</sup> must pay a patient fee<sup>6</sup> for each visit to a healthcare centre, hospital or any clinic that has an agreement with the county council. After a number of visits within a period of 12 months, or once the patient has reached a fee ceiling, the patient does not pay any further patient fee, regardless of which type of clinic the patient visits.

4. There are no government grants for the construction of buildings for healthcare facilities, and no distinction is made between privately or publicly run healthcare facilities. Financing for the construction of healthcare facilities is a question for the county councils themselves. The healthcare facilities are generally owned by the county councils even if there are private providers of healthcare within the facilities. One example is S:t Görans

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<sup>1</sup> 13 out of 20 county councils in Sweden have additional responsibility for regional development and have the right to be called "regions". For the purposes of this contribution, references to "county council" equally apply to those with the title region.

<sup>2</sup> One municipality, Gotland, an island located in the Baltic Sea, has the same responsibilities for healthcare as the county councils.

<sup>3</sup> In 2016, 84 percent was funded by public authorities, 15 percent by households themselves and 1 percent by private health insurances, SCB Hälsoräkenskaper 2016.

<sup>4</sup> In 2017, the average county tax rate was 11.42 percent and the total tax revenue was 249 billion SEK. 80 – 85 percent of this revenue goes to public healthcare.

<sup>5</sup> Up to 18 years of age there is no patient fee.

<sup>6</sup> The fee is decided by the county council/region and can differ.

hospital in Stockholm where the hospital's operations itself is run by the healthcare company Capio but the hospital building is owned by Stockholm County.

## 1.2. Provision of healthcare

5. The Health and Medical Service Act (2017:30) regulates healthcare. According to the act, healthcare does not need to be performed by a public administration except in the case of legal psychiatric care. The act contains goals and guidelines for all healthcare and the general principle that care given should maintain a good quality and be provided equally. The act contains a healthcare guarantee with a set timeframe, stipulating that patients should be able to have contact with primary care the same day by phone, visit at a doctor in primary care within 7 days and visit at a doctor in specialist care within 90 days. Upon a decision for treatment, for example a surgery, the patient shall be seen within 90 days. The healthcare guarantee is only valid in the county council where the patient is resident. There is a national website for the follow-up of healthcare guarantees and waiting lists.

6. There are both public and private providers of healthcare. Private providers are mainly companies. The existence of non-profit companies within healthcare in Sweden has historically been low. One reason is that the Swedish healthcare market has increased rapidly within the last 25 years, and that this growth would not have been possible with only non-profit companies, which normally do not wish to or do not have the possibility to expand. Privatisation of healthcare services in publicly funded healthcare markets has primarily been implemented through two alternative models, public procurement and systems of choice.

7. Over time, county councils have utilised more and more healthcare from private providers. In 2016, the county councils bought healthcare services from private providers for SEK 40.5 billion, which is 16 percent of the total cost of healthcare. Between 2006 and 2016, the proportion increased by 10 percent.<sup>7</sup> Private providers of healthcare therefore fulfil an important function in Sweden.

8. Overall, most private providers of healthcare are active within primary care. Since 2010 it has been mandatory for the county councils to provide a system of choice for users in primary care, whereas the provision of a system of choice for specialist care is voluntary for county councils. Stockholm County is the county in Sweden that has promoted competition most vigorously in healthcare within different specialisations. At present, the county has 37 different care choice systems within primary care and somatic specialist care. On a national level, private providers of specialised care are concentrated within metropolitan areas (Stockholm, Gothenburg and Malmö). More than 80 percent of all patient visits within private specialist care in 2017 were conducted at clinics located in metropolitan areas.<sup>8</sup> There are counties in Sweden that do not have any private specialist clinics located in them.

## 1.3. Private healthcare insurance

9. Around six percent of the population in Sweden has a private healthcare insurance. Employer-provided insurance accounts for around 70% of this total. One reason why

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<sup>7</sup> Swedish Competition Authority, *Konkurrensen i Sverige 2018*

<sup>8</sup> SALAR, *Ekonomi- och verksamhetsstatistik för landsting och regioner, 2017*

employers might pay private healthcare insurance may be to get quick access to care for their staff so that staff can return to work faster after illness. Unions also offer group insurance to protect their members from loss of income and 25 percent of private health insurance is paid by group insurance. Only 5 percent of private health insurance is paid by the insured.<sup>9</sup>

10. Private providers normally also have a contract with the county council to treat patients that come through publicly funded care, and should only use their overcapacity for private insurance patients. Therefore, although the private insurance patient market is a growing market for private providers, privately funded healthcare only competes with publicly funded healthcare to a limited extent, and is rather a complement to publicly funded healthcare.

## 2. Primary care

### 2.1. Introduction

11. The base of the organisation of Swedish healthcare is primary care and all inhabitants are listed at an approved healthcare centre, regardless of which specific needs the inhabitants have to visit primary care. If they do not make an active choice, they are automatically listed by the county council or region at the nearest healthcare centre located to their registered address.

### 2.2. Systems of choice

12. In 2007 the county council of Halland was the first to introduce a consumer choice system within primary care, known as a system of choice. In 2008 two other county councils followed, Stockholm and Västmanland. That same year, the Swedish parliament decided on the introduction of the Act on Systems of Choice in the Public Sector (2008:962), which entered into force on 1 January 2009. The Act applies to health and social services and is an alternative to the Public Procurement Act (2016:1145). Since 1 January 2010 it has been mandatory for county councils to have a system of choice within primary care, following section 5 of the Health Care Act (2017:30).

13. Systems of choice according to the Act on Systems of Choice in the Public Sector refer to a procedure whereby the individual is entitled to choose the supplier to perform the service with which a contracting authority has approved and concluded a contract. The compensation follows the individual's choice and re-election. The contracting authority shall treat suppliers in an equal and non-discriminatory manner. The contracting authority must observe the principles of transparency, mutual recognition and proportionality when applying a system of choice. The contracting authority sets the level of the payment given to the suppliers. The payment depends on the amount of users choosing the supplier as their service provider, which is similar to a voucher system.

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<sup>9</sup> Socialdepartementet, Privata sjukvårdsförsäkringar inom offentligt finansierad hälso- och sjukvård, Ds 2016:29

### *2.2.1. Purposes of a system of choice*

14. Prior to the introduction of systems of choice in primary care, the county council enlisted inhabitants at the healthcare centre that was located closest to their residential address. In most county councils this was a publicly run healthcare centre. This procedure is still done if the inhabitant does not make an own active choice, however nowadays the nearest healthcare centre can also be private run.

15. The main purpose of introducing a system of choice was to increase freedom of choice for users, and to improve quality, accessibility and efficiency by encouraging competition and diversity among actors in the healthcare and social services sectors. The system is supposed to provide county councils with a new tool that they can use in situations where they wish to expose in-house-provided healthcare services to competition and to transfer the choice of provider to the user. The entry barriers for private providers are lower in a system of choice than with public procurement. For private providers the contracts are until further notice, which may also give a more secure situation over the long-term and increase the willingness to invest.

### *2.2.2. Design of systems of choice*

16. The county councils are free to design the system of choice by themselves, which means that assignments, remuneration principles and cost responsibility<sup>10</sup> differ. There is freedom of establishment as long as the provider fulfils the demands<sup>11</sup> listed in the specifications by the county council. After the accreditation approval, the contract is valid until further notice. The county councils require that the healthcare centres must have a financially stable situation, that the operations manager should be a specialist in general medicine and that the healthcare centre normally has at least 40 opening hours per week, usually within business hours 8 am – 5 pm, Monday – Friday. During the opening hours, the healthcare centre must always have a certain number of GPs on duty. Digitalisation within healthcare in Sweden is developing rapidly, and some county councils require as of 2018 that patients should be able to book an appointment with a doctor at the healthcare centre online.

17. The remuneration to providers within the system of choice should be equal to all providers, public or private. All county councils have divided remuneration into a fixed and a flexible remuneration. The fixed remuneration is based on how many patients are listed at the healthcare centre (capitation) at a given time and should reflect the demographic conditions. The fixed remuneration is also adjusted according to Adjusted Clinical Groups (ACG)<sup>12</sup> and to the Care Need Index (CNI) for socioeconomic conditions.

18. The flexible remuneration is a sum for each patient visit/medical treatment that is carried out at the healthcare centre. There are large differences in the design of the remuneration among county councils. There is no common perception of the most effective remuneration model. The economic outcome of the models are followed-up and if

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<sup>10</sup> As for example pharmaceuticals, laboratory services and medical travel.

<sup>11</sup> There are demands concerning staffing, the physician in charge, business hours, phone availability, economic stability.

<sup>12</sup> ACG is a system where the patients are divided into 81 different ACG-groups. All patients within the same group have similar health conditions, which makes it possible to describe patient groups with different states in a selected population using ACG-groups.

necessary adjusted over time by the administrations. It is a continuous work of development.

### *2.2.3. The Swedish Competition Authority's analyses of systems of choice in primary care*

19. The Swedish Competition Authority (SCA) is the supervisory body for Public Procurement and for the Act on System of Choice. During the period 2009 – 2014, the SCA was furthermore assigned by the government to analyse the development of diversity within primary care and to analyse the preconditions for competition on quality within the system of choice in primary care. The results have been published in three reports in 2010, 2012 and 2014.<sup>13</sup>

#### *Preconditions for competition on quality*

20. One of the rationales for systems of choice is that the ability for the patient to choose leads to competition among healthcare centres, meaning that providers compete on attendance, accessibility and reputation, regardless of whether they are publicly or privately run.

21. In its reports, the SCA has looked at the preconditions for competition on quality. One such precondition is that patients know that they have an opportunity to choose a healthcare centre. A second precondition is that patients have at least two healthcare centres to choose from within a reasonable geographical distance.<sup>14</sup> A third precondition is that they have sufficient information about the healthcare centres.

22. The SCA noted in 2014 that in large parts of Sweden, these conditions had been met. The opportunity to choose a healthcare centre was well known, with 95 percent of inhabitants aware of the possibility to choose. Two thirds of inhabitants felt that they had made an active choice. Eight out of ten inhabitants had at least two healthcare centres within a reasonable distance. Furthermore, it is now easy to choose a healthcare centre through a national website. The healthcare centre may not generally deny any patient the ability to register at the healthcare centre.<sup>15</sup>

#### *Availability of primary care as a result of systems of choice*

23. One important result of the system of choice is that since 2010, the availability of primary care has been significantly improved in most county councils. In 2009 there were approximately 1000 healthcare centres in Sweden and in 2016 the number had increased to 1144 healthcare centres.<sup>16</sup> With the reform, the number of healthcare centres rapidly increased during the period 2010 – 2011. Most new healthcare centres are privately run, often by small undertakings. The majority of the healthcare centres are geographically located in metropolitan areas or areas with high or very high availability to healthcare

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<sup>13</sup> Swedish Competition Authority, Uppföljning av vårdval i primärvården, 2010:3, Val av vårdcentral, 2012:2, Etablering och konkurrens bland vårdcentraler, 2014:2

<sup>14</sup> In February 2014, 80 percent of the population had less than five minutes' travelling time by car to another healthcare centre than the one located closest to their residence.

<sup>15</sup> [www.1177.se](http://www.1177.se).

<sup>16</sup> Swedish Competition Authority, Konkurrensen i Sverige, 2018:1

centres. In 2014, essentially all residents, 99 percent, had less than 20 minutes' travelling time by car to a healthcare centre.<sup>17</sup>

24. However, systems of choice may lead to problems in achieving the establishment of healthcare centres in rural areas, due to the fact that it is necessary to have a certain population size to run a healthcare centre. For example, it will be hard to attract a private provider to establish in an area with a population base that is too small. On the other hand, the same problem can occur with a publicly run healthcare centre in a rural area, which may have to rely on deficit coverage by the county council. The publicly run healthcare centres that have been closed down since 2010 have been located in areas with a decreasing population base, not in city centres. The SCA has suggested that in rural areas public procurement may be an alternative to a system of choice.<sup>18</sup>

*With the system of choice, private providers entered the market to a greater extent*

25. Before 2010, the market share for private providers was low within primary care in most county councils. In some county councils, there was not a single privately run healthcare centre. In 2016, the market share of private providers had increased to around 42 percent on a national level. The regional differences are wide concerning public and private market shares. In Stockholm County, almost 70 percent of the healthcare centres were private in 2016 and in Norrbotten County only approximately 10 percent.<sup>19</sup>

26. Therefore, there is no homogeneous view of competition among the county councils. The county councils that use only the mandatory choice system consider that it is costly to have a system of choice and that private providers often tend to choose to treat patients with better health rather than high healthcare consumption patients (cherry picking).

*4 out of 10 healthcare centres were running a deficit*

27. Of the 1065 healthcare centres included in a survey by the SCA in 2012, 4 out of 10 were running a deficit. Almost half (48 percent) of the publicly run healthcare centres and 28 percent of the privately run healthcare centres were running a deficit. In areas with low availability, 67 percent of the healthcare centres were running a deficit. This is an indication that the compensation within the system of choice is often not enough in rural areas. Factors that influence why healthcare centres are running a deficit are decreasing population bases within the municipality, costs for vulnerable groups of patients and high costs for locum doctors. In Sweden there is a shortage of GPs. Especially in the northern part of Sweden, decreasing population bases are a problem. To be able to run a healthcare centre there must be a certain limit of inhabitants within a reasonable geographical area that use its services. In its report in 2014, the SCA estimated that 25 percent of the healthcare centres in the country would have a decreasing population base by 2020.<sup>20</sup>

<sup>17</sup> Swedish Competition Authority, *Etablering och konkurrens bland vårdcentraler*, 2014:2

<sup>18</sup> Swedish Competition Authority, *Etablering och konkurrens bland vårdcentraler*. 2014:2

<sup>19</sup> Swedish Competition Authority, *Konkurrensen i Sverige*, 2018:1

<sup>20</sup> Swedish Competition Authority, *Etablering och konkurrens bland vårdcentraler*, 2014:2

### *Risk of “cream skimming”*

28. The most common criticism against systems of choice is that it may lead to the displacement of vulnerable groups of patients by healthcare providers (cream skimming) and that healthcare centres have incentives to treat patients with less complicated medical issues rather than the opposite. The county councils weight the fixed compensation with ACG and CNI to take into account the above-mentioned groups. The proportion of the fixed remuneration in relation to variable remuneration varies among the counties/regions, but it is generally 70 – 90 percent of the total compensation, with the exception of Stockholm County, which has a proportionally higher percentage of variable compensation.

### *Alleged market distortions*

29. In some counties, privately run healthcare centres have criticised the county council/regions’ allegedly distortive behaviour of subsidising deficits in their own publicly run healthcare centres. It is argued that this leads to competitive disadvantages for private providers. Some private healthcare centres have been closed down due to deficits after the system of choice became mandatory in 2010. In 2013 and 2014, there were bankruptcy proceedings among a few private undertakings due to heavy deficits. If a private provider fails and exits the market, the county council/region must re-list all of its patients at another healthcare centre. This may result in the patients having to travel longer to reach the nearest healthcare centre.<sup>21</sup>

#### ***2.2.4. Evaluations of system of choice within healthcare***

30. Evaluations that have been carried out by different national authorities of the system of choice in the county councils show that it is difficult to evaluate the different systems of choice within primary care on a national level. One problem is that the systems have had different political goals, that the systems have been designed differently, and that the data concerning quality before and after the introduction of the system of choice is limited. One factor is also that population conditions vary widely in Sweden. However, some general results can be noted. The variety of care, diversity, freedom of choice and accessibility has been improved with the introduction of systems of choice. The results also show that the number of visits to healthcare centers increased more in socioeconomically more advantaged groups than among patients with a greater need of care. There are also challenges with respect to continuity and cooperation.<sup>22</sup>

31. In Stockholm County, the number of visits has increased much more than estimated. Some of the patient visits do not depend on patient needs, rather they are an effect of competition and high demand.<sup>23</sup>

### **2.3. Cost for locum doctors is a problem in primary care**

32. The high cost of locum doctors is a national structural problem due to a lack of GPs, but some counties suffer financially within primary care. There are examples of publicly run healthcare centres, located in sparsely populated areas, which have been shut down by

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<sup>21</sup> Swedish Competition Authority, Etablering och konkurrens bland vårdcentraler, 2014:2

<sup>22</sup> Vårdanalys, Vårdval och jämlik vård inom primärvården, 2015:6

<sup>23</sup> Stockholm County Council, Vårdval 10 år, 2018

the county council due to heavy costs for locum doctors. The SCA has therefore also chosen to analyse the use of locum doctors in primary healthcare. In 2015, it published a report which looked at the county councils' procurements and costs for locum doctors. In 2014, county councils paid over SEK 1.1 billion to locum doctors in primary care. A follow-up in 2017 by the SCA showed that in 2016, the cost for locum doctors had risen to SEK 1.6 billion in primary care, which is a 45 percent rise over just two years.<sup>24</sup>

33. Calculations made by the SCA show that a locum doctor is 1.5 – 2 times more expensive than a permanent doctor. At the same time, the Authority's supervisory activities have shown that some county councils engage locum doctors without the necessary public procurement.<sup>25</sup>

### 3. Hospital care

#### 3.1. Provision of hospital care

34. Competition in hospital care has not occurred to any significant extent in Sweden. Patients are not able to choose their provider of hospital care in the same way as they are able to choose their provider of primary care. A major reason is that in Sweden, university and emergency hospitals are in general publicly run by the county councils.<sup>26</sup> Only one emergency hospital is privately run but publicly funded in Sweden. In this case the county council in Stockholm has entrusted the assignment to a private contractor.<sup>27</sup> In 2016 a bill was proposed which would restrict the entrusting of university hospitals to any party other than the county councils.<sup>28</sup> The proposal has not yet been considered by the Swedish parliament. The SCA took the view that the proposal may lead to lower effectiveness if the county councils were not able to organise hospital care as they like.<sup>29</sup>

35. Some county councils have introduced a system of choice in specialised care on a voluntary basis. Stockholm County has moved out some of the specialised care from public hospitals to private clinics, for example orthopaedics, specialised gynaecologic care, and planned surgery as hip and knee prosthesis surgery and back surgery. Common to these private clinics is that they have a contract with the county council but also treat patients that have private health insurance.

#### 3.2. Public procurement is used for demarcated assignments in hospital care

36. In some county councils, private providers have been allowed within the facilities of the public hospital for demarcated assignments to perform medical services, laboratory

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<sup>24</sup> Swedish Competition Authority, Hyrläkare i Primärvården, 2015:10, Konkurrensen i Sverige, 2018:1

<sup>25</sup> Swedish Competition Authority, Hyrläkare i Primärvården, 2015:10

<sup>26</sup> There are around 70 emergency hospitals, whereof seven are university hospitals.

<sup>27</sup> Capio, S:t Görans Hospital in Stockholm, the contract is valid to 2021.

<sup>28</sup> Department of Health, Driftsformer för universitetssjukhus, Ds 2016:28

<sup>29</sup> Swedish Competition Authority, consultation response, case number 504/2016

services or X-ray services that the county council has procured. One reason why county councils procure laboratory analyses is that it is easy to decide the price per unit, compared with the price for an emergency operation for example.

37. In a report from 2012, the SCA stated that exposure to competition through procurement is a key factor for lower prices. From a competition perspective, county council procurements generate positive synergies, as more stakeholders can establish themselves in the laboratory service market.<sup>30</sup>

### 3.3. Cost effectiveness within hospital care

38. During the 1990s, the number of employees at public hospitals significantly decreased because more care was performed outside of hospitals. In general, technical developments has resulted in improved care and a reduced number of hospital beds. There is a trend within the administrations in the county councils towards reducing the number of hospitals beds over time, as well as towards moving out hospital care to day care which can for instance be performed at healthcare centres.<sup>31</sup>

39. 20 of 21 county councils use a method for cost-control that calculates the Cost per Patient (KPP) within somatic care and other care. KPP is a patient-based cost accounting system<sup>32</sup>. KPP calculates the healthcare system's cost for each individual healthcare contact. Over 1.2 million contacts were registered in hospital care in 2016 with KPP. The average cost per patient was more than 50,000 SEK in hospital care in 2016, compared with 3000 SEK in open care.<sup>33</sup>

40. As a means of control since the economic recession in the early 1990s in Sweden, county councils have, instead of competition, introduced producer/ provider-split models for hospital care to improve cost efficiency and reduce deficits. The administration tries to control hospital care with, for example, volume limits for production. When the production ceiling is reached the compensation per performance is reduced, and the hospital must reduce its costs to increase productivity instead of increasing volumes. It is, however, hard to control production or consumption of hospital care and this type of budget control can lead to difficult priorities for the hospital management.

## 4. Conclusions and recommendations

41. The system of choice within primary care in Sweden has created diversity and competition on quality among providers of healthcare centres. Accessibility to primary care has been significantly improved in the country with the help of consumer choice of healthcare centres. Systems of choice increase the possibilities for individual preferences to be met. If the patient is well informed and has the opportunity to choose among providers within a reasonable geographic distance, a system of choice works well. Services that are

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<sup>30</sup> Swedish Competition Authority, *Konkurrens inom laboratorietjänster*, 2012:5

<sup>31</sup> *Läkartidningen*, Sverige har lägst antal vårdplatser i Europa, nr 6 2007

<sup>32</sup> KPP includes the methods and system that are necessary to present the activities and treatments that are carried out within hospital care for each patient and the cost for each patient.

<sup>33</sup> SALAR, *Kostnad för NordDRG 2016*

often repeated and measurable like patient visits to the healthcare centre are suitable for competition.

42. A system of choice within specialist care like hip or knee surgery differs considerably in the sense that patient consumption is of a one-time nature or occurs very rarely (2 -3 times over a person's life). It can be difficult to evaluate indicators of quality between different providers of such surgery. In many cases, the GP will recommend which provider the patient should choose, and act as an agent for the patient. It will not then be an independent consumer choice, but rather a professional choice, which could potentially lead to the private provider of surgery being treated unequally. However, a choice based on medical competence when the patient is not able to choose does not necessarily mean that it is not objective.<sup>34</sup>

43. Only a few county councils have introduced consumer choice within specialist care, and the majority of these systems of choice are found in Stockholm County.

44. Private providers of specialist care are mainly located within county councils that already have several systems of choice within specialised care. The basic conditions to introduce consumer choice for specialised care outside these areas may be less favourable due to a lack of private providers. Instead of a system of choice, a smaller county with a limited population could alternatively utilise public procurement.

45. Public procurement can preferably be used for services such as laboratory services where the price per unit is easy to measure. The SCA has shown that county councils that have procured laboratory services have reduced the price per unit significantly compared to the county councils that have retained the laboratory operations in-house.<sup>35</sup>

46. Some healthcare services such as emergency care are not in general subject to competition, where traditional market solutions may work poorly. If such services are outsourced, it demands well-developed relations over a long period between the county council/region and the private provider.

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<sup>34</sup> Swedish Competition Authority, regulatory decision regarding the system of choice for private psychotherapy, case number 62/2013

<sup>35</sup> Swedish Competition Authority, *Konkurrens inom laboratorietjänster*, 2012:5