

Summary

Health- and medical care in Sweden has a long tradition of being a government responsibility. This applies to both funding and the provision of medical care. While the public financing has been unchanged in the last few decades, the role of the public sector as a producer has been reduced and has been supplemented with private care. The extent of this trend has varied for different parts of medical care. In primary care and part of the specialist outpatient medical services and certain medical services (for example laboratory tests), there has been a strong increase in the private share. Specialist hospital care is still largely run by the public sector. However, the trend differs considerably between different county councils.

Privatisation and contracting of medical services have largely been implemented according to two models: public *procurement/the entrepreneurial model* and *the customer choice model*. In public procurement, the public buyer and the funder buy services from private or public agents in accordance with the rules for public procurement and contractual agreements. The entrepreneurial model is thus characterised by *competition for the market*. In those cases when private agents win the public procurement, production is thus privatised. In a customer-choice model (choice of medical care), the patient herself gets to choose between suppliers of medical care that have been approved by the buyer. The suppliers of medical services can be either private or public. This means that patient choice governs the flow of resources to producers – there is *competition in the market*.

The effects of privatisation and outsourcing are normally uncertain and for health- and medical care, there is to a large extent a lack of adequate evaluations. However, there is unanimity about the fact that institutional factors, i.e. characteristics of different services in health- and medical care and the interaction of these

characteristics with regulations and contractual conditions, affect the outcome. The overall objective of this report is thus to analyse how institutional factors affect the conditions for an efficient participation by private agents in health- and medical care. What role do, for example, the possibilities for the buyer and the patient of evaluating the quality in different services for medical care play for the expediency of public procurement, customer choice and production in the public sector? The study takes its starting point in government funding, based on taxes and, on this basis, analyses alternatives for outsourcing and private production within this framework.

Privatisation and outsourcing of medical services have both advantages and disadvantages. A basic expectation is usually that those activities that are privatised will be supplied more efficiently than under public authority. A related aspect is that the introduction of private alternatives and subjecting activities to competition can also lead to an increased efficiency in those activities that remain in the public sector. At the same time, it is seldom appropriate to give the market forces complete liberty within such an area as health- and medical care. Both national and international experience shows that insufficient regulation and control can bring undesired effects. However, this report is not mainly about advantages and disadvantages of private or public production. The central starting point of the report is instead to discuss under which conditions private forms of operations can be used to create the largest possible social utility. Thus, the report discusses the basic conflicts of goals and those adjustments that need to be made when private forms of care constitute an alternative. The analysis is based on institutional economic theory to categorize health- and medical care for their suitability for different modes of contracting. The theoretical framework is then tested empirically against key parts of the Swedish health care.

The transaction costs are in focus when evaluating the conditions for outsourcing

The analysis is based on economic theory on organisations and transactions – the so-called transaction cost approach. According to this approach, it is the interaction between the characteristics of a good or a service – which we will call *transaction characteristics* in

the following – and the capacity in available forms of governance and organisations that determine whether an activity is most suited to take place within the organisation of the principal or whether it should be outsourced. If a service is produced by a public agent, it can be said to have a hierarchal structure according to basically the same logic as a public authority. If it is outsourced, it will at least partly follow the logic of the market. The most important transaction characteristics are:

- *Transaction specificity*, i.e. to what extent that those resources that are required to carry out a transaction can be used in another activity without a reduction in their production value. High specificity creates a risk for opportunistic behaviour in market relations and constitutes an argument against outsourcing/privatisation.²
- *Frequency*. Refers to how often the transaction occurs. This determines whether it is profitable to invest in specialised control systems, for example ambitious follow-up systems. Recurring transactions favour the possibilities for contracting/privatisation.
- *Uncertainty*. Captures to what extent there are several known alternatives, if the partners have insufficient information and the risk for unexpected events occurring during the contract period. Great uncertainty constitutes an argument against contracting/privatisation.
- *Measurability*. The larger are the difficulties and the more complicated it is to measure the quantity, quality and costs for a transaction, the larger are the transaction costs for negotiating, writing and supervising contract solutions. It is also clear that the conditions for measuring costs and quality affect an appropriate control and monitoring of an activity. It might also be the case that certain measures can be manipulated, which reduces the possibilities for using the measures and the possibilities for a follow-up.

In the choice of the form of control and organisation, the market and its hierarchy constitute complete opposites. The market is

² An example of a technology with high transaction specificity within medical care is Extracorporeal Shock Wave Lithotripsy (ESWL), which can only be used to treat kidney stone (and to a certain extent gallstone). Equipment for testing blood pressure is, however, an example of a technology with low specificity, since this can be used for a wide range of diseases.

mainly characterised by limited contract periods, relatively complete contracts, mainly strong incentives and tough budget restrictions and control through prices and contracted remunerations. Market control is particularly efficient for services that are simple, easy to specify and measure and that do not require any special investments. The hierarchy is instead characterised by more long-term relationships, weaker incentives and softer budget restrictions as well as governance through internal control and administrative rules. Hierarchy constitutes an advantage when the transaction contains specific investments, when the contracts require regular renegotiations and when production is difficult to specify and measure.

If the characteristics of the transaction constitute one side of the coin for efficient contracting, the actual design of the contract constitutes the other side. Thus, we also identify and analyse a number of *contract characteristics*, for example the regulatory framework for accreditation, remuneration systems, contract length and follow-up. The characteristics of transactions and contracts are then studied within a number of central sub-areas of health- and medical care. A number of case studies illustrate both contracting through public procurement and customer choice arrangements. An example of contracting of private providers is the procurement of laboratory work and hospitals for emergency care (S:t Görans Hospital in Stockholm). The different models for choice of medical care within primary care and parts of specialist outpatient care (mainly planned surgery) constitute examples of private influence on consumption. We also analyse the contract form for private practitioners within specialist open care who are subject to special regulations, i.e. those who work according to the so called national fee.

There is a certain relationship between the characteristics of the activities and the share of outsourced medical care

In this study, we evaluate the possibility for an alternative use of different technologies within health- and medical care and find that it varies between different forms of medical care. For primary care and simple planned activities, there are often alternative uses for premises and equipment. Also human capital in the form of trained staff has more areas of use, both geographically and as concerns its

activities (for example, occupational health care). Thus, the transaction specificity in primary care is relatively low. From this perspective, primary care is a kind of care with is suitable for outsourcing. When it comes to specialist care, the specificity is generally higher but there is a variation between specialist areas also in this case. For most choices of medical care with a specialisation that involves surgery, the specificity is moderate since there are alternative areas of use for standardised operation capacity and also for certain staff. But the specificity is higher for surgeons with specialist competence and specialising in certain kinds of surgical operations. For other parts of specialist care, such as emergency medical care and laboratory work, the specificity is instead relatively high. This does, in particular, apply to capital-intensive activities, such as certain kinds of laboratory equipment which can only be used for specific medical analyses. When contracting such activities, the transaction is carried out with contracts over longer periods of time. Contracts and agreements in this area do also largely build on an on-going dialogue with a long-term follow-up and evaluation of the activity.

As concerns the *frequency* of the transaction, most kinds of medical care are characterised by a large share of outsourced medical care with recurring transactions. In primary care, this is shown by the often recurring contact between the patient and the supplier of medical care. Several of the areas of specialist care with the possibility for health care choices, such as childbirth, cataract-surgery, and hip- and knee surgery, are also characterised by a high frequency and a large number of patients. Treatments of rare diagnoses and illnesses, such as certain surgical treatments or special forms of cancer, are, however, characterised by a lower frequency. Thus, these are more seldom subject to external contracts.

In medical activities, there is always an *uncertainty* about both the costs for and the outcome of a treatment. In primary care, there is primarily an uncertainty about the outcome of treatments and the course of the illness since the need for costly and demanding treatments is often dealt with through referrals to specialist care. There is also a limited capacity in primary care which means that the costs can often be controlled. In specialist care, there is a relatively larger risk as concerns both costs and outcome. However, there is a difference in the uncertainty of, for example, planned operations/treatments and emergency care. The

uncertainty in emergency care is larger in several respects, as concerns the number of patients in a certain time period, resource use as well as the outcome of the treatment. Contracting in specialist care has mainly taken place within kinds of care where there is less uncertainty. In those models for choice of medical care that have been introduced, so-called risk patients have also been exempt, which has further served to reduce the uncertainty. Thus, the agreement with S:t Görans Hospital does not include highly specialised care. There has been a decrease in the uncertainty of laboratory work with a trend towards standardised analyses. For less frequent analyses, there is, however, some uncertainty.

Measurability as concerns quality, costs as well as volume is another central factor when choosing organisational form. The conditions for evaluating and measuring quality vary considerably between different forms of care. Certain kinds of care have obvious criteria for the result and a clear relationship between the resources used and quality. In primary care, however, with its wide range of illnesses and health problems, there are large difficulties in evaluating the quality of care and the effect of the measures used. There are no overall clinical measures for the overall objective of primary care. There are, however, examples of specific measures that are used in primary care, for example measures of blood sugar levels within diabetes care. The quality criteria that are most often used in primary care concern information about the patients' own evaluations and information about availability and waiting times at the district health center.

In somatic specialist care, there are often illness-specific quality criteria, for example as concerns patient survival, the ability to function and health-related quality of life. The models for choices of medical care within specialist care have also mainly been introduced in areas where established quality registers have existed for a long period of time. Besides the buyer's basic requirements for, for example, competence and equipment, there is no accreditation system for independent controls and ensuring quality as concerns both processes and the treatment outcomes. The only form of medical care that has developed and applied an accreditation process for quality that is independent of the buyer is laboratory work. In this work, accreditation, also of processes and quality outcomes, is a requirement for obtaining a contract.

Altogether, we find that activities that are characterised by a low transaction specificity, high frequency, less uncertainty and the

possibility to follow-up and measure are to a larger extent outsourced to private agents. In particular, this concerns areas of care such as primary care and planned treatments with a relatively low uncertainty which can be measured. The large share of private care within primary care, which is characterised by few clinical quality measures, is explained by the fact that this kind of medical care instead has good conditions for measuring quality through the patients' own evaluations. In specialist care, it is mainly specialties with clear quality criteria that have been subject to external contracting while care with uncertain quality indicators is almost exclusively carried out by public providers. We also see that forms of medical care with large uncertainty have a smaller share of external medical care.

The contract solutions also vary with the characteristics of the areas of medical care

Contract solutions or contract design constitute important means for controlling external providers of care. Those control mechanisms that are studied in this report are regulatory frameworks for accreditation, remuneration systems, contract length and follow-up. Altogether, there is a pattern where contract solutions vary with the characteristics of the different forms of medical care.

In general, the *accreditation* of providers of care has mainly focused on requirements concerning input factors (staff competency, staffing and equipment) and economic stability. This concerns both the systems for choice of care within primary care and specialist care. In the latter case, there is also a requirement for experience, for example a certain volume of previous operations/treatments. A more long-term accreditation procedure, based on random quality controls carried out by independent accreditation institutes, exists in laboratory work.

The principles for remuneration depend on the characteristics of the form of medical care and constitute central parts of the contracts. The principles for remuneration have several objectives. They are to define the cost ceiling, but also provide incentives for high productivity and quality, as well as avoiding a selection of patients. In order to avoid too strong incentives in any direction, mixed remuneration models are used in several areas of medical

care. As an example, in primary care, a share of the remuneration is paid on basis of each listed individual, i.e. a fixed remuneration independent of the number of visits/medical treatments, which favours cost control. In order to encourage simultaneous good availability and high productivity, there is also a share of flexible remuneration per visit/medical treatment that is carried out. Moreover, in several county councils, a smaller share of the remuneration is connected to quality-related objectives. However, there are large differences in the design of the remuneration between county councils. There is no consensus on the optimal mixture of different remuneration forms, but there is both theoretical support and support based on experience of this kind of combined remuneration system being preferable to pure models.

In specialist care, the remuneration is to a larger extent related to the number of visits and the number of operations/treatments. In order to ensure cost control and stimulate that quality is subject to development, it should, however, be noted that that in several cases, the buyer does also, to a larger extent, transfer financial risks related to a high use of medical care and insufficient quality of the providers to medical care. By, for example, remunerating the total episode of medical care with a common package price instead of the remuneration being paid at each individual visit and for each individual treatment, the providers of medical care are given incentives to keep the number of activities down. At the same time, the buyer sometimes tries to mitigate the uncertainty in outcomes through requirements that clinics that perform surgery are to take a responsibility (economic and clinical) for possible complications that emerge after a completed treatment and discharge. The contract does thus also deal with a responsibility in the longer run. This does, to an even larger extent, apply to the contracting of emergency activities like the contract with S:t Görans Hospital within Stockholm County Council. When it comes to the remuneration system, there is no general application of more market-oriented incentives (i.e. more focus on prices for well-defined parts of the treatment) that is used in outsourcing. Instead, there is a trend towards more mixed forms of remuneration and an increased focus on remuneration for overall responsibility and quality outcomes.

The *contract length* varies with the degree of uncertainty and transaction specificity. Longer contracts are, for example, found for S:t Görans hospital in Stockholm, where the activity is

characterised by large uncertainty and large investments. Also within laboratory work do the contracts run over longer time periods. Primary care and simpler, planned treatments are contracted for 1-2 years.

As concerns the *follow-up* of existing contracts, there is often a lack of clinical measures for the activities of primary care and the buyers' follow-up of primary care primarily focuses on patient-perceived quality and the waiting times and availability of medical care. Within specialist care, the follow-up is to a considerably larger extent based on clinical quality measures, often through established quality registers. The national fee for private practitioners in medical care is distinguished by the fact that the government stipulates the remuneration form and that there is largely no follow-up of quality and patient satisfaction; the county councils thus have small possibilities to control this activity.

Conditions for freedom of choice in primary care

In several respects, primary care is the form of medical care where the introduction of models based on freedom of choice has made most progress. The following points summarize the experiences of the reform in the choice of medical care (2010) (which has, however, only been in use for a short period of time):

- There has been an increase in the availability of medical care (mainly in densely-populated areas). There has partly been a geographical increase through the emergence of more district health centres, partly in terms of the actual use of medical care.
- The cost trend is in line with the period before the introduction of the reform of choice of medical care.
- The follow-up that has been done does not show any repression of the consumption of medical care for groups with particularly heavy needs for medical care. The trend differs partly between socio-economic groups, however.
- Patient-perceived quality is relatively unchanged, but there has been an increase in the confidence of the population in primary care.
- It is not possible to evaluate the effects of the reform on clinical quality. This is due to the lack of measures within this area.

- A majority of Swedish patients state that they want to choose their district health centre in primary care. However, only a small share of patients and citizens do actively search for information and make active choices.

Even if we have mainly identified positive effects of freedom of choice in medical care, there is reason to look up and consider those driving forces that freedom of choice in primary care create from a wider perspective. It is clear that freedom of choice in primary care has driven the activity towards a larger sensitivity to the desires for services etc. of the average user. An increased use of medical care in the population as a whole is an expression of this trend. This trend is completely reasonable but not exempt from complications. This raises two direct questions:

- Does this trend take place at the cost of the interest of groups that are far from the average user?
- Are there driving forces that can, in the longer run, affect the activity in a direction where the quality of medical care is given lower priority than what is desirable?

We do not find that the trend towards better fulfilling the preferences of the average user has crowding out effects that constitute a considerable threat to the service to other patient groups. We consider that those demands that are made by the principals, the national regulatory frameworks and the firmly rooted priorities of patient safety that exist in the system of norms in the medical profession, as a whole constitute a good guarantee for ensuring quality in medical care. However, this does not mean that potential undesirable driving forces can be ignored.

Conditions for freedom of choice within planned specialist care

There are several decisive differences between the choice of doctor in primary care and the choice of provider of care within specialist care. These should be taken into consideration in the design of the supply of information, regulatory framework etc. The choice of doctor in primary care provides a larger scope for subjective evaluations since the consumption of primary care is generally of a repetitive nature, which means that the patient has the possibility of building up knowledge through experience and contacts with

friends and family. The choice of provider of care for specialist treatments like cataracts and hip-replacement surgery etc. is of a one-time nature, however, which makes the choice more difficult. The supply of good information about effects, side-effects and other quality indicators can facilitate the choice. At the same, these aspects are difficult to judge for a person in need of treatment. The choice of supplier of specialist medical care could, however, be facilitated if the doctor in primary care acted as an agent for the patient and provided support in the choice between different alternatives. One way of promoting the supply of information to patients is to improve the possibilities to meet the same doctor in primary care.

Outsourcing requires measurability

A general aspect to consider in outsourcing is the extent to which it is possible to measure and follow-up resource use and quality. We see a pattern where the transfer to private production is largest when the conditions for this are good. It can be assumed that an increase in private production will increase the demand for information and indicators of quality. The national quality registers do, of course, constitute a source for this, the contents of which could be used as follow-up parameters in the contracts. Such a procedure entails several problems, however. Since the quality registers have been created by representatives for the medical profession, these will have a decisive influence on what is followed-up by the principals. This contributes to a remaining information asymmetry between buyers and providers. A closely related problem is that reporting to the quality registers is affected or even manipulated if the quality of these indicators affects the future resource allocation. This could be counteracted by a validation process for reported data, which is to a certain extent also the case today. An alternative would, however, be to establish an independent accreditation with a random collection and control of data which is entirely separate from the data collection of the quality registers. The market for laboratory work could serve as a role model here.

A larger element of accreditation is desirable

In the longer run, these observations mean that a more formalised and, in particular more publicly available, accreditation would in many cases play a more extensive role as a quality control for buyers and guidance for patients. We consider there to be room for an institution that could fill such a role; for example by

- verifying that the quality criteria have been fulfilled (the formal control of this would probably have to remain with the principals),
- publishing open comparisons that are quite similar to the one that is currently made available by the Swedish Association of Local Authorities and Regions,
- giving grades partly based on the open comparisons and partly on evaluations and feedback from patients according to fairly strict but not entirely mechanical models.

This kind of patient support would serve to fulfil two important objectives. It would strengthen the patient by improving her information and it would guarantee a great deal of room for objective measures of the quality of medical care. This might counteract possible risks that choices are to a too large extent based on factors of convenience or marketing.

The level and characteristics of measurability control the conditions for outsourcing

We find that the measurability of different quality aspects has constituted a central part in the emergence of different contract solutions in medical care. In general, there is an increase in the possibilities for quality control if the services must be adjusted to both subjective and more objective quality criteria. More subjective quality criteria here mean quality characteristics that concern the individual patient's view of medical care (for example as concerns how they are received, influence, the effect on health etc.). Objective measures of quality do instead mean measures that mainly concern clinical processes and a clinical measurement of results where there is well-documented evidence and a consensus on how the results as concerns quality are to be measured.

Arrangements involving customer choice have better possibilities than public procurement to promote quality aspects that are difficult to measure, quantify or validate, for example how they are received and their influence. A long-term relationship that is built on trust in one's doctoral contact within primary care does, in this respect, emerge as an important quality aspect of the patient's subjective experience. Even if there are deficiencies in today's system, the conditions for customer choice would probably be better for services in primary care than for other medical services since the consumption of individual primary care is recurring and the major part of the population is in contact with primary care in the course of a year. Customer choice systems within primary care do, thus, have possibilities to favour a positive competition as concerns quality, mainly from a subjective quality dimension.

A central point is thus that the conditions for an appropriate contract design are reinforced if measurability is good, either subjectively or objectively. The conditions are further reinforced if the measurability is good in both these dimension. The choices of medical care that are studied within specialist care do, in this respect, show other conditions than what is the case in primary care. In these areas, there are often well-established measures of different clinical aspects of quality, either in the form of medical measures or patient-related outcomes. These increase the possibilities to follow the quality trend and to design follow-up and quality-related remuneration.

Conclusions and policy recommendations

As a conclusion, we would like to emphasize a few concluding observations on the conditions for outsourcing and also point out certain specific conditions that reinforce the arguments for an arrangement with customer choice rather than public procurement. Finally, we would also like to make some recommendations on how contract solutions, given the choice to outsource production, can be made to work as well as possible.

Hierarchy versus market

The choice between own production and outsourcing to external agents is affected by several factors. The conditions for contracting and privatisation in health- and medical care are determined by the characteristics of individual medical services. We observe a certain pattern where there is an increase in the share of outsourced medical care if the characteristics of the service are more similar to the market. This means that services with a low level of specificity, which are often repeated and have a low degree of uncertainty but a high degree of measurability, are more often subject to outsourcing.

An overall conclusion is that market use is appropriate if there are either good and reasonably accessible measures of the quality of the activity or if there are good possibilities for the patient herself to make well-informed and rational choices. In the former case, public procurement is more appropriate (for example for laboratory services) while arrangements with customer choice are preferable in the latter (for example primary care). In those cases when there is neither measurability nor possibilities for informed choices, there are bad conditions for traditional market solutions to work well which, for example, applies in the case of emergency care. In these cases, production is generally best carried out by public agents. The alternative is more long run and complex contract solutions when outsourcing this kind of production.

Customer choice versus public procurement

Models for customer choice mean freedom of choice for the consumer and increase the possibilities for individual preferences to have an impact. In particular, patients might also catch non-measurable dimensions in their deliberations on choice between providers of medical care to a larger extent than in a public procurement procedure. Models of customer choice require a regulation of the market and an accreditation of providers of medical care. For these to work well, it is also required that the patient has real possibilities to choose and access to comparable information about the quality of providers of medical care.

If quality is to be considered in public procurement, measurable processes and outcomes must be assumed. We note a trend with a

general decrease in public procurement in favour of increased outsourcing according to the customer choice model. This transition can be explained by the presence of important non-measurable quality aspects within several kinds of medical care. Our evaluation is that the presence of customer choice, mainly due to increased incentives for a continuous development of quality, makes a positive contribution to the outcome of outsourcing and privatisation both in primary care and specialist care.

Within those kinds of medical care where there are good possibilities for subjective measurability, accreditation and consumer choice have larger possibilities of favouring a well-working competitive market where all producers are given equal conditions. In public procurement, there is a larger risk that all producers are not treated equally; the conditions are equal only for part of the market, unless the whole supply is subject to public procurement.

Concluding recommendations

There are strong arguments for public sector involvement in the accreditation of providers of medical care. This can preferably be done using a model that combines collection and processing of quality data with user experiences and a measure of collective evaluation. Thus, there is a decrease in the risk that 1) the buyer is to a too large degree left in the hands of the knowledge and information of the medical profession and 2) that patients to a too large extent make choices that are determined by factors such as convenience and marketing.

When it comes to the remuneration forms in contracts with external providers of care, there seems to be a trend towards more well-reasoned structures of incentives. There is also a tendency for increased requirements for follow-up. This should lead to contract forms, such as the national rate, which combine the remuneration per visit and treatments without any clear follow-up of the clinical outcome of the activity and patient satisfaction being replaced by contract forms where the providers of care take a larger risk and the buyer is given possibilities to follow up the activity. A customer-choice model based on accreditation where the county councils control the conditions, consisting of, for example,

demands for reports of clinical results and patient satisfaction, is preferable within specialist outpatient care.

Moreover, it is important to reinforce the role of the doctor in primary care as an agent for the patient. This is particularly important for the choice of specialist care where the doctor can help the patient in balancing subjective and objective quality measures. One way of reinforcing the continuity and provision of information to patients about medical care is to ensure that patients who want to have a permanent contact in primary care will have this.