Steering health and social care through quasi-markets

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Abstract

Municipalities and county councils try a multitude of different strategies when they design and steer health and social care markets to ensure that goals such as quality and equity are met. Depending on the strategies used, different problems arise. The aim of this thesis is to examine how local authorities can design quasi-markets in a way that achieves public goals such as equity and high quality. To answer the aim, four empirical studies were carried out.

The studies show that when designing a market by contracting-out through public procurement, the issues lay primarily at specifying and defining what is meant by quality before a service is privatized. This is especially difficult to do concerning soft areas such as elder- and healthcare. If this is not done properly, it can lead to crucial issues for monitoring quality since the contracting authority cannot hold the provider responsible for delivering an aspect of a service if that aspect is not specified in the contract.

When a market is designed as in the patient choice systems in primary care, it creates a whole other set of difficulties for the local governments. Here, it is not as important to specify quality beforehand in the contracts since quality monitoring is done retrospectively by both the counties themselves as well as the patients who with their choices can monitor quality by punishing providers with poor quality by registering with another provider. Instead, the crucial problem is how to design reimbursement system that will lead to an equal access to health care. In this respect, the county councils utilize different methods. However, despite these measures, the primary care choice reform have led to inequity, both geographical inequity in regards to where new private primary health care centres are located but also, to a larger degree, socio-economic inequity relating to what kind of socio-economic groups of individuals are registered with private PHCCs. In other words, county councils do not manage to fully counteract risk selection behaviour by the design of their reimbursement system which could imply issues with unequal access to health care.

Keywords: patient choice, contracting, equity, health policy, public procurement, quasi-markets

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To Martina, Tage and Stellan
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


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Abbreviations

ACG    Adjusted Clinical Groups
CNI    Care Need Index
NPM    New Public Management
PCCR   Primary Care Choice Reform
PHCC   Primary Health Care Centre
SES    Socio-economic status
Introduction

Two of the main principles guiding the Swedish health care system are solidarity and equity, with health care services primarily financed publicly via taxes, and resources allocated according to medical need (Anell, Glenngård, & Merkur, 2012; von Otter & Saltman, 1991). Beginning in the 1980s, far-reaching reforms within the public sector were initiated in Sweden, as in many other countries. The reforms, which sought to make the public sector more cost-effective, were inspired by a set of ideas which have become known as New Public Management or NPM (Gruening, 2001; Christopher Hood, 1991; Pollitt & Dan, 2011). NPM originated in a criticism of the bureaucratic, centralised government and a desire to reduce the ever-increasing costs of the public sector. The basic idea behind NPM is to use mechanisms similar to those found in the private market in order to increase efficiency by reducing costs and increasing quality (Christopher Hood, 1991; Walsh, Deakin, Smith, Spurgeon, & Thomas, 1997).

One of the most notable ideas that sprung from the NPM movement is the privatization of welfare service delivery such as health and social care. The privatization of the production of health care can be achieved through several methods such as contracting or by introducing so-called patient choice systems. Patient-choice systems are based on the principle that patients themselves choose between competing care providers – both public and private – within a publicly regulated and financed system.

Both contracting and patient choice systems have been introduced in Swedish health and social care. Since the early 1990s, Sweden has seen an ongoing movement towards marketization of the welfare system where private health and social care providers have been encouraged to enter and compete with public providers. The introduction of competition and private, including for-profit, providers in health and social care has been considered by some to be a threat to the Swedish health care system’s principles of need-based, equal access to health care services for all citizens. One concern has been that private providers will focus on the more profitable groups of patients, e.g. those with the lowest health care needs, and neglect other groups (Burstrom, 2010; Dahlgren, 2008).
Contracting and patient choice systems can both be viewed as forms of quasi-markets, i.e. systems with features of both a hierarchical bureaucracy and a conventional market (Fotaki, 2007; Le Grand & Bartlett, 1993). Quasi-markets are generally understood as a mix between hierarchical steering and traditional markets (Kastberg, 2008; Le Grand & Bartlett, 1993). The creation of quasi-markets pose new challenges for policy makers with respect to governance (Boyne, 1998; Donahue, 1989). When governing health care systems, politicians and bureaucrats need to ensure that laws are followed and public goals such as equity and high quality are met. In a fully public system such as that in Sweden during the 1970s, organized as a Weberian bureaucracy, politicians and civil servants can micromanage the production and distribution of medical services. When a public organisation privatises – wholly or in part – the production of care services, the system increasingly relies on the market forces and contracts to achieve desired outcomes. To achieve public goals such as high quality or equal access to health care for all citizens, the public authorities responsible for health and social care (e.g. municipalities or county councils), must create the right incentives for health care providers (Le Grand & Bartlett, 1993; Puig-Junoy, 1999; Sappington & Stiglitz, 1987). This can for example be done through specification of quality criteria that providers must follow, and through financial reimbursements that rewards certain behaviour. The intricate task for the public authorities managing a quasi-market, however, is to construct these incentives in a way that makes it possible to monitor, or verify, the desired behaviour on part of the providers. When it comes to the goal of quality, the first challenge is to define what is meant by the concept. The second challenge is to formulate quality criteria that both cover all aspects of the health service, but are also possible for a public authority to monitor. If quality criteria are not able to be monitored, economic incentives are created for the providers, especially profit-driven ones, to deliver services with an inferior quality, i.e. the quality-shading hypotheses (Domberger & Jensen, 1997). In the case of equity goals, the challenge for public authorities trying to steer a quasi-market in health care, is to ensure that services are delivered according to need.

Another way of steering quasi-markets is through different forms of reimbursement systems. In order to ensure high quality care, the public authority must design the reimbursement system in such a way that it creates incentives for the providers to provide high quality care. The greatest challenge here is that regardless of how a local government designs a system, health care providers have the possibility to adapt their behaviour in response to that reimbursement, thus maximizing their profits (Koning & Heinrich, 2010). In a more general sense this issue has been well-known for a long time and its essence is captured in Goodhart’s law: “When a measure becomes a target, it ceases to be a good measure” (Elton, 2004). Within health care, an important
goal is equity in the delivery of services. One of the main concerns with regards to marketization and equity in health care is the behaviour that arises when providers adapt to economic incentives by prioritizing some patient groups and excluding others. This have been referred to in the literature as risk selection, or *creaming* (Ellis, 1998). Creaming here refers to an over-provision of treatment to patient’s that are possible to treat at low-cost (Ellis, 1998).

Irrespective of what type of quasi-market is being utilized, this organizational form implies that a new way of governing is introduced for politicians and bureaucrats. The challenge for governments engaging in this form of governance lies foremost in carefully deciding when to marketize, or privatise, a service, and when that it is done, what mechanism to use to achieve desirable political goals. How this is done in practise by public authorities and what effect it has on goals such as quality and equity is the topic of this dissertation. The dissertation examines these processes through the Swedish case, which in several ways is distinct from other national health care systems. The Swedish health care system is characterized by a high degree of decentralisation, with the primary responsibility for health care governance delegated to 21 local governments. These local governments are directly elected, and have the responsibility for the delivery and financing of health care.
Aim and research questions

Steering through markets creates new challenges for local authorities. By designing relevant and explicit quality criteria and reimbursement systems, they try to create market conditions that lead to desirable outcomes. The aim of this thesis is to examine how local authorities have designed quasi markets to achieve public goals such as equity and quality.

The main research questions in the thesis are:

- How do municipalities and county councils design and steer health and social care markets to ensure that public goals such as quality and equity are met?
- How does the design of the quasi-markets affect equity within health care?

To answer these research questions, four empirical studies were carried out. In the first study we examined contracts in elder care and measured to what degree the quality requirements were monitorable. The second and third study examined in different ways if a quasi-market introduced in Swedish primary care challenged equity in access to health care. The fourth study examined how local governments try to design the patient choice system to avoid risk selection of patients that can lead to inequity in access to health care.
The Swedish social and health care system is highly decentralized compared with other nations. Both health care and social care are considered public responsibilities in Sweden and are financed through state grants and local taxes levied by the county councils and municipalities (Anell et al., 2012). The government is organised into a multi-level system consisting of the national government, county councils and municipalities. The county council have the main responsibilities for health care while the municipalities are principally responsible for providing social services, including elder care (Anell, 2005). However, it is the national government through the Ministry of Health and Social Affairs who determine the general policies regulating health and social care, including formulating the main goals of the system. The national government also provide state grants to the county councils, covering 15-20 percent of their health care expenditures (Anell et al., 2012).

National goals of the health and social care systems

Two of the main goals of the Swedish health care and social care systems are equity and quality. One of the key paragraphs in the Health and Medical Services Act (SFS 2017:30) states that “The goal of the health care is good health and care on equal conditions for all citizens” (§ 3, SFS 2017:30). The next paragraph states that “[the care] should be of good quality with a good hygienic standard […]” (§ 3, SFS 2017:30).

For social care, similar key paragraphs exists in the Social Services Act (§ 1, SFS 2001:453):

“The society’s social service shall on the basis of democracy and solidarity promote citizens’:
- Economic and social safety
- Equity in living conditions
- Active participation in social life”

These goals could be formulated by any level of government, i.e. national, regional or local, but irrespective of the principal of a certain goal the one responsible for carrying out these goals in practice are the county councils and municipalities (Anell et al., 2012). Thus, each county council or municipality
has the responsibility of organizing health and social care in a way such that these goals are reached. This is the case irrespective of whether the providers of health and social care are the local government itself or a third party such as a private company.

**Development of privatized social and health care in Sweden**

Until the beginning of the 1990s, most health and social care in Sweden was provided by publicly owned provider units. Coinciding with the economic crisis in the beginning of the 1990s, Sweden, along with most parts of the western world, was influenced by the set of ideas which came to be known as New Public Management or NPM (Harrison & Calltorp, 2000; C Hood, 1995; Stolt & Winblad, 2009).

One major change that took place under NPM was the introduction of purchaser-provider splits, entailing a separation of the purchasing and providing function of a government (Almqvist, 2001; Bevan & van de Ven, 2010; Tynkkynen, Keskimäki, & Lehto, 2013). This enabled different providers (public or private) to compete between each other. The separation of these two functions later facilitated the privatization of health and social care; when there already existed a separate arm of the government responsible for providing care, the step to contracting out at least part of this provision was less problematic (Stolt & Winblad, 2009). Up until 1992, only around 1-2 % of health and social services were privatised. From then on, a steady increase in the share of privatized services has occurred (Jordahl & Öhrvall, 2014).

When discussing privatisation, it is important to distinguish between different forms of privatisation (Donahue, 1989). A simple distinction is between privatisation of production, financing and regulation, see Figure 1. Privatisation of regulation means that something that has previously been regulated by the government now is unregulated or less regulated. Privatisation of financing occurs when a service that has previously been financed via taxes now is financed privately, for instance via insurance or out-of-pocket payments. Finally, privatisation of production happens when a service that was previously produced by a publically owned unit is produced by a privately owned unit. Examples of ways privatisation of production can come about include public procurement and the creation of patient choice- or user choice-systems.
It should be noted that privatization of production does not necessitate the privatization of financing or regulation. When contracting out health- or social care through public procurements or patient choice-schemes in tax-based welfare states, it is more common than not that financing still mostly occurs through taxes and the services are still to a high degree regulated by a national or local government (Blomqvist, 2005).

Public procurement and competitive tendering

The introduction of NPM reforms in Sweden coincided with the preparation to enter the European Community. As part of the preparation, an EC directive on Public Procurement was implemented in the Swedish Act on Public Procurement (1992:1528). Thus, the legal framework for contracting-out social services and health care was set out which up until then legally had been a grey area (Bianchi & Guidi, 2010; Stolt & Winblad, 2009). The Act on Public Procurement (2016:1145) sets out a distinct process all local authorities must follow whenever they want to contract-out a good or a service. The local authority must first write contract documents that specifies what is being contracted out, the quality requirements and the criteria for selecting the winning tender. After this is done, all interested organizations may send in tenders which are then evaluated based on the selection criteria previously decided upon (M. Bergman & Lundberg, 2013; Forsberg, 2004). In other words, all quality requirements must be decided upon before the winning tender starts providing the service and the competition between companies generally takes place ex ante, i.e. before providing the services (Domberger & Jensen, 1997).

The Act on Public Procurement (2016:1145) states that the contract must be provided to either the tender with the lowest bid or the tender that is economically most advantageous. In the first case, the bidder that offers to perform a service for the lowest price wins the procurement as long as it fulfils all general requirements (M. Bergman & Lundberg, 2013). In the second scenario
the contracting authority must set up selection criteria and a formula on how to calculate an index used for deciding the winning tender. In Sweden, as well as in Europe, it has been increasingly common for contracting authorities to use a combination of price and quality for supplier selection (M. Bergman & Lundberg, 2013). Since the contracting authorities must decide upon a winning tender before the services are being produced, quality must be evaluated in ways other than by measuring the quality of the actual services provided. In health and social care, this is often done by letting the bidders describe how they will achieve good quality and then giving a quality score to each tender based on their description. The description of how a tender should work with quality later on becomes part of the contract and the winning provider is contractually obligated to follow it (M. Bergman & Lundberg, 2013; Lunander & Andersson, 2004).

Vouchers and user/patient choice systems

An alternative to contracting out via competitive tendering and public procurement are user choice systems. The basic principle behind a user choice system is that the contracting authority authorizes providers without any guarantee of a user base. All users may choose any of the authorized providers and the providers are consequently reimbursed based on how many users have chosen that provider (Forssell & Norén, 2013; Lundvall, 2012).

User choice systems were introduced in Sweden in 1985, when a municipality wanted to let their users of choose their provider of medical pedicures (Winblad, Andersson, & Isaksson, 2009). During the 1990s local authorities came to use similar systems in primary education as well as medical and social care (Socialdepartementet, 2008; Winblad et al., 2009). In 2008, the Act on System of Choice (2008:962) was introduced, creating a clearer legal ground for local authorities wanting to establish user choice systems. The central government wanted to promote this form of privatization and offered grants to municipalities wanting to create user choice systems within social care (Socialstyrelsen, 2010). Only two years later, it was made mandatory for all county councils to establish patient choice systems in primary health care (Winblad, Isaksson, & Bergman, 2012).

The mechanisms behind user choice systems, which can be viewed as a form of contracting in that they build on contracts between local public authorities and private providers, are in several aspects different from the mechanisms behind public procurement. In a user choice system, all providers who meet certain basic requirements are allowed to participate on the quasi-market. Thus, the competition between different providers does not take place in the contracting situation but rather later as providers compete over patients (Forssell & Norén, 2013). In other words, user choice systems are based on
ex-post competition where the patients/users evaluate quality. At the same time, Swedish laws prescribe that it is the legal principal of a service (huvudman), i.e. the municipality or county council, that is still mainly responsible for the quality of care services. (Andersson, Janlöv, & Rehnberg, 2014). This creates a difficult situation concerning how politicians and civil servants can monitor the services in a user choice system.
How can local governments achieve their goals through contracting?

The county councils have the main responsibility for health care whilst the municipalities are responsible for social care in Sweden (Anell et al., 2012). However, since Sweden is not a federal state, it is the national government that has the overarching responsibility for all general policies, including policies focusing on health and social care. Thus the national government, through the Ministry of Health and Social Affair, can set out certain goals for the health and social care system (Anell et al., 2012). Two of the main national goals for health and social care are equity and a high level of care quality (Anell et al., 2012; Fredriksson, Blomqvist, & Winblad, 2013; Stolt, Blomqvist, & Winblad, 2010).

Despite the goals being set out by the national government, it is the responsibility of the local authorities, i.e. the county councils and municipalities, to organize and carry out the care in a way that these goals are reached. The local authorities have this responsibility regardless of whether they produce the services themselves or if they choose to contract it out to another provider (Anell et al., 2012). However, when contracting out to another provider, some of the means by which authorities can govern are no longer there. This could create new obstacles for authorities when trying to achieve public goals such as high quality and equity.

Contracting and incomplete contracts

A situation where a government contracts with a private party to deliver goods or a services can be described as a principal-agent relationship where the government can be viewed as the principal that delegates tasks to an agent (Amirkhanyan, Kim, & Lambright, 2011; Eisenhardt, 1989). In this relationship, an integral problem is asymmetrical information between the parties where the agent generally has more information than the principal regarding how the operations are being run (Williamson, 1975). Thus, the relationship is susceptible to opportunism by the agent which creates (among others) two potential problems: adverse selection and moral hazard (Amirkhanyan et al., 2011). Adverse selection refers to hidden information in the initiation of the
contracting relationship, i.e. the principal does not receive correct information regarding the agent’s ability to meet its contractual obligations (Eisenhardt, 1989). Moral hazard, on the other hand, is related to hidden action where an agent has the possibility to take advantage of asymmetrical information and not fulfil its contractual obligations, for instance by ‘skimming’ (Arrow, 1985; Eisenhardt, 1989; Ellis, 1998). In other words, adverse selection relates to problems with asymmetrical information ex ante, whereas moral hazard relates to problems with asymmetrical information ex post.

Contracts can be seen as a document which aim to specify the responsibilities between a purchaser and a supplier (Trevor L. Brown, Potoski, & Van Slyke, 2007). One method for trying to reduce the risks of opportunistic behaviour by the agents is to meticulously describe the terms and quality expected of an agent when carrying out a contract (Trevor L Brown, Potoski, & Van Slyke, 2006; Domberger & Jensen, 1997). However, research shows that contracts are imperfect tools for regulating the relationship between a principal and an agent (Trevor L. Brown et al., 2007; Slyke, 2013). Contracts containing every possible aspect of a relationship, i.e. complete contracts, can in practice be considered utopic and can never be achieved in practice due to imperfect information and uncertainty about the future (Artz & Brush, 2000; Oliver Hart & Moore, 1999). It is basically impossible, or at least very costly, for a contracting principal to specify every imaginable or unimaginable situation which could arise during the term of the contract (Trevor L. Brown et al., 2007; Hendrikse & Veerman, 2001).

The observation that the complexity of the real world makes it too costly, if not impossible, to describe all possible aspects in a contracting relationship is the foundation for the theory of incomplete contracts (Hendrikse & Veerman, 2001; Sclar, 2000). The incompleteness in a contract means that not all possible situations can be described ex ante when constructing a contract which eventually may give rise to opportunistic behaviour by the agent ex post (Oliver Hart & Moore, 1999; Hendrikse & Veerman, 2001; Segal, 1999). When some aspects of a service is non-contractable, i.e. not specified clearly in the contract, it is difficult for the principal to prove that the agent does not provide the desired quality. As a result of the non-contractability, the agent’s incentive to reduce costs increases, which ultimately may lead to a reduction in quality, i.e. the quality-shading hypotheses (Domberger & Jensen, 1997).
Choice and equity

Equity in health care can be defined as “the absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage – that is wealth, power, or prestige.” (P. Braveman & Gruskin, 2003). The definition above is an example of socio-economic equity. Another more specific form of equity regards access to health care. Equity in access can be defined as a fit between the demand for health care services among the population and the supply of care by providers; i.e., health care services need to be affordable, contain the appropriate treatments in relation to medical needs and be physically situated so that patients can get to them (Neutens, 2015; Penchansky & Thomas, 1981). The last point relates to geographical accessibility, which is a concept that can be understood as the distance or travel-time between patients and providers. Equity in geographical accessibility, or geographical equity, can be defined as all individuals having similar or a minimum travel-time to the nearest health care provider (Gravelle & Sutton, 2001; Luo & Wang, 2003; Newhouse, Williams, Bennett, & William, 1982; Rice & Smith, 2001).

‘Choice’ has been held out as an important value in social services like health and social care foremost after 1980, when the concept was popularized by thinkers like Milton Friedman (Blomqvist, 2004; Friedman & Friedman, 1980). ‘Choice’ as an organizational form in publicly regulated and financed systems of social services typically refers to the idea that public and private providers compete for users or patients within a publicly financed system. Furthermore, the allocation of resources is based on the choices of the users which in theory will lead to improved quality since users will choose providers with the highest quality, thus providing them with more resources (Appleby, Harrison, & Devlin, n.d.; Dixon & Le Grand, 2006; Fotaki, 2010).

Several scholars argue that choice and equity are two incompatible virtues (Bevan, Helderman, & Wilsford, 2010; Mendis, 2009; Oliver & Evans, 2005). A choice system is built upon the premise that people should decide what service provider is the best option for them. This notion can seem trivial but many argue that less educated and in other ways vulnerable groups do not have the capacity to make well informed choices (Burstrom, 2010; Dixon & Le Grand, 2006; Fotaki et al., 2005). If vulnerable groups are not able to make well-informed choices, the consequence of this could be that they will receive health or social care of worse quality (Barr, Fenton, & Blane, 2008; Fotaki, 2010). Empirical studies give clear support for the idea that vulnerable groups with low socio-economic status indeed make fewer and less well-informed choices (Cheng, 2004; Dixon, Robertson, & Bal, 2010; Harris, 2003; Ringard, 2011; Robertson & Burge, 2011; Winblad et al., 2012). There is however a lack of
Unequal possibilities to make well-informed choices are not the only issue that is discussed with regards to choice and equity. Another common theme in the literature is that of cream skimming. Cream skimming refers to the perceived practice of providers choosing users instead of users choosing providers (Le Grand, 2009). The idea is that providers in different ways will try to attract patients that are profitable (Koning & Heinrich, 2010). Within healthcare the concept of cream skimming has been captured in the terms creaming, skimping and dumping (Ellis, 1998). Creaming refers to an over-provision of treatment to patient’s that are possible to treat at low-cost, skimping is the conduct of under-provision of treatment to high-cost patients and dumping when a provider refuses to accept high-cost patients (Ellis, 1998). To prevent cream-skimming from arising, local authorities try to design their reimbursement systems in different way to counter this behaviour (Barros, 2003).

Even though there exists a large theoretical discussion regarding the difficulties for governments to steer social services and health care through quasi-markets and contracts, relatively few empirical studies have examined systematically how contracts are actually written or what effects different contract designs have on outcomes with regards to quality and equity. Patient choice systems are mainly phenomena that occur in tax-funded Beveridge type health care systems, and the literature examining the effects of patient choice will largely be limited to studies from NHS and the nordic countries.

Some studies of the English NHS have investigated effects of increased competition and patient choice on equity. In one study that looked at the effect of competition on equity found that competition did not undermine equity (Cookson, Laudicella, & Donni, 2013). Another study from the English NHS examined the possible effects of increased financial incentives on equity and found that it could lead to reduction of inequalities in delivery of health care (Doran, Fullwood, Kontopantelis, & Reeves, 2008). In contrast to these results, other studies of the English NHS have found that increased competition, similar to a patient choice system in primary care led to unclear effects on equity (Asaria, Cookson, Fleetcroft, & Ali, 2016; Goddard, Gravelle, Hole, & Marini, 2010).

A few studies have examined how the Swedish PCCR has affected equity. These studies have mainly been performed in the county councils of Stockholm and Skåne. The results show that the PCCR seem to have increased patient visits for all groups (Agerholm, Bruce, Ponce de Leon, & Burström, 2015; Beckman & Anell, 2013). However, there seems to be some tendencies that the increase in patient visits have been smaller for patients with high
health care needs (Agerholm et al., 2015; Beckman & Anell, 2013). Taken together, the empirical studies that have examined what effect patient choice has on equity have inconclusive results that is difficult to interpret.
Methods and findings

This thesis builds on four studies that were all carried out in Sweden. The first study focuses on how local governments have tried to formulate contracts when contracting out residential elder care. The second and third study centres on primary care and how the Swedish Patient Choice reform has affected equity. The second study contains a descriptive quantitative analysis to assess the effect the Patient choice reform had on geographical equity based on the location of new primary health care centres (PHCCs). In the third study, the effect on equity was investigated by looking at what types of patients have been registered with private and public PHCCs. Lastly, the fourth study focuses on how local governments try to counteract risk selection, or cream-skimming, by the design of local reimbursement systems.

The four studies address different aspects of how local authorities can design and steer markets. By looking at both primary care and elder care, a broader understanding of how local authorities can design markets to reach public goals can be reached.

Study I – Contracting out care homes

The aim of this study was to examine how local governments in Sweden write quality requirements when contracting-out residential elder care. In the analysis, we examined contracts from four municipalities that started to contract-out residential eldercare immediately after the Swedish legislation change in 1992 and which all have a relatively large share of their residential homes run by private contractors (between 20-80%). In this sense, the selected municipalities can be considered as ‘most likely’ cases; they have a relatively long and extensive experience of contracting in this area. The ‘most likely’ case selection logic implies that if outcomes are poor, it is likely that other municipalities with less favourable circumstances will perform as bad or worse (King, Keohane, & Verba, 1994).

Each contract contains around 100-200 so called quality requirements where the local government specify what the provider should provide. In total 1005 quality requirements were analysed. In order to assess the ability to monitor the quality requirements, these were classified into three different categories
depending on how *monitorable* they were perceived to be. The first category consists of those requirements which cannot be monitored. They are formulated in such a loose and general fashion that it is impossible to determine whether or not they have been met. This category was labelled “*non-monitorable*.” The second category contains requirements formulated in such a way that they could be monitored by giving a ‘yes’ or ‘no’ answer as to whether or not they have been fulfilled. In this sense, the requirements in this category are possible to monitor in a dichotomous way but are still non-measurable in a quantitative way. Such requirements are labelled ‘*partly monitorable*’ as we see them as monitorable in a more crude sense. The third category consists of requirements which we see as *fully monitorable*; that is, when it is possible to determine also the extent to which a quality requirement formulated in the contract has been met. These requirements are thus formulated in a way that makes them measurable and quantifiable; this implies that it is possible to determine the degree to which the requirement is fulfilled by the provider, and if not, how far actual quality standards are from the target. This provides considerably more information both about the quality objectives of the principals, e.g., what this actor really wants, and the quality of the service performed.

**Results**

Of the quality requirements analysed there was a clear focus on care work and social activities, organisation and staffing as well as rehabilitation. Most of the requirements were classified as party monitorable (71%) and only a small fraction of the requirements were classified as fully monitorable, i.e. both monitorable and measurable (5%). The share of the quality requirements that were classified as not at all monitorable was 25 percent.

A majority of the quality requirements concerned processes (80%) whereas almost 20 percent of the quality requirements concerned structural quality. Outcome requirements were very rare, less than 1%.

The results showed that the ‘softer’ areas of care work and social activities to a considerably less amount could be considered to be monitorable than ‘harder’ areas such as law, taxes and economy, and organisation and staffing. This indicates that the risk of moral hazard could be higher when contracting out ‘soft services’ compared to ‘hard’ services such as garbage disposal.
Study II – How does patient choice affect geographical equity

The aim of this study was to examine what effect the patient choice reform in primary care has had on the geographical distribution of health care services. What types of providers (public or private) established PHCC’s after the introduction of the patient choice reform and where were they located? To investigate this, a cross-sectional data set containing socio-economic data of the geographical areas of all primary health care centres in Sweden was used.

The study was carried out by analysing where new PHCC had established themselves in the 21 county councils. The design of the study was to compare socio-economic data on individuals who reside in the same electoral areas in which the primary health care centres in Sweden are located. The socio-economic data on the persons living in these areas was gathered from Statistics Sweden and consists of the following variables:

- Mean income
- Percentage of citizens born outside western Europe and North America
- Percentage of single mothers/fathers living with children under 18 years
- Percentage of low-educated
- Percentage of unemployed or in public programs
- Percentage of people over 65 years living alone
- Percentage younger than 5 years

Since all primary health care centres belong to a specific county council and thereby are affected by different reimbursement systems as well as different county characteristics, the primary health care centres were grouped in a secondary level variable, i.e. the county councils.

To examine whether there are any differences in regard to where old and new primary health care centres choose to locate after the patient choice reform, 2-sided t-tests were used. In our main models where we controlled for county councils and municipalities, generalized estimating equations (GEE) models were used. This method was used since the socio-economic variables can be correlated within certain municipalities and/or county councils and regular OLS regressions therefore would risk violating the independence assumption (Hubbard et al., 2010).
Results

Of the 285 PHCC’s that were established after the introduction of the PCCR, 270 (95%) was owned by private companies. This number can be compared to the situation before the reform where only 30% of the PHCCs were privately owned.

When comparing the areas where old and new PHCCs are located, the results showed that new PHCCs were located in areas with statistically significantly fewer single parents, fewer older people living alone, higher mean income, lower degree of unemployment and fewer low-educated people.

When analysing the data using GEE-models to control for the effect of the county councils, the results show a significant effect on three variables: new PHCCs had fewer people over 65 years living alone, fewer single parents, and a higher percentage of immigrants from outside of Western Europe. However, when including multiple socio-economic variables in the same model and choosing the model with the best fit according to the QICC-score, there were no statistically significant effect on percentage of immigrants outside of Western Europe. Still, the significant effect of people over 65 years living alone and single parents remained. This indicates that new private providers do have a tendency to establish in areas that are relatively affluent.

Study III – Risk selection in Swedish primary care

The aim of this study was to assess socio-economic differences between patients registered with private and public primary health care centres. The design was a population-based cross-sectional study controlling for municipality and household. Socioeconomic data on all individuals residing in Sweden (n=9,851,017) was collected from Statistics Sweden and linked to individual registration data from all 21 Swedish regions. The data set thereby makes it possible to identify which PHCC each Swedish individual is registered with.

The main outcome variable was ownership of the PHCC an individual was registered with. Socioeconomic individual level variables were selected based on previous research suggesting an association between the variable and differences in health needs and. The following socioeconomic variables were included in the analysis:

- Country of birth (grouped into clusters)
- Disposable yearly income per household member in SEK
- Highest level of finished education
- Recipient of sickness benefits
• Recipient of unemployment compensation
• Recipient of labour market compensation
• Recipient of early retirement compensation

A linear probability model was used to analyse the probability of selecting private PHCC conditional on socio-economic variables. Apart from analysing all individuals in a total population-model, two different samples were separately analysed. The samples included only individuals living in municipalities that could be considered to have access to alternative PHCCs.

Results
After controlling for municipality and household, individuals with higher socio-economic status were more likely to be registered with a private primary health care provider. Individuals in the highest income quantile were 4.9 percentage points (13.7%) more likely to be registered with a private primary health care provider compared to individuals in the lowest income quantile. Individuals with one to three years of higher education were 4.7 percentage points more likely to be registered with a private primary health care provider compared to those with an incomplete primary education. Individuals born in Africa and Asia were respectively 5.6 and 3.5 percentage points less likely to be registered with a private PHCC compared to individuals born in Sweden. The results show that there are notable differences in registration patterns, indicating a skewed distribution of patients and health risks between private and public primary health care providers.

Study IV – Risk adjustment measures in Swedish primary care
In this study, the aim was to analyse how the county councils, have acted in order to combat risk selection in primary care following the introduction of the primary care choice reform. To answer the question, we analysed contracts and reimbursement systems from all county councils in two different years (2013 and 2016). A framework for analysis was constructed and the material was classified deductively. Furthermore, data on political majorities in the counties at the two time points were gathered.

Results
The results showed that the counties have used a multitude of strategies to combat risk selection, such as financial risk adjustment and requirements regarding the scope and content of the provided services. Furthermore, it seems
as if though ideology was associated with the degree of risk adjustment in 2013, i.e. county councils with left-wing majorities were more likely to combat risk election to a higher extent. However, the difference between counties governed by right-wing and left-wing majorities disappeared in 2016 where a convergence between the counties was noticed. These results imply that a policy learning process has taken place where counties use empirical data on how their system works and get ideas from other counties on how to combat risk selection, regardless of ideology.
Discussion

Principal findings

When local governments create quasi-markets they have two main ways of steering the providers: by specifying what should be done through contracts or by creating reimbursement systems that incentivize desirable behaviour from the providers. The studies included in this dissertation show that both ways of steering comes with difficulties. A general finding is that it is difficult for local governments to specify what quality is in soft services such as elder care. Furthermore, despite several efforts from county councils to increase equity in access to primary care, there still seem to be equity issues in regards to access to care.

The results from study I indicate a clash between the logic of competitive contracting and the logic of achieving quality in eldercare. Since competition between different providers in a competitive contracting type of public procurement is undertaken ex-ante, it is the principal, in this case the municipalities, which assess the quality of the different tenders before the provision of the services has started. What constitutes quality of elder care is to a large degree subjective, i.e. different users of elder care services have different needs and desires. The principals have the intricate task of assessing quality of care for all individuals that receive elder care whilst they must do so in a neutral way. Furthermore, in line with the results from Almqvist (2001) and Almqvist and Högberg (2005), a large majority of the quality requirements were focused on processes and structures rather than outcomes or results. This implies that contracting municipalities try to control the process, e.g. how tasks are carried out, rather than the end result. This could arguably present a problem according to contracting theory (T. L. Brown, Potoski, & Van Slyke, 2009; O Hart, Shleifer, & Vishny, 1997). The basic premise when a principal, e.g. a municipality, contracts-out a service to an agent is a belief that the agent will be able to achieve similar or better output to a lower price (M. A. Bergman, Johansson, Lundberg, & Spagnolo, 2016; Hefetz, Warner, & Vigoda-Gadot, 2014). If the principal stipulates exactly how an agent should act by formulating requirements focusing primarily on processes and structure, the agent has its hands tied and limits the possibility to produce the services in a more efficient and innovative way.
The results from study II show that there seem to be some negative effects on geographical equity after the introduction of the patient choice reforms. New providers have mainly established themselves in areas with higher socio-economic status – a pattern that may lead to a skewed allocation of health care resources. However, the effects are not very large and also seem to vary between county councils. A possible explanation for this could be the construction and design of the reimbursement systems which vary between all county councils and could buffer some of the unintended effects of the patient choice system. For instance, some county councils have chosen to weigh the capitation reimbursement based on socio-economic status or diagnoses among the listed patients. The incentive structures are therefore significantly dissimilar in different county councils.

Study III strengthens the results from study II and shows that there are substantial socio-economic differences between individuals registered with private and public PHCCs. When controlling for municipality we can still find that individuals registered with private PHCCs have higher income, higher education and are more likely to be born in Sweden compared to individuals registered with a public PHCC. These results indicate that we might see indication of cream skimming in the Swedish primary care where private PHCCs try to attract more profitable individuals to register with them. This can be done both by locating in more affluent areas within a municipality but also through other indirect means such as offering a certain set of services that is likely to attract patient groups with low costs.

An alternative explanation to the results found in study III is that individuals with higher levels of income and education are more prone to choosing a private PHCC. Highly educated individuals are generally more likely to make active choices of providers and therefore can be expected to choose private PHCCs to a higher degree (Dixon, Robertson, Appleby, et al., 2010). Alternatively, individuals with a high socio-economic status could be more ideologically keen to choose private PHCCs since high socio-economic status are correlated with having more liberal ideological viewpoints (Brooks, Nieuwbeerta, & Manza, 2006; Elff, 2009). Taken together, it is difficult to assess to what degree differences in socio-economy between individuals registered with private and public PHCCs can be explained by mechanisms at the provider level or individual level. I argue, based on the results from study II and study III as well as previous research that it is likely to be a combination of both. Regardless of the cause of socioeconomic differences in PHCC registration patterns, it can still be seen as a problem from an equity perspective. If individuals that are less likely to have high health care needs are more likely to register with private PHCCs, this can lead to a skewness in the resource distribution for primary care. If individuals with high socio-economic status and low health care needs are registered with a PHCC in a county council, this
means fewer resources for other PHCCs in that county council where individuals with high health care needs are registered. If these PHCCs are publicly owned, it is possible for the county council to share the costs between them, but this is not viable if the PHCCs are owned by different legal entities.

In an attempt to combat this potential skewness, the county councils can use a range of different strategies. To what extent different strategies have been employed and how the adaptation of these policies have developed over time was examined in study IV. The results showed that the counties have used a multitude of strategies to try to combat risk selection. Furthermore, it seems as if ideology could explain the degree of risk adjustment at the onset of the introduction of the patient choice-systems where left-wing majorities were more likely to adopt several methods to combat risk selection. However, the difference between counties governed by right-wing and left-wing majorities disappeared later on, where we could see a convergence between the counties. This result implies a policy learning process where counties use empirical data on how their system works and get ideas from other counties on how to combat risk selection. Additionally, it indicates that the political goals relating to access in health care does not differ much between left-wing and right-wing majorities.

Methodological considerations

When considering how to conduct sampling in the different studies we have tried to be thorough and use a sensible and purposeful sampling strategy. In Study I, a most-likely case sampling was utilised for the purpose of creating more ‘generalizable’ or ‘transferable’ conclusions. In Study II, III and IV, all possible units of analysis were included in the sample, thus minimising the problems associated with sampling. However, in study III we decided to, apart from the total population, analyse the data with samples where individuals living in municipalities without alternative PHCCs to choose from were excluded. In study IV, we chose to include data from only two years. The reason behind this is that we wanted to capture changes in the political majorities in the county councils which regularly only happens each fourth year.

When performing a regular OLS regression one of the main assumptions is independence between the different units of analysis. E.g. if we want to study the effect on a certain treatment on patients and these patients are being treated at different clinics, the possibility exist that the effect of the treatment is dependent upon which clinic a patient belongs to, i.e. the data is clustered. In the case of study II and study III, the unit of analysis are all Swedish PHCC that all belong to different clusters in the form of municipalities and county councils. The municipalities could have a clustering effect since a municipality
could have a higher mean income than its neighbouring municipality or in other ways have different socio-economic characteristics. The PHCCs are also clustered within a county council that can affect the results since each county council has a certain reimbursement system and other regulations that affect all PHCCs in that county council. Thus, it is important when working with clustered data to somehow control for this cluster effects (Begg & Parides, 2003). When doing this there are several possibilities, e.g. one could control for the county councils using a fixed effect model, a random effect model or, as we opted for, utilise a generalized estimating equation modelling (GEE) technique. In Study II we opted for a GEE approach since we are not interested in the effects of belonging to a certain municipality or county council but rather treats it as a nuisance that we wish to control for (Begg & Parides, 2003; Gardiner, Luo, & Roman, 2009).

In study III, data from all individuals residing in Sweden was gathered. Due to the large number of units of analysis, the issue with clustering that was noted above could be solved by controlling for dummy-coded municipalities in a fixed-effect model. A possible solution would have been to instead utilize a random-effect model but since the fixed-effect model requires fewer assumptions (e.g. no need to make assumptions regarding the error of the random effect) we considered it to be a better choice for these analyses.

Another methodological consideration that arose in both Study II and Study III is whether it is suitable to control for any variables in the regression models. One could argue here that full multiple regression models are more interesting since we, when controlling for other variables get closer to the ‘true effect’ of a single predictor variable. However, I believe that in both Study II and Study III, it is of more value to look at the crude estimates where we only control for geographical areas. Since we are not interested in developing a causal or predictive model but rather use the socioeconomic variables of interest as a proxy for socio-economy, I argue that the crude estimates with no control variables added give a better indication of socio-economic differences between private and public PHCCs. In the studies, we chose to include several, both crude and full, models, which allows the readers to decide for themselves what models are of most interest.

An issue that was noticeable in both study II and study III is how to operationalise and measure socio-economy (SES). This is a subject that have been discussed in length by previous research (P. A. Braveman et al., 2005; Ghawi et al., 2015; Rubin et al., 2014). It is difficult to find a clear consensus regarding how to define and operationalize socio-economy but in general SES can be said to consist of a combined measure of several variables such as an individual’s income, level of education and social status (P. A. Braveman et al., 2005; Marshall et al., 2015). Some scholars have argued that objective measures of
SES such as income and level of education overlook intersectional aspects of SES that can be better captured by combining objective measures with self-evaluations (Rubin et al., 2014). However, in the studies included in this dissertation, we have been limited to measures that can be gathered from Statistics Sweden for all individuals residing permanently in Sweden. This limitation excludes the use of more subjective measures of socio-economy such as self-identification of SES. An alternative approach in both Study II and Study III would have been to create indices for socioeconomic status by adding multiple variables together. One advantage with this approach would have been that it might have been easier to interpret for the reader. A disadvantage however, is that we would lose information and detail since the association between single socio-economic measures and the outcome would become hidden.

In both Study I and IV, a question that arose was how to deal with quantitative data in studies that had lot of qualitative elements. Especially Study I with an inductive coding process, was to some degree subjective, meaning that a different coder probably would not have coded all quality requirements exactly the same way. Due to the approximate nature of the data in these studies, we argue that formal statistical tests such as t-tests were not suitable. A formal statistical test would give the reader a notion of exactness that did not correlate with the validity of the coding process. Instead, we chose to use simple descriptive statistics to show differences between groups and complement this with more examples of how different items were coded. In this way, transparency increases and the readers can themselves follow the process and decide if our conclusions are valid.
Theoretical and policy implications

The studies carried out in this dissertation indicate that there might be a conflict between quasi-market models as they have been introduced in Sweden and the ability for local governments to design markets so as to achieve equity and quality in health and social services. These results indicate that the theoretical approach to contracting needs to be complemented by looking further into the monitorability of contracts. Further, more emphasis should be put on the possibility to steer markets depending on what type of contracting mechanisms are being used. Competitive contracting via public procurement creates different opportunities to monitor an agent since the competition between tenders occurs before the services are being performed compared to the case in a user choice system where the competition occurs during and after the services are being provided. Thus, when using competitive contracting mechanisms to contract out, it creates a situation where the principal needs to specify all requirements in advance which, as shown in study I, can be problematic. When a principal utilizes a user choice system to contract-out other obstacles ensue. Compared to competitive contracting the principal loses control in a user choice system with free establishment for providers. This means that the principal no longer has the ability to control where providers are established and these decisions are instead transferred to the quasi-markets which consist of the providers and the user/patients. To be able to achieve desirable goals in a user choice system, the principal must take a more reclined approach and try steering through the creation of different incentive structures.

Is it possible for local authorities to design patient choice systems in a way to minimize equity issues? As shown in the studies in this dissertation, this is difficult. Within primary care, there is a distinct imbalance in where new PHCCs have been set up and what individuals are registered with private PHCCs. The differences are systematic and consistent over the whole country. The central government and the county councils have tried to mediate this by forbidding a PHCC to refuse an individual to register and to risk adjust the reimbursement based on socioeconomic variables, diagnoses and distance to a large city. Despite these efforts, we still see tendencies towards risk selection. This implies that the steering and design of the markets does not work completely as intended.
A possible remedy is to increase the degree of risk adjustment even more since there is clear evidence that providers respond to financial incentives (Andersen, 2009; Anell, Dackehag, & Dietrichson, 2018; Barros, 2003; Croxson, 2001). Thus, it is reasonable to believe that an increase in the degree of risk adjustment would affect the behavior of the providers such that they try to locate in less socioeconomically affluent areas and attract patient groups with higher health care needs. However, this solution might not be entirely satisfactory.

First, there is the question what type of risk adjustment measure to use. Today in the Swedish PCCR, there are mainly two types of measures that are used to adjust the capitation reimbursement: Care Need Index (CNI) and Adjusted Clinical Groups (ACG). CNI is beneficial mainly since it is not possible to affect for the providers. It is calculated using official statistics of aspects such as age and country of birth of the enlisted patients. This means that it is inexpensive to use and the local authorities do not need to be concerned about providers manipulating the data. However, if the goal of using CNI is to capture health care needs, it is not the best measure to use. Since CNI only captures socioeconomic variables it can only be used indirectly to measure health care needs. It is for instance reasonable to believe that there are large variations in health care needs among different 75 year old people that live alone (one of the variables included in CNI). Furthermore, if the county councils instead put more emphasis on diagnoses-based risk adjustment such as ACG, the advantage is that it measures health care needs more directly. The disadvantage with using ACG is that it is based on diagnoses, meaning that providers can game the system by recording more severe diagnoses or irrelevant diagnoses for patients, thereby increasing their revenue. The county councils can monitor this by scrutinizing journals to see if the recorded diagnoses are correct and reasonable. This is however costly to do and it can be seen as a type of transactional costs for contracting-out health care. Furthermore, there is also a risk for increased costs for the providers since they need to make sure all diagnoses are recorded correctly at each visit. Some county councils have worked around this problem by only calculating ACG using diagnoses recorded by specialists at hospitals. This could be a solution but means the ACG-scores are not as correct since all diagnoses are not included.

Second, increasing the degree of risk adjustment does not solve an intrinsic problem with adjusting reimbursement based on characteristics of the registered patients. Since all listed patients on a PHCC contribute to the capitation payment and the capitation is based on a computed average costs to treat a single patient over a year, there will still be individuals, i.e. patients with the highest health care needs, that will not be profitable for the providers. Irrespective of the degree of risk-adjustment, the most profitable patients in a reimbursement system that relies on capitation will always be the patients that
do not visit the PHCC. Conversely, the most costly patients are those with the most visits to a PHCC. This creates incentives for the providers to not be as responsive to the needs of these groups of high costs patients and indirectly push them to choose a different provider. This is in direct contrast to the main principles behind a patient choice system – that the providers should compete with high quality to try to attract patients. To remedy this, a solution that have been put forward in other health care systems, is for the health care authorities to create a separate high cost pool for patients that are not profitable, i.e. providers are reimbursed from a separate pool of money, for the small group of patients with the highest costs (Schillo, Lux, Wasem, & Buchner, 2016).

Third, despite most county councils having tried to increase the reimbursement for PHCCs outside large cities, there are still very few PHCCs that have been established in areas that are more rural. It seems difficult to incorporate a reasonable reimbursement policy that can work for both urban and rural settings. A problem is the large scope of services that many county councils demands all PHCCs to provide, which makes it difficult to establish a PHCC in areas with fewer potential patients. A possible solution could be to create different patient choice systems for urban areas and rural areas that can take into consideration the special challenges that are present when creating a reimbursement model in different areas.

Taken together, the studies presented in this dissertation have clear implications for policy, not least in Sweden. Given that policy makers both at the national and local levels still make equity a high priority within the system, it seems as if there is a need to review to the legal and financial conditions for establishment of new private care providers. Furthermore, national and local authorities should pay close attention to how contracts with private providers of health and elder care are written when contracting-out services to these, not least with regards to the possibility for the local authorities to monitor out-contracted services.
Further studies

The conclusions of this dissertation call for further research in several areas. Among these, a better understanding of how reimbursement systems and risk adjustments affect listing patterns within a patient choice system. This could be done by utilizing individual level longitudinal data and study changes in reimbursement system and the effect this has on what PHCCs patients are registered with.

Furthermore, studies are needed that look into how local governments can utilize combined mechanisms when contracting out and how these can work together. For instance, it is possible to combine ex-ante competition with quality requirements with ex-post competition through for instance a patient or user choice system. What incentives can these combinations create and what are the effects on quality of care and equal access to care?
Summary

Municipalities and county councils use a multitude of different strategies when they design and steer health and social care markets to try to meet goals such as quality and equity. Depending on the strategies used, different problems arise. The aim of this thesis is to examine how local authorities can design quasi-markets in a way that achieves public goals such as equity and high quality. To answer the aim, four empirical studies were carried out.

The studies show that when designing a market by contracting-out through public procurement, the issues lay primarily at specifying and defining what is meant by quality before a service is privatized. This is especially difficult to do concerning soft areas such as elder- and healthcare. If this is not done properly, it can lead to crucial issues for monitoring quality since the contracting authority cannot hold the provider responsible for delivering an aspect of a service if that aspect is not specified in the contract.

When a market is designed as in the patient choice systems in primary care, it creates a whole other set of difficulties for the local governments. Here, it is not as important to specify quality beforehand in the contracts since quality monitoring is done retrospectively by both the counties themselves as well as the patients who with their choices can monitor quality by punishing providers with poor quality by registering with another provider. Instead, the crucial problem is how to design reimbursement systems that will lead to equal access to health care. In this respect, the county councils utilize different methods. Despite these measures, the primary care choice reform has led to inequity, both geographically in regards to where new private primary health care centres are located but also and to a larger degree, socio-economic inequity relating to what kind of socio-economic groups of individuals are registered with private PHCCs. In other words, county councils do not manage to fully counteract risk selection behaviour by the design of their reimbursement system, which could imply issues with unequal access to health care.


Att styra en upphandlad verksamhet skapar således nya utmaningar för kommuner och landsting. De övergripande syftet med denna avhandling är att undersöka hur lokala myndigheter kan utforma kvicksilvermarknader så att politiska mål som hög kvalitet och jämlik tillgång till vård kan uppnås.

I den första studien undersöktes hur kommuner skrev avtal med privata företag vid upphandling av äldreboenden och om kvalitetskraven i dessa avtal kunde sägas vara uppföljningsbara. En kvalitativ innehållsanalys gjordes för att analysera totalt åtta kontrakt från fyra olika kommuner. 1005 kvalitetskrav
identifierades och kodades utifrån vilket område de fokuserade på, huruvida kravet rörde strukturer, processer eller utfallskvalitet samt i vilken grad kvalitetskravet var uppföljningsbart. Analysen visade att kvalitetskrav som rörde mjuka områden såsom sociala aktiviteter och omvårdnad hade en mycket låg grad av uppföljningsbarhet. Dessa krav karakteriseras av att de var skrivna på ett vagt och oprecist sätt vilket innebär att det är svårt för kommunen att avgöra huruvida ett sådant krav är uppfyllt.

I den andra studien var syftet att undersöka hur vårdvalsreformen i primärvården har påverkat den geografiska jämligheten. Detta gjordes genom att undersöka i vilken typ av områden vårdcentraler som öppnade efter vårdvals införande ligger och jämföra detta med de områden där tidigare etablerade vårdcentraler ligger. Forskningsdesignen byggde på att analysera socioekonomiska uppgifter om personer som bor i samma valdistrikt där de 1411 primära vårdcentralerna i Sverige är etablerade. Resultaten visade att vårdcentraler som etablerats efter vårdvals införande låg i områden med signifikant färre äldre ensamboende samt färre ensamstående föräldrar - grupper som i allmänhet har lägre socio-ekonomisk status och ett högt förväntat sjukvårdsbehov. Emellertid observerades inga signifikanta skillnader för andra socioekonomiska variabler som medelinkomst, andel invandrare, utbildningsnivå och arbetslöshet.

In den tredje studien var syftet att undersöka socioekonomiska skillnader mellan patienter registrerade hos privata och offentliga primärhälsovårdscentraler. Designen var en befolkningsbaserad tvärsnittsstudie där vi kontrollerade för kommun tillhörighet. Socioekonomiska uppgifter om alla personer bosatta i Sverige (n = 9 851 017) samlades in från SCB och sammanlänkades med uppgifter om vilken vårdcentral alla var listade på. Individer med högre socioekonomisk status var i högre utsträckning listade på privata vårdcentraler. Exempelvis var individer i den högsta inkomstkvantilen 4,9 procentenheter mer benägna att lista sig hos en privat primärvårdspersonal jämfört med individer i den lägsta inkomstkvantilen. Vuxna individer med en universitetsutbildning på 1-3 år var 4,7 procentenheter mer benägna att vara listade hos en privat vårdcentral jämfört med individer som gått mindre än 9 år i grundskola. Resultaten visar att det finns tydliga skillnader i listningsmönster baserat på socioekonomi.

I den fjärde och sista studien var syftet att analysera hur landstingen har agerat för att motverka att vårdcentraler försöker attrahera framförallt friska individer med förväntat lågt vårdbehov att lista sig hos dem, så kallad riskselektion. Vidare ville vi ta reda på om politisk majoritet kunde förklara i vilken utsträckning landstingen försökt motverka riskselektion. För att undersöka detta analyserade vi kontrakt och ersättningssystem från alla landsting för åren 2013 och 2016. Analysen visade att landstingen har använt ett flertal olika strategier
för att försöka bekämpa riskselektion, däribland olika former av justeringar av ersättningen. Vidare verkar det som att ideologi skulle kunna förklara i vilken grad landstingen försökte motverka riskselektion under 2013 då landsting som styrdes av en vänstermajoritet var mer benägna att använda flertalet åtgärder för att motverka riskselektion. Dock minske dessa politiska skillnader år 2016, där vi istället kunde se en konvergens mellan landstingen. Detta resultat kan innebära att vi ser en politisk inlärningsprocess där landstigen använder empiriska uppgifter om hur deras styrning fungerar samt får idéer från andra län om hur man kan motverka riskselektion och på sätt lär sig både av sig själv och av varandra.


När en marknad är utformad som en kvasi-marknad, såsom i vårdvalet i primärvården, skapar det en helt annan uppsättning svårigheter för de lokala myndigheterna. Här är det inte lika viktigt att specificera kvalitetskrav i kontrakten eftersom kvalitetsövervakningen, om allting fungerar som det är tänkt, sker av patienterna eller brukarna som med sina val kan ”straffa” utförare med dålig kvalitet genom att välja en annan utförare. Istället är en av de mer grundläggande utmaningarna i dessa system att utforma vårdvals- och ersättningssystem som leder till jämnt tillgång till vård. I detta avseende använder landstingen olika metoder. I avhandlingen visas emellertid att trots dessa åtgärder leder vårdvalet inom primärvården fortfarande till ojämlikhet. Både geografiskt ojämlikhet när det gäller var nya privata vårdcentraler etablerar sig, men också i större utsträckning när det gäller listning där individer med hög socioekonomisk status i högre grad är listade hos en privat vårdcentral. En slutsats som kan dras från denna avhandling är att landstingen inte fullt ut lyckats med att motverka riskselektion vilket riskerar att leda till problem med ojämlik tillgång till sjukvård.
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A doctoral dissertation from the Faculty of Medicine, Uppsala University, is usually a summary of a number of papers. A few copies of the complete dissertation are kept at major Swedish research libraries, while the summary alone is distributed internationally through the series Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine. (Prior to January, 2005, the series was published under the title “Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine”.)