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Making markets work in the interest of patients

A review of international evidence of the role of market mechanisms in publicly funded health and social care

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Making markets work in the interest of patients

A review of international evidence of the role of market mechanisms in publicly funded health and social care

Tuomas Haanperä and Sofia Nyström

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Abstract

The health and social care in Finland and Nordic countries perform well in international comparisons. Owing to an ageing population and increasing health and social care needs, the soaring health expenditure is adding pressure to improve productivity.

Implementation of market mechanisms to complement public health and social care has in many cases increased the availability of services and led to cost savings. However, there are also examples of situations where markets have failed to deliver for patients and taxpayers.

This study aims to shed light on the role different market-based mechanisms have had in other selected countries; what can be usefully learned from these examples.

The study underlines the availability and use of information about service quality and outcomes, performance and costs. Information is the core building block of functioning markets and service development.

Information makes it possible for patients to make informed choices. Information on patient outcomes and service producers' performance is a prerequisite for commissioners to match customer needs to best available services. Information also provides comparative benchmarking data for service producers to compare their service to peer producers.

As we move to outcome-based health and social care approach, it is of utmost importance to focus on developing suitable indicators to support these needs.

Contact person at the Ministry of Economic Affairs and Employment: Mikko Martikainen, mikko.martikainen(at)tem.fi, tel. +358 295 064 795

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Tiivistelmä

Suomen, ja yleisemminkin pohjoismaiden, terveys- ja sosiaalipalvelut pärjäävät hyvin eri kansainvälisissä vertailuissa. Johtuen väestön ikääntymisestä sekä sosiaali- ja terveyspalveluiden kysynnän kasvusta ja kustannuspaineista, huomiota on kiinnitettävä palveluiden tuottavuuteen.

Markkinamekanismin hyödyntäminen julkisten terveys- ja sosiaalipalveluiden tukena on monessa tapauksessa lisännyt palveluiden saatavuutta ja tuonut kustannussäästöjä. On kuitenkin esimerkkejä, joissa markkinamekanismi ja markkinatoimijat ovat epäonnistuneet tuomaan hyötyjä asiakkaille ja veronmaksajille.

Tässä tutkimuksessa kuvataan sitä, miten markkinamekanismeja on hyödynnetty eri maissa ja mitä näistä kokemuksista voidaan oppia, huomioiden erot eri maiden sosiaali- ja terveysjärjestelmissä.

Tutkimus korostaa palveluiden laatua, vaikuttavuutta ja kustannuksia koskevan informaation keskeistä roolia markkinoiden muotoilussa ja palveluiden kehittämisessä.

Informaation avulla potilas voi tehdä tietoon perustuvia valintoja. Potilaiden tarpeiden ja parhaiden palveluiden yhdistäminen edellyttää informaatiota potilaiden hoidon vaikuttavuudesta ja palveluiden tuottajien toiminnasta. Eri tuottajia koskeva informaatio antaa tuottajille mahdollisuuden vertailla omaa toimintaansa muihin.

Tulevaisuudessa, siirryttäessä kohti vaikuttavuuspohjaista palveluiden tarjontaa, on tätä tukevia indikaattoreita edelleen kehitettävä.

Contact person at the Ministry of Economic Affairs and Employment: Mikko Martikainen, mikko.martikainen(at)tem.fi, tel. +358 295 064 795

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Referat

Social- och hälsovårdstjänsterna i Finland, och de nordiska länderna i allmänhet, klarar sig bra i internationell jämförelse. På grund av en åldrande befolkning samt en ökande efterfrågan på social- och hälsovårdstjänster och kostnadstryck ska uppmärksamhet fästas vid hur produktiva tjänsterna är.

Att utnyttja marknadsmekanismer för att stödja offentliga social- och hälsovårdstjänster har gynnat tillgången till tjänster och medfört kostnadsbesparingar. Det finns dock exempel på att marknadsmekanismen och marknadsaktörerna misslyckats med att generera fördelar för klienterna och skattebetalarna.

Denna undersökning beskriver hur marknadsmekanismerna har utnyttjats i olika länder och vad man kan lära av dessa erfarenheter, med beaktande av skillnaderna i olika länderns social- och hälsovårdssystem.

Undersökningen betonar den centrala rollen av information om tjänsternas kvalitet, effekter och kostnader i utformningen av marknaden och utvecklingen av tjänster.

Utifrån informationen kan patienten göra kunskapsbaserade val. För att förena patienternas behov och de bästa tjänsterna krävs information om effekterna av vården och om tjänsteproducenternas verksamhet. Utifrån information om olika aktörer kan producenterna jämföra den egna verksamheten med andra.

I framtiden, då vi går över till ett effektbaserat tjänsteutbud, ska de indikatorer som stöder detta vidareutvecklas.

Contact person at the Ministry of Economic Affairs and Employment: Mikko Martikainen, mikko.martikainen(at)tem.fi, tel. +358 295 064 795

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PREFACE

The Finnish health and social care system ranks high in international comparisons. However, like in many other European countries, owing to the ageing population and increasing health and social care needs, health expenditures are soaring and adding to the pressure to improve productivity in the provision of care. The Finnish government is determined to reduce health and welfare disparities between regions and individuals through greater resourcing of public services over the coming years. At the same time, the government seeks to promote innovation across the economy, including in health and social care. The Ministry of Employment and Economic Affairs asked Copenhagen Economics to examine whether and how other countries have succeeded in using market-based systems as one of the ways of enhancing innovation and productivity whilst preserving a high standard of publicly funded health and social care services.

LIST OF ABBREVIATIONS AND EXPRESSIONS

ACM	The Dutch Authority for Consumers and Markets
AI	Artificial intelligence
AQP	Any Qualified Provider
BMA	The British Medical Association
CCG	Clinical Commissioning Groups
CMA	The UK Competition and Markets Authority
COC	Continuity of Care index
CQC	Care Quality Commission
CSU	Commissioner Support Units
DRG	Diagnosis Related Groups
DTC	Diagnosis Treatment Combinations
GDP	Gross Domestic Product
GGZ	The Dutch Association of Mental Health and Addiction Care
GP	General practitioner
HRG	Healthcare Resource Groups
ICS	Integrated Care System
IGJ	The Dutch Health and Youth Care Inspectorate
LOV	The Swedish Act of Choice
Monitor	The former executive non-departmental public body of the Department of Health, responsible for ensuring healthcare provision in NHS England was financially effective
NHS	The National Health Service (England)
NZa	The Dutch Health Care Authority
OECD	The Organisation for Economic Co-operation and Development
PbR	Payment by Results
PLICS	Patient level information and costing system
SALAR	The Swedish Association of Local Authorities and Regions
SCA	The Swedish Competition Authority
STP	Sustainability and transformation partnerships

VAT	Value Added Tax
WLZ	The Dutch Long-Term Care Act
WMO	The Dutch Social Support Act
ZVW	The Dutch Health Care Insurance Act
Commissioners	Buyers of health and social care
Providers	Suppliers of health and social care

INTRODUCTION AND EXECUTIVE SUMMARY

The Finnish health and social care system ranks high in international comparisons. However, like in many other European countries, the ageing population and increasing health and social care needs are adding to the pressure to improve productivity in the provision of care. The Finnish government is determined to reduce health and welfare disparities between regions and individuals through greater investment in public services over the coming years. At the same time, the government seeks to promote innovation across the economy, including in health and social care. The Ministry of Employment and Economic Affairs asked Copenhagen Economics to examine whether and how other countries have succeeded in using markets as one of the ways of enhancing innovation and efficiency whilst preserving a high standard of publicly funded health and social care services.

The health and social care systems in Finland and other Nordic countries perform well in international comparisons. For example, according to the World Health Organisation, Finland is one of the highest performing countries with the lowest maternal mortality ratio and in top five when it comes to international health regulation capacity[1] and health emergency preparedness.[2] However, owing to an ageing population and increasing health and social care needs, the soaring health expenditure is adding pressure to improve productivity. Further, there are notable inequalities in the quality and especially accessibility of health and social care services across the country. For example, the proportion of people reporting unmet needs for medical care is high relative to other EU countries on average with employed people generally having better access to care through occupational health services than unemployed or retired people.[3]

1 International health regulation capacity is the ability to detect, assess, notify and report events and respond to public health risks and emergencies of national and international concern, see World Health Organisation (2019b).

2 World Health Organisation (2019a).

3 OECD (2019), Finland: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/20656739-en

This has spurred previous governments as well as the current government to try to improve the situation through attempts to reform the health and social care system, including how the provision of care is commissioned, organised and regulated. As set out in the Government Programme, more efficient and effective health and social care services are needed in order to meet patients' growing needs.[4] Against the backdrop of the objective to spur productivity in health and social care, the Ministry of Employment and Economic Affairs is interested in learning more about the different ways to increase efficiency and boost innovation through forms of market mechanisms. These aim to respond to patients' choices, improve the quality of services and control costs. Implementation of market mechanisms has in many countries increased the availability of services and led to cost savings. However, there are also examples of situations where markets and market participants have failed to deliver for patients and taxpayers. **We sought to shed light on the role different market-based mechanisms have had in other selected countries.**

What is meant by 'market mechanisms' in health and social care is not clear-cut. Models of choice and competition are not limited to opening services for private sector providers. Further, the role of the private sector is not straightforward in health or social care services. Often, the private sector is involved in care labelled as public, for example through outsourcing, provision of technology, and through a variety of public-private partnerships. Further, all countries have at least some privately provided healthcare paid by patients themselves at the point of use, or via an insurance. **In this study, we focus on the provision of health and social care services where these services are (wholly or partly) funded and commissioned by the public sector and provided by public, private and third-sector providers.**[5]

The role of market mechanisms is generally well-explored with respect to the provision of healthcare. For social care, both which services are defined as 'social care' and the evidence of market outcomes appear to be more fragmented. For this reason, we placed more emphasis on the evidence of healthcare but refer to aspects of social care as well (e.g. elderly care). Further, as becomes clear below, the international examples of 'market-based mechanisms' are not limited to the use of the private (or third) sector providers. Indeed,

4 Programme of Prime Minister Sanna Marin's Government 10 December 2019. Inclusive and competent Finland – a socially, economically and ecologically sustainable society.

5 In this study we use a generic term "commissioner" when referring to public bodies assessing the needs of their populations, planning and organizing services to meet those needs, and procuring and contracting with providers. A commissioner can thus be a municipality, a local authority or a "clinical commissioning group" (England), which vary by country. Further, again for presentational consistency, we refer to "providers" as the organisations that provide health and social care services. We focus on the experiences in using of choice and competition in the provision of health and social care; questions such as state aid implications are outside the scope of this study.

incentives to respond to patients' choices, and to perform well in comparison to other providers, have been created to encourage and reward public providers.

Experiences from other countries provide useful lessons on the use of market mechanisms and their effects. Recognising that no country offers a 'one size fits all' solution that can be exported to other countries, this report investigates the role of market mechanisms implemented in **Denmark, The Netherlands, Sweden** and the **United Kingdom** (mainly England). We examined the following questions:

1. What the 'building blocks' of designing well-functioning markets in health and social care are, given the market failures inherent to these services?
2. How different countries have gone about using markets in health and social care in practice; what has worked, what has not and why?
3. Given the learnings on successes and challenges, what does it take to implement and oversee markets in health and social care in terms of resources, steering and support?

1 Building blocks of making markets work for patients and taxpayers

Market-based systems manifest themselves in a myriad of ways. **Patients' choices** are in some countries expected to encourage providers to improve quality and availability of care (e.g. freedom of choice, vouchers, personal health budgets). Further, **competition for service contracts** can be an effective way for commissioners to find the provider that best meets the needs of their patients (e.g. competitive tendering, full or partial outsourcing). Cutting through the complexity of the variety of ways in which markets have been used in health and social care, we framed our assessment along the following 'building blocks' that appear to be central to the functioning of any market-based system:

- **Informed choices:** The ability of the patient or the commissioner to choose between providers based on comparative evidence
- **Providers' incentives and ability to respond to choices:** Financial and other incentives for providers to innovate, enter and exit the market
- **Securing societal objectives:** Regulation and steering of services determining how much room there is for alternative ways of providing care while preserving patient safety and securing the societal objectives of health and social care

Building on these factors, we examined how different countries had put in place laws, regulations and commissioning practices to ensure that competition works in the interest of patients. There are vast differences in the institutional set-up and other characteristics of different countries. We found that while the successes and failures observed in different countries relate to the above 'building blocks' in different ways, there is no one-size-fits-all solution for all countries. Indeed, market-based systems have had mixed success across countries. For example, England is on course to scale back competition in parts of the healthcare system with an increased focus on collaboration and integrated care, while Denmark has never introduced competition in public healthcare in a similar fashion to other selected countries.

2 Commissioners and government bodies determine the role of market mechanisms, and there are important lessons to be learned from other countries

There is a body of international evidence of the impact of market mechanisms in different forms, and the determinants of success are typically related to the aforementioned three 'building blocks'. Our main findings were three-fold:

First, the success of **patient choice-based systems** (including freedom of choice, healthcare vouchers, personal health budgets) depends critically on who chooses, and on what basis. There is limited evidence to suggest that patients' right to choose their primary care provider (e.g. a general practice, health centre) has been a significant lever of quality improvement. Patients may not have access to information about clinical quality or may not be well placed to engage with such information to inform their choices. On the other hand, there is empirical evidence indicating that choice of elective hospital services – facilitated by a doctor (GP) at the point of referral – contributed to competition and improved patient outcomes in England. An important feature of the English system is that the prices paid to providers of chosen by patients (whether private or public) are fixed and regulated, which means that providers can only compete on quality. Similarly, the evidence regarding choice-based regimes is mixed in Sweden, where the introduction of choice around 10 years ago has triggered entry and helped improved access to primary care, but where access to transparent information has not been implemented by some commissioners effectively enough. Overall, patients' ability to choose their provider appears to be more effective in improving services when patients are supported by transparent information and when choices are facilitated by experts (e.g. a general practitioner or by a commissioner choosing on behalf of patients).

Second, when services are funded from the 'public purse', the **funding needs to provide adequate financial incentives to enter and to enable a high standard of care**. This requires commissioners to have a sound understanding of the underlying costs and associated patient outcomes. We found examples where either the contract value or the payment based on treatments was considered too low to trigger entry. For example, in Sweden and England, providers as well as the national regulators have expressed concerns over inadequate reimbursements paid to providers, especially in the more challenging areas. In Sweden, publicly run units have been allowed to make losses which are carried by the region without adjusting the reimbursement to privately run units, raising questions about competition neutrality. Conversely there are examples where more financially attractive (regulated) payments triggered entry to certain health services. Importantly, further to the level of publicly funded reimbursement, **what matters is the way in which the payments are designed to create incentives to improve services**. A cross-cutting theme across many countries is the desire to move from remunerating providers for activities and procedures to paying for patient outcomes with an increased focus on integrated and preventative care. While the development of such payment models is still work in progress, the direction of travel towards more outcomes-based funding is apparent.

Third, there are vast variations between and within countries in **how commissioners assess their existing providers' performance, on what basis they intervene and how they might open services for alternative providers**. The evidence of opening services up for competitive tender (e.g., local commissioners outsourcing services partly or wholly) is case-specific and difficult to generalise. While it is generally more common to use competitive tenders and outsourcing for services such as primary, community and social care services and for adjacent services like certain laboratory services, we did not find systematic evidence to suggest that outsourcing works better for certain services than others. The use of tendering and outsourcing has brought significant cost savings, improved access and quality improvements across a spectrum of sectors; yet there have also been failures putting patient safety at risk. The mixed evidence suggests that the effectiveness of opening services for competition depends on how well the contracts are designed, how the selected provider's performance in delivering good outcomes for patients is monitored, and how commissioners and regulators can intervene to address any inadequate performance early enough.

3 Comparative information on the effectiveness of care and associated costs is key to effective commissioning

Making the above 'building blocks' work for patients is easier said than done. Indeed, the evidence reviewed for this study suggests that the success of markets is not only contingent on the design of the systems but often on the rigour of the way the systems are implemented and operated. We investigated the strategic and practical challenges related to monitoring and steering.

Given the challenges and successes experienced in different countries and regions within them, we sought to identify what is needed from commissioners and authorities to make good use of market mechanisms. The following three factors stood out:

1. **'Infrastructure' needed for evidence-based understanding of how well providers meet patients' needs.** A finding cutting across all aspects of our study is that reliable evidence of patient outcomes, performance and costs is a salient prerequisite for commissioners regardless of how they use market-mechanisms. First, **patients'** ability to make informed choices over where they receive care necessitates transparent information. Second, **commissioners** themselves cannot assess the needs of local populations and secure services from the best possible providers without information on patient outcomes and on provider performance. Further, systematically collected information on patient outcomes is a prerequisite for commissioners' ability to design funding models. Third, **providers** and **health professionals** employed by them benefit from comparative information to identify opportunities for improvement. Fourth, **regulators** need up-to-date evidence for monitoring the quality of care provided.

   The countries reviewed as part of this study collect and publish data on healthcare providers' performance and patient outcomes. Developing information that is useful for providers, professionals, commissioners and for patients has proven to require longstanding efforts and infrastructure. The English NHS, for example, shows how the data collection and processing efforts need to be deployed consistently to ensure comparability across providers and regions. It also shows how designing appropriate indicators, recording outcomes and assuring the quality of data come with significant resource requirements, and how, therefore, national-level support can be essential. Similarly, the Swedish National Quality Registries systematically collect data on outcomes with the purpose of ensuring equal care across the country and improving the quality of provided care.

2. **Financing models to ensure incentives for innovative, quality-enhancing services.** Where services are (wholly or partly) publicly funded and (wholly or partly) privately provided, commissioners need to design funding mechanisms that encourage new entry but do not over-compensate providers.

   Our review identified examples where the public funding systems were not conducive to triggering entry in areas with the most challenging needs. Further, some systems have been found not to align incentives, so that care is provided at the most efficient setting. For example, if primary care is funded based on the number of registered patients and hospital care based on activity, the payment model does provide a financial incentive to treat the patient outside a hospital setting (or to promote preventative care). The English NHS is currently seeking to address 'siloed' commissioning and provider models through greater integration between commissioners of different types of health care service, and between health and social care. Further, the direction of development across the countries we reviewed is towards more 'value-based' and less transaction-based funding models - i.e. remunerating providers based on health and wellbeing of their patient populations rather than based on the number of activities undertaken. Again, setting the publicly funded reimbursements to a level that encourages cost-efficiency and preventative, in some cases integrated care requires granular cost data and evidence on patient outcomes.

3. **Resources and scale for active commissioning based on local health needs and effective performance management.** Both English and Swedish examples show that the approaches to commissioning vary greatly between different local commissioners. Some (smaller) commissioners would appear to benefit from additional resources to actively monitor existing providers' performance and to engage in finding options for alternative models of providing services, possibly by alternative providers. The direction of development in England, for example, is towards integrating local commissioners with a significantly larger geographic footprint and, further, with greater collaboration between commissioners of different types of service. Integration between commissioners (and associated funding models) and providers is believed to enable integration of care.

Central government bodies can play a role in supporting local commissioners and providing a consistent framework for providers across regions

It may be unrealistic to assume that all small local commissioners (e.g., small municipalities) could independently resource the complex prerequisites for active, evidence-based commissioning. Indeed, we found wide variations in commissioning practices, for example, between Stockholm and the rest of Swedish regions, and approaches vary considerably within the England, too. This is in part due to local characteristics (e.g. population size) but also due to a lack of resources available in small localities. We therefore explored the role of central steering in the England, Sweden and the Netherlands where national bodies play a role in supporting and overseeing health and social care systems.

The role of central steering depends largely on the institutional framework which in turn varies across countries. We nevertheless found transferrable lessons of how national bodies have supported local commissioners and contributed to more consistent market conditions across regions. For example, while the English NHS is a collection of hundreds of self-governed organisations, the system relies on strong national organisations that, amongst other functions, support commissioners and providers and regulate them where needed. The Swedish National Board of Health and Welfare is often involved in, and sometimes responsible for, the collection of performance data. Similarly, they publish national guidelines that support municipalities and regions prioritising and efficiently allocating resources. However, the municipal autonomy is protected with the purpose of being able to meet local needs.

Developing an efficient financial architecture that rewards public and private providers for outcomes (not just outputs or activity) requires careful planning and resources to collect reliable data on costs, on patient outcomes and on the effectiveness of different incentives that can be built into the payment model. Similarly, the ability to collect and benchmark costs between providers on a comparable basis is central to the implementation of any publicly funded payment system. **Central bodies have played a role in ensuring consistency in determining what information is collected and why, and how the data is processed.** We also found examples of national bodies developing resources, such as guidelines, tendering approaches and practical consulting support, to help local commissioners. Finally, continuous evaluation of what works and why, knowledge sharing and benchmarking between regions are often centrally led (where they happen).

Finally, both in the Netherlands and England, competition authorities (ACM and CMA, respectively) have had roles in healthcare markets, e.g. through merger control. Both countries have also established economic regulators with powers on competition, choice and procurement-related matters, although in England, the role of the regulator has diminished with the general trend of scaling back competition in parts of healthcare.

Further, in health and social care, commissioners are often considered to face a trade-off between promoting competition on the one hand and enabling integration of care on the other. The Dutch and English regulators have provided the sector with guidance on how collaboration can be compatible with competition and procurement rules and serve the interest of patients.

The remainder of the report discusses these findings in greater detail. The report is structured as follows:

- Chapter 1 sets the scene by outlining the main characteristics of the selected countries.
- Chapter 2 outlines the building blocks of effective health and social care markets and provides an overview of the economic research on this topic.
- Chapter 3 investigates how government bodies and local commissioners have succeeded in designing and making a good use of markets.
- Chapter 4 describes the types of resources and capabilities that commissioners and supervising authorities need to monitor and steer health and social care markets.

Chapter 1. Comparative approach to examining health and social care markets

In this study, we investigate what can be learned from other countries regarding how health and social care services are organised. Our focus is on the role of market-based mechanisms in securing good outcomes for patients. Several countries have introduced forms of competition both to incentivise competition between public sectors providers and to trigger entry from the private sector to complement public services and to spur innovation.

Learning from the experiences of other countries requires caution. The institutional set-ups vary considerably between different countries, and the market outcomes witnessed in different countries stem from a combination of historical reasons dating back decades, rather than any specific new policy. Further, it is not straightforward to disentangle the effect of competition and markets from other policies and developments that shape healthcare provision in different countries. Indeed, different countries with very different systems perform similarly in terms of productivity and high-level indicators of patient outcomes. Denmark's "government-owned healthcare sector" looks similar to the Dutch model of 'managed competition' in high-level country comparisons.[6] Further, as becomes clear in this report, no country offers a perfect, 'best practice' blueprint that could be transferred to other countries. All countries in our review and beyond have witnessed benefits associated with market mechanisms and the involvement of the private sector; on the same token, health policies introducing competition have in some cases come with unintended consequences.

In this report, we focus on four countries: **Denmark, The Netherlands, Sweden and the United Kingdom (mostly England[7])**. These countries have all deployed different

6 Bogetoft et al. (2019) in Sauter et al. (2019), p. 129.

7 The National Health Service builds on the same principles across the UK; however, the legislative framework is different for England compared to Northern Ireland, Scotland and Wales. Choice and competition-based reforms have applied particularly to the English NHS.

approaches to health and social care policy and the role of markets. As such, they provide a useful set of insights and experiences from different perspectives.

Owing to the considerable differences in ways in which health and social care systems are organised and governed, we did not attempt to use a single template for all countries but rather sought to learn from what we believe are the most relevant and transferrable insights from each of the countries. Health and social care systems are highly complex; while we provide an overview of the key aspects of market mechanisms, our review is not intended as an exhaustive assessment of all services where competition plays a role in different ways.

1.1 Overview of relevant comparison countries

All the countries we examined in our report are similar in terms of their core characteristics. All countries spend a relatively high share of their GDP on health and social care, see Figure 1 for healthcare spending.

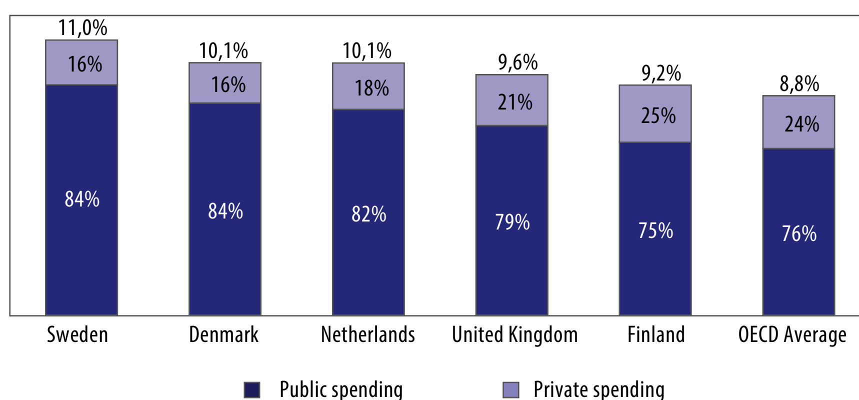

Figure 1. Most economies have a mix of public and private spending in healthcare. Percentage of GDP and shares of public and private expenditures, 2017.
Source: Data extracted on 23 October 2019 from OECD.Stat Health expenditure and financing.

We note that the comparable, well-established OECD statistics refer to the private and public expenditure, but do not capture how these services are provided and how the private share is broken down across different types of service. We discuss the relative shares of private sector provision in different care settings (where possible) below in Chapter 3. For completeness, Figure 2 displays the shares of public social spending (as of GDP), noting that there are no similar recent figures available for private social care.

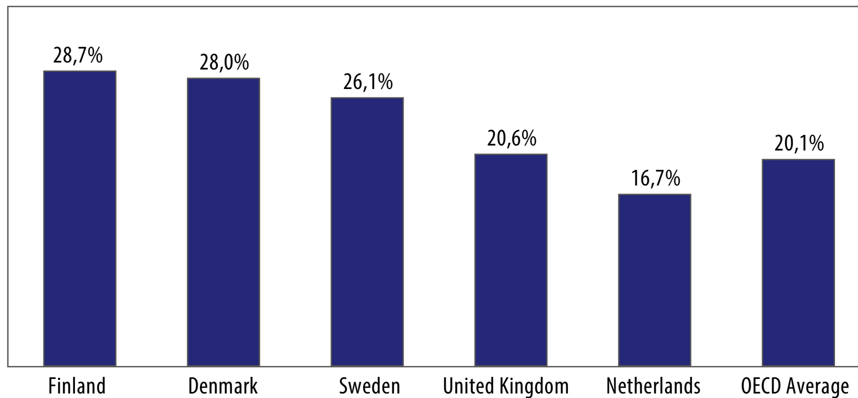

Figure 2. Social care spending across countries. Percentage of GDP, 2018.
Note: Note that data of private social spending is not available.
Source: Data extracted from OECD, Social Expenditure Database (SOCX) on 11 December 2019.

All countries under review are wealthy European countries with ageing populations and increasing health and social care needs. As becomes clear below, there are further similarities between these countries in specific aspects of, for example, funding models. However, there are stark differences in the institutional set-up and the role of the private sector. The headline characteristics of health and social care markets in these countries are depicted in Figure 3 below, followed by the subsequent overview of the health and social care systems in each country.

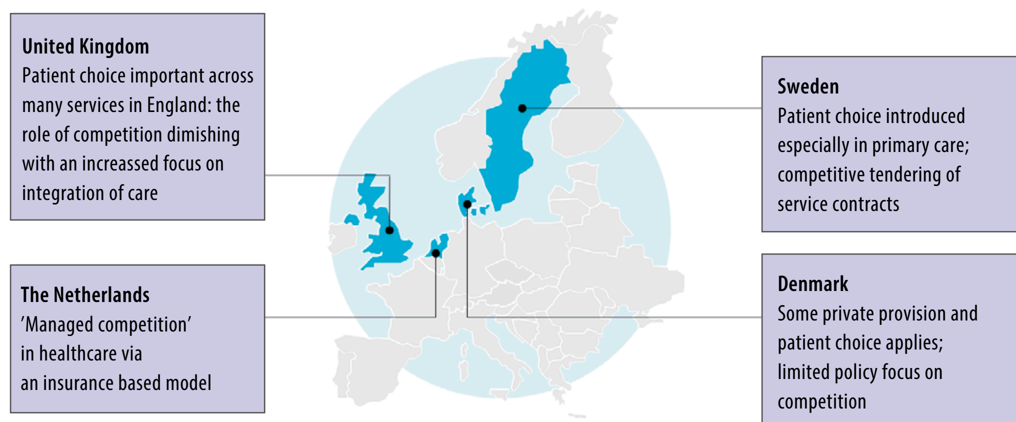

Figure 3. The role of markets varies significantly across comparison countries.
Source: Copenhagen Economics

Below, we explain the key characteristics of the selected countries that are reviewed in greater detail in this study.

1.1.1 Sweden

All Swedish healthcare is regulated by the Health and Medical Care Act (2017:30). There are two principal rules: good health and care should be provided on equal terms for the entire population, and those with the greatest need should be prioritised.

The responsibility for health and social care is shared between the government, the regions and the municipalities, see Figure 4. The role of the government is mainly high level and political, creating conditions for the basic rules and establishing guidelines and nationwide principles. However, the government is also responsible for personal assistance to individuals in need of, on average, more than 20 hours of assistance per week. The role of the regions is to organise the primary and specialised care. The role of municipalities is to organise social care for elderly and people with disabilities, personal assistance for people in need of no more than 20 hours of assistance per week and healthcare for schoolchildren.[8]

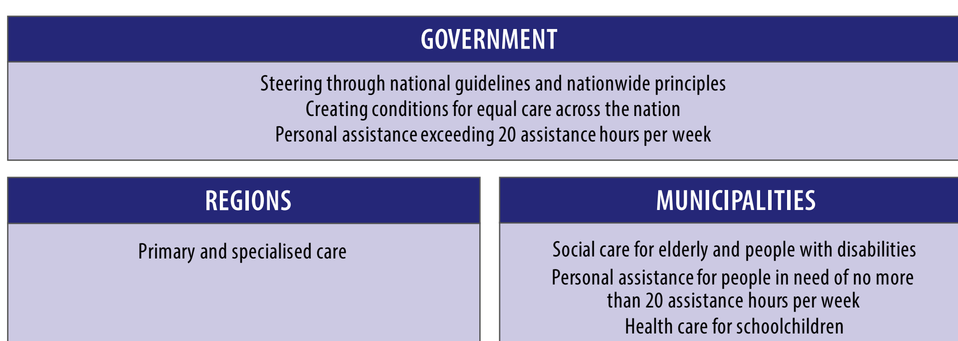

Figure 4. Roles and responsibilities.
Source: OECD (2018a) and ISF (2017).

Private providers are present in many parts of Swedish health and social care, although mainly in primary and social care. Swedish patients have a legal right to choose their primary care provider, according to the Act of Choice, while patient choice in care additional to primary care is optional and whether to implement it is decided by each individual municipality/region.[9] There are therefore large differences between regions in how patient choice is applied in other care than primary care. The Stockholm region uses patient choice most actively, applying it to 39 healthcare services within primary and specialty care, the Uppsala region and the Skåne region apply patient choice to eleven healthcare services, and the average of the remaining 18 regions is three healthcare

8 OECD (2018a).
9 Swedish Act of Choice (2008:962).

services, see Figure 5. Some health and social care services are procured (under the Public Procurement Act (2016:1145)), and some are not available to private providers.

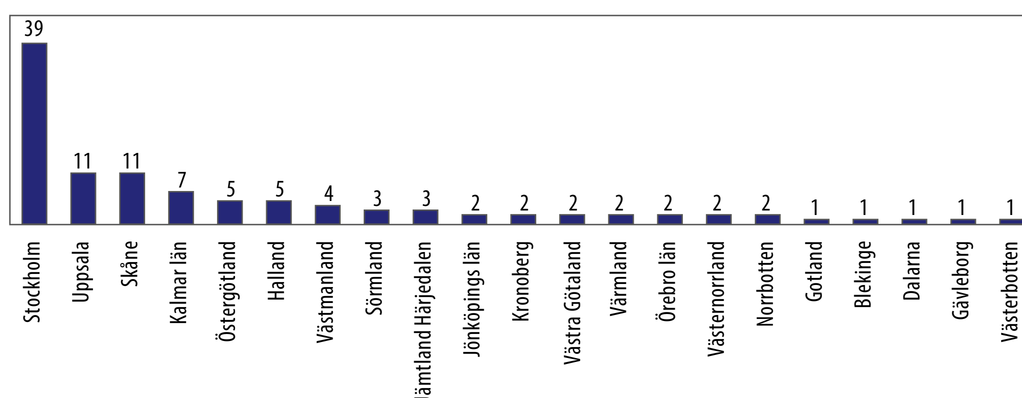

Figure 5. Stockholm region offers most patient choice, within 39 different healthcare services. Number of health and social care services

Note: Including primary care.

Source: Swedish Association of Local Authorities and Regions (SALAR) (2019c).

Swedish health and social care are mainly tax funded. In 2017, 84 per cent was funded by the public sector, 15 per cent by patients out-of-pocket and about one per cent by private health insurances.[10] The patient fee is paid out-of-pocket by most adult patients but capped at 1,150 Swedish kronor per every 12 months from the first visit as an adult patient.[11] Private care that is not financed by any region or municipality is paid for entirely by the patient. This is usually cosmetic plastic surgery or other procedures without medical justification.[12]

1.1.2 England

The National Health Service (NHS) in England is a publicly funded healthcare system employing around 1.5 million people and with an overall budget of around £140 billion in 2019.[13] The NHS is led by the Department of Health and Social Care and the Secretary of State for Health and Social Care. Further to the government department, NHS England and NHS Improvement are national leading organisations (now jointly) overseeing and

10 Data extracted on 23 October 2019 from OECD.Stat Health expenditure and financing.

11 1177 Vårdguiden (2019a).

12 1177 Vårdguiden (2019b).

13 For further analysis and development over time, see: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget; For workforce numbers, see: https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers

steering the provision and commissioning of healthcare services, determining national prices and enforcing the rules on procurement, patient choice and competition. They set the direction (subject to government approval) and determine priorities for the NHS nationally, most recently set out in the NHS Long Term Plan.[14]

Commissioning of health and social care in England

The NHS in England is funded mainly through taxation supplemented by National Insurance contributions. The majority of funding is allocated to NHS England, which commissions, for example, primary care and specialised services directly and further allocates funding to 191[15] local clinical commissioning groups (CCGs).

The CCGs are clinically led statutory NHS bodies responsible for the commissioning of healthcare services for their areas, accounting for around two thirds of the health budget.[16] Their role involves contracting with providers and assessing and responding to the needs of local populations by designing and driving changes to services where needed. CCG's are led by elected governing bodies, which include doctors and other clinicians together with lay members. CCGs commission services from, for example, acute hospitals, mental health providers, community care providers, and ambulance services. The secondary care services commissioned by CCGs include planned hospital care, urgent and emergency care and most community health services.

Other commissioners include NHS England, with the responsibility of commissioning primary care (with CCGs) and specialist services. Local authorities commission, among others, social care services. The financing and governance relationships between the key NHS organisations is depicted in Figure 6 below.

14 The documentation setting out the NHS Long Term Plan can be found here: https://www.england.nhs.uk/long-term-plan/.

15 NHS Clinical Commissioners website https://www.nhscc.org/ccgs/.

16 https://www.nhscc.org/ccgs/.

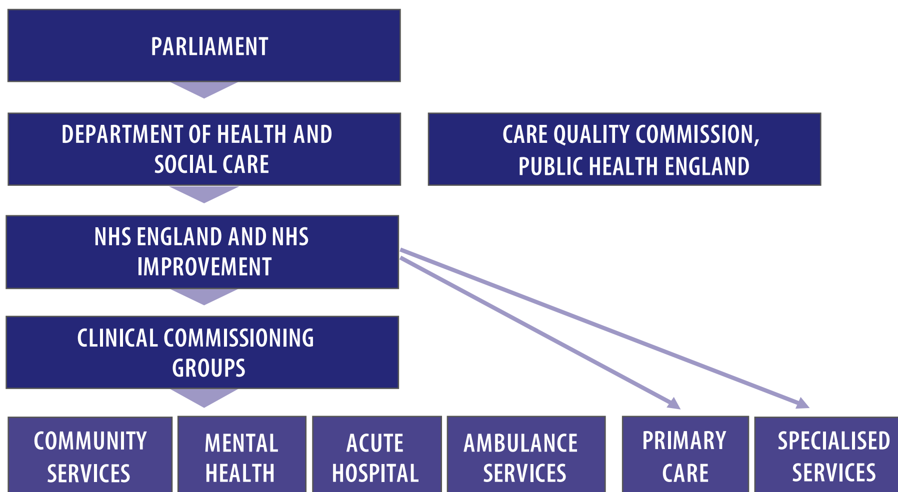

Figure 6. The NHS financing and governance illustrated
Source: Copenhagen Economics based on Sauter et al (2019).

Provision of health care in England

The vast majority of community, hospital and mental healthcare services are provided by the NHS organisations, namely NHS Trusts and Foundation Trusts. Most of the primary care is provided by general practices (GP), which are independent contractors to the NHS. Around 96 per cent of these contracts are held by general practitioners (doctors) who hold contracts for a given practice. Only around four per cent of the GPs in England under contracts can be held by private companies, such as publicly traded companies and other healthcare chains (e.g., Virgin Care, Care UK).[17] Altogether, the independent sector (private, third sector) has been estimated to account for around seven to over 20 per cent of the NHS expenditure (the range stems from the different definitions of how the share of private sector is calculated).[18] In addition to NHS services, patients can also access private hospital services by paying out-of-pocket charges or purchasing private healthcare insurance. It is estimated that, across the UK, private healthcare insurance is held by around 11 per cent of the population.[19]

Central to the introduction of competition and choice in the English NHS was the move from a fully integrated system to a split between providers and purchasers of healthcare, which was first introduced in the 1990s and has prevailed since then. Over the years, many

17 Monitor (2015) Improving GP services: commissioners and patient choice.
18 For discussion on the different estimates of the share of the private sector, see The Kings Fund (2019).
19 The King's Fund (2017).

policies have been introduced to reinforce choice and competition in the NHS in England. In particular:[20]

1. since 2006 NHS patients have had a right to choose from qualified independent sector providers when referred to a hospital by a GP for an outpatient appointment;
2. the introduction of Payment by Results (PbR) in 2003 and the subsequent years until now. PbR is a case-based payment model, whereby prices are determined nationally for each unit of care based on pre-determined currencies, Health Resource Groups (HRGs)[21]. The payments are paid to the provider that treats the patient.[22] Thus, the (fixed) funding was set to follow patient choice and providers were expected to have a financial incentive to compete on quality to attract patients;
3. changes to the commissioning of services, most recently through the introduction of clinical commissioning groups (CCGs) in 2013 together with regulations and substantive guidance on patient choice, procurement and competition;
4. the establishment of foundation trusts with greater autonomy to retain and reinvest surpluses (described in detail below); and
5. developments in the scope of patient choice and the infrastructure supporting it. For example, online services such as the central NHS website (previously NHS Choices) provide patients with information about the different providers they can choose from.[23]

The role of choice and competition has changed in the NHS since the Health and Social Care Act 2012 was introduced. **The direction of development is towards a greater collaboration between public providers, rather than encouraging them to compete.** This includes both vertical collaboration (or integration) of providers of different types of health service as well as horizontal consolidation of, for example acute hospitals, mental health providers and GP practices. In its recent enquiries, the Competition and Markets Authority has found that competition plays a limited role in public hospital providers' decision-making in today's NHS.[24] This is due to several factors, including at least:

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20 The Competition and Markets Authority (2017).

21 In sum, HRGs group clinically similar treatments which use comparable levels of healthcare resource to enable consistent commissioning of health services: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/isb-0070-healthcare-resource-groups-hrgs.

22 See, for example, The Health Foundation (2017).

23 See NHS Choices: https://www.nhs.uk/pages/home.aspx.

24 See, e.g., the CMA's inquiry into the proposed merger between Central Manchester University Hospital NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust.

1. policy initiatives that encourage providers to collaborate and work within integrated care systems rather than compete;
2. increasing pressures on providers' capacity and finances, diluting the incentives to compete and attract additional patients; and
3. some commissioners' decisions to use funding models that are not linked to patient volumes, e.g. fixed sum ('block') contracts (i.e. there is no financial incentive to treat additional numbers of patients).

Notwithstanding these developments, as we describe in greater detail below, **patient choice continues to be central to the NHS** and private providers' role remains important in complementing hard-pressed public providers with long waiting lists for elective care. In particular, the NHS offers a number of important lessons in identifying the features that prevail even when the policy focus has shifted from competition to collaboration. These include: patient choice itself (which is set to prevail), transparency, measurement of outcomes and good understanding of costs underlying payment models. We return to these themes below in Chapters 3 and 4.

1.1.3 The Netherlands

In the Netherlands, the healthcare system's overarching objectives are to ensure accessibility, affordability and quality improvements. The Dutch system of healthcare has undergone a wholesale reform over the past decade. Sauter et al (2019) report that this overhaul was introduced through the enactment of several new pieces of legislation.[25]

Notably, the Health Insurance Act aims to extend health insurance for all residents of the Netherlands. In the Dutch system, unlike any other European system we reviewed, the insurers are responsible for ensuring efficient and high-quality services for all residents. The Health Insurance Act stipulates that all citizens have a healthcare insurance, and it also obliges healthcare insurers to accept all applicants as "policyholders". The insurers are private legal entities, although almost all of them are not-for-profit organisations. Most of the revenues received by hospitals and mental healthcare providers come from the healthcare insurers.

Prices, particularly in hospital care, have been liberalised to a significant degree and are determined by agreement between providers and insurers. Health insurers bear financial risk in relation to their expenditure. Healthcare insurers are set to compete with one another to attract policyholders. The contracts between providers (hospitals) and

25 More specifically: The Health Insurance Act (Zorgverzekeringswet or ZVW), The Long-Term Care Act (Wet langdurige zorg or WLZ), The Social Support Act (Wet maatschappelijke ondersteuning or WMO) and The Young Persons Act (Jeugdwet). Sauter at al. (2019).

insurers are, in turn, determined through bargaining. Hospitals and insurers negotiate on the prices, quantities of operations and consultations provided and on quality of care. The outcome of the bargaining is effectively determined by the relative positions of the provider and the insurer.

This system, where competition manifests itself as competition for patients' choices over insurance policies, and as competition between hospitals, is often referred to as 'managed competition' – illustrated in Figure 7 below.

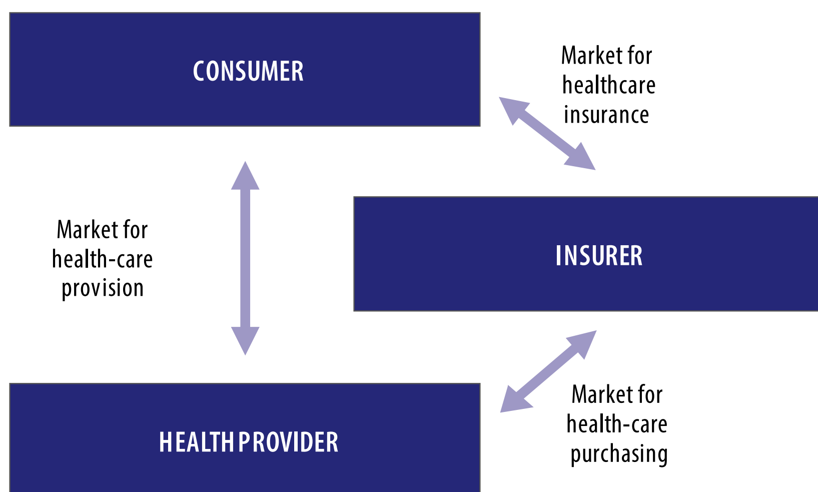

Figure 7. The Dutch healthcare market illustrated
Source: Copenhagen Economics based on ACM (2016)

Central to the functioning of the market-based system in the Netherlands is the role of the regulators – notably the Dutch Health Care Authority (NZa) and the Competition and Consumers Authority – each with roles in ensuring that competition works in the interest of patients, e.g., through competition law, market investigations and merger control.

1.1.4 Denmark

As in Sweden, the responsibility of the healthcare system is shared between the state, the regions and the municipalities. The state sets the regulatory framework and holds the supervisory function in health and social care. The five regions are responsible for hospital care, including emergency care, for psychiatry and for healthcare services provided by GPs and specialists in private practices. The municipalities are responsible for multiple health

and social services, including home nurses, health visitors, some dental services, school health services and other services for elderly people.[26]

The healthcare system is primarily publicly funded. In 2017, public expenditures accounted for 84 per cent of total health spending, while about 14 per cent was patient out-of-pocket and 2 per cent was voluntary healthcare payment schemes.[27] In 2014, about 2.2 million Danes had complementary voluntary health insurance, which covers statutory co-payments such as pharmaceuticals and dental care. Additionally, nearly 1.5 million people held supplementary insurance to gain expanded access to private providers.[28]

Most hospital services are publicly provided, as approximately 97 per cent of hospital beds are publicly owned, but private providers are present in different parts of the healthcare system – e.g., almost all GPs are self-employed and are paid by the regions via capitation and fee-for-service.[29] The service-based fees are used as financial incentive to prioritise service, as people can register with any available local GP. Moreover, citizens in need of hospital care may, within certain limits, freely choose any public and some private hospitals. If the region is not able to ensure treatment within 30 days, the patients have the right to go to a private hospital in Denmark or to a public or private hospital abroad. Additionally, the municipalities are responsible for social psychiatry and care and can choose to contract with a combination of private and public service providers, but most providers are public.[30]

1.2 Approach and sources

In Chapters 2 to 4 we draw on evidence from these four countries. We gave more weight to England (NHS) and Sweden, given that these countries appeared to have transferrable lessons for Finland and readily available evidence on the effects of choice and competition. Our review is mainly based on public sources and our own earlier work in this area. For completeness, and to ensure that our understanding of the different systems is up to date, we interviewed several experts from organisations listed in Table 1 below.

26 SUM (2017).

27 Data extracted on 1 November 2019 from OECD. Stat Health Statistics.

28 Center for Politiske Studier (CEPOS) (April 2014).

29 Karsten Vrangbaek (2016).

30 Karsten Vrangbaek (2016).

Table 1. Interviewed organisations

COUNTRY	ORGANISATION
Sweden	Swedish Association of Local Authorities and Regions
Sweden	Mora municipality
Sweden	Region Stockholm
The Netherlands	The Dutch Healthcare Authority (NZa)
England	NHS England and NHS Improvement, Provider Development
England	NHS England and NHS Improvement, Pricing and Costing
England	NHS Partners Network

Source: Copenhagen Economics

We want to thank each of the interviewees for taking the time to contribute to this study.

Chapter 2. How markets work for patients in health and social care: the building blocks

Health and social care markets exhibit features that make them different from 'normal' markets of goods and services. In economic terms, these services are prone to *market failures* for several reasons. Patients might know more about their health than, for example, insurers. Patients, unlike providers, may not know which treatment (if any) best meets their needs, let alone the clinical quality of care different providers can offer. Similarly, *asymmetric information* prevails between providers and commissioners of healthcare, with the former typically having a better understanding of the effectiveness and costs of the services provided. Further, some services exhibit economies of scale and scope which may give rise to market power. There are also, for example, important *externalities* with the health of one patient impacting on the health of others.

These economic rationales in part explain why healthcare is, by and large, both publicly funded and provided throughout Europe, and why healthcare markets are strictly regulated from standardisation of technologies and regulation of pharmaceuticals to the provision of care to patients. Indeed, healthcare markets are often called '*quasi-markets*' where governments and local commissioners have created public and/or private providers with incentives to respond to patients' choices, but where providers operate under stringent clinical and financial regulation.

In this chapter, we:

1. set out the main, aspirational 'building blocks' of well-functioning market-based systems in health and social care; and
2. provide an overview of how, in the light of empirical evidence, the selected countries have succeeded in designing markets to the benefit of patients.

2.1 Building blocks of markets in health and social care

healthcare professionals are generally driven to provide as good care for patients as possible; indeed, we should not lose sight of the role of these inherent altruistic incentives when assessing healthcare markets and the role competition can play in improving services. The question we sought to answer is therefore the role market mechanisms (in their various forms) can play over and above the inherent desire to help patients – e.g. how any levers created through choice and competition may drive management incentives to invest and improve services.

For a market to work and deliver a desired outcome, certain conditions 'on the ground' need to be in place regarding demand and supply characteristics. In publicly funded provision of health and social care, where the role (and even existence) of markets is in the hands of policymakers, the functioning of the markets depends on the underlying regulatory framework, financing system and commissioners' approaches.

Figure 8 depicts what appear to be the 'building blocks' for the aspirational, well-functioning health and social care markets where patients make informed choices about which provider is best placed to meet their needs, and where providers respond by improving services while ensuring the public interest.

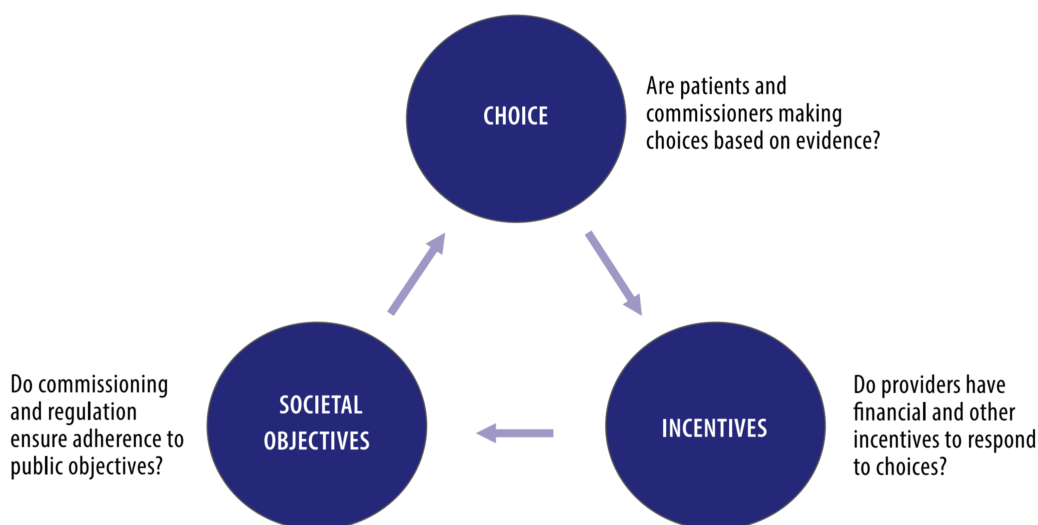

Figure 8. Factors shaping the functioning of health and social care markets – an illustration
Source: Copenhagen Economics.

We discuss each of the 'building blocks' below.

2.1.1 Patient and commissioners’ choices

Choice is a key ingredient of any market-based system in health and social care. Choices can be made by patients, or they can be exercised by commissioners on patients’ behalf:

- **Patient choice.** In many countries, patients can choose where they receive their publicly funded healthcare. Patients can choose between public hospitals, health centres and sometimes where they receive their social care services. There is some inherent value in choice itself in enabling patients (who know their own circumstances) to be in control of their own care. There is also an apparent benefit in allowing patients to ‘vote with their feet’ in response to inadequate care. Whether patient choice can drive incentives to improve services (or reduce prices) is less clear-cut. This necessitates that (at least a sufficient number of) patients can indeed assess on an informed basis which provider best meets their needs, or that an informed advisor supports the patient in making the choice (e.g., a general practitioner acting as a gatekeeper and assisting the patient with a referral from primary to secondary care).[31]

- **Commissioners’ choice.** Patient choice is not always meaningful or even financially possible. Where there are significant economies of scale and/or scope, or for example constraints in the supply of trained workforce, a commissioner (say a municipality) may decide that a single provider will best meet the needs of the local population. The question is then how the commissioner exercises its choice over providers, whether it decides to continue with the existing provider or investigates whether an alternative provider could meet patients’ needs better and more cost-effectively through, say, a competitive tender.

Whether choices are made by patients themselves or by commissioners (or insurers) on their behalf, **the role of choice as a lever of improvement depends critically on what the choices are based on: on an informed evidence-based assessment or on convenience and instinct.** As we will explain in Chapter 3, a lack of reliable and accessible information has been a central factor in inhibiting the benefits of market mechanisms for patients where markets have been tried and tested. This applies to both patients’ ability to make informed choices and the degree to which commissioners are able to assess which provider best meets the needs of their local population.

31 See, for example, Monitor (2015a).

2.1.2 Financial incentives to be present on the market, to provide high-quality services and to innovate

If choice was to incentivise providers to improve, there ought to be an adequate financial remuneration attached to each patient that chooses certain provider over others. Contracts put out to a competitive tender will not be viable unless they enable providers to generate a reasonable rate of return.

Where providers set their own prices without regulation, the prices are dictated by patients' willingness to pay and by competitive offers. However, since patients tend to find it difficult to judge what they need and which providers is best placed to treat them, it can be difficult for patients to judge whether they receive good value for money (e.g., whether a certain treatment is in fact needed or not). Therefore, the private provision of healthcare is often remunerated either partly or wholly from the state or municipal budget with regulated payments.

The publicly funded reimbursements are typically regulated and seek to enable providers to meet their efficiently incurred costs, not to over- or underfund providers. Where the regulated charges are publicly funded, their affordability ultimately depends on the budget available. Both in Sweden and England, there have been concerns that funding attached to each patient has not been sufficient to enable providers to recover the costs associated with (especially) patients with the most significant health needs and therefore there is little or no incentive to attract these patients.[32] Conversely, in the 2000s, the fixed and regulated prices triggered entry from the private sector to certain services, such as orthopaedic surgery.[33]

Importantly, further to the level of publicly funded reimbursement, what matters is the way in which the payments are designed to create incentives to improve services. As we report below, a cross-cutting theme across many countries is the desire to move from remunerating providers for activities and processes to paying for patient outcomes.

2.1.3 Regulatory environment to ensure that private interests are aligned with the public interest

Health and social care are without exception heavily dependent on the national policy and the underlying legislative, regulatory framework. National legislation provides the basis

32 See, for example, Monitor (2015).

33 See, for example, Cooper, Gibbons, Skellern (2018), Does competition from private surgical centres improve public hospitals' performance? Evidence from the English National Health Service, Journal of Public Economics, Volume 166, pp. 63–80. NHS England and NSH Improvement are continuously working on developing national prices. See NHS England and NSH Improvement (2019).

for any market mechanisms and is often exposed to political uncertainty and change, given the priorities.

Thus, while the use of finite public resources needs to align with the *public interest*, what is meant by the *public interest* varies according to the government and the health and social care needs at any given time period. At least the following three factors, which are ultimately determined by policymakers, have shaped the use of markets in the provision of health and social care services:

Priorities driven by current care needs: Whether and how the use of markets is considered appropriate depends on what policymakers seek to achieve. Political aspirations tend to be loosely defined and include goals to ensure equal access to care, high quality and cost efficiency. There are, however, important trade-offs, given the finite budget and the inherent challenge to promote competition on the one hand, and integration of care on the other. For example, the UK government was determined to use competition and choice to cut waiting times for non-urgent hospital care in the late 2000s and early 2010s and succeeded in attracting considerable private-sector entry, and hence new capacity, into hospital services. However, the current priority in the English NSH is to integrate care, owing to, for example, the quickly growing number of patients with comorbidities, and there is an explicit policy desire to move away from competition and facilitate collaboration between providers of different types (we return to the trade-off between competition and collaboration below).[34] Further, with respect to aspects of health and social care (e.g. primary care for patients with long-term illnesses), continuity of care can be important, that is receiving the care from the same provider (and often the same doctor) on an ongoing basis. This means that commissioners need to consider the contract length of service contracts and put mechanisms in place to ensure patients are not harmed if a provider needs to exit (e.g. due to financial viability, or due to regulatory intervention on poor quality of service).[35]

Public financing and resources: Except for out-of-pocket payments or private insurance, health and social care services are either partly or entirely publicly funded, whether directly or through subsidies. The heavy reliance on public funds means that the incentives of providers to enter and expand, and their ability to invest, depends on public finances and, ultimately, on the budget agreed on by national parliaments. Linked to funding, the supply of clinical workforce depends on national policies on the training and remuneration of doctors, nurses and social care workers. As Chapter 3 explains, there are examples where the role of competition has been diluted by inadequate resources.

34 The 'road map' for the NHS in England has been most recently set out in the NHS Long Term Plan documentation, available from: https://www.england.nhs.uk/long-term-plan/.

35 ?????????

Regulation and oversight: Regulation ensures patient safety and adherence to service standards. It therefore ensures the wider public health objectives are met. Only those providers should be able to provide health and social care services that meet the regulatory requirements, whether to do with clinical quality, treatment of patients or financial performance. As such, regulation sets the basis for service innovation. Providers' ability to differentiate and reconfigure services needs to comply with the underlying regulations, which can be stipulated by national clinical rules and guidance or by local commissioners. Further market steering takes effect through the enforcement of relevant procurement and competition rules. As we explain below, England and the Netherlands have specific regulatory approaches and roles for health and social care related to procurement, competition and patient choice matters.[36]

2.2 Research on the use of 'quasi-markets' in health and social care

There is a body of research of how markets – or 'quasi-markets' as they are often called - have worked for patients in healthcare. Healthcare markets have been assessed by public authorities and academics in England, the Netherlands and, to some extent, in Sweden. There is limited similar evidence available on the impact of the use of markets in social care.

Before explaining the determinants regarding *why* market-based systems have succeeded or failed in Chapter 3, below we summarise the available evidence of *how* competition and choice have been found to affect outcomes. In summary:

1. Choice-based competition, where qualified private providers can provide publicly funded services, has triggered entry, **increased accessibility** and to some extent alleviated long waiting time in primary care in Sweden.[37] Choice and 'money follows patient' payment reforms have also brought new capacity to the English hospital sector and there is research to suggest this has had a positive effect on efficiency[38] without undermining equity.[39] Further to choice-policies, competitive tenders have been used to find new providers to areas with unmet patient needs.

36 As we explain in Chapter 4, in the UK and the Netherlands competition authorities and sector regulators have statutory roles in overseeing health care markets.

37 OECD (2018b).

38 Marshall et al. (2014) reviews evidence on the impact of the 'Payment by Results' system.

39 Cooper et al. (2009).

2. There is limited research to suggest that patient choice policies have significantly contributed to better **clinical quality of primary care services**, although appears to be partly due to a lack of monitoring quality indicators and (consequently) a lack of research on this topic.[40] For example, Gravelle et al. (2018) found that competition (proximity of other providers) was associated with better patient satisfaction and certain quality indicators although the impact was small (the analysis covered the years 2005–2012).[41] The sector regulator Monitor (2015), found that few patients were engaged in making active choices, and that providers were generally resource constrained diluting their incentives to compete for patients.[42] In Sweden, the Competition Authority reports that "*the data concerning quality before and after the introduction of the system of choice is limited*".[43] In other words, further data would have been needed to evaluate whether the introduction of patient choice contributed to clinical quality in Swedish primary care.

3. There is a body of literature on the impact of quality-competition on the **quality of care in hospital services**. This research broadly suggests that competition on quality can improve care in certain elective hospital services. The published research (mainly from England and the Netherlands) is not entirely unanimous, which suggests that the effectiveness of competition depends crucially on the circumstances policy makers and regulators have created to promote competition.[44]

4. In the Netherlands, where the providers of hospital services compete both on price and on quality, there is some evidence on the relationship between **concentration and prices**, and that the reforms introducing competition have reduced costs.[45]

5. There is some, albeit scattered and case-specific, evidence to suggest that where commissioners have run **competitive tenders** to choose a provider, they have in some cases achieved cost savings and quality improvements, although the evidence is mixed. There appears to be a need to collect

40 Monitor (2015a).

41 Gravelle et al (2018).

42 Monitor (2015).

43 OECD (2018a).

44 For example: Bloom N. et al.. (2015); Cooper Z. et al (2018); Mikkers M. (2018); ACM (2016); Berden et al. (2019). Gaynor et al (2013); Skellern M. (2018).

45 Krabbe-Alkemade (2017); Kemp et al. (2012).

further evidence on the use of competitive tenders and public outsourcing of health and social care services; however, the mixed experiences suggest that the success of these models depends on *how* the contracts are tendered and outsourced by each local commissioner.

The headline findings for each of the countries reviewed in this report are summarised in Table 2.

Table 2. Evidence of the effects of competition and choice in healthcare

	Hospital-based care	Primary / out-of-hospital care
Denmark	No evidence found on effects of competition.	Patient choice applies but no evidence found on its impacts on quality.
The Netherlands	Research to suggest that competition between hospitals tends to be associated with lower prices. Some empirical evidence to suggest that less concentrated hospital service market structures are associated with better quality.	No evidence; role of competition limited in primary care according to our interview with the Dutch Healthcare Authority. There is limited room for price competition because payments are largely regulated. Limited information available to inform patients' choices not conducive to quality competition.
Sweden	Some private provision. Limited empirical evidence on the role of markets (an example of successful outsourcing of certain hospital services discussed below in Chapter 3).	The legislations enabling entry and choice have improved accessibility of primary care services. Limited evidence on the impact choice has had on clinical quality of services (we discuss this below).
United Kingdom (England)	Much (but not all) of the relevant economic research suggests that competition and choice contributed to better patient outcomes in the late 2000s and early 2010s following reforms aimed at promoting competition especially in elective hospital services. Competition has more recently been found to play a limited role owing to increased policy focus on collaboration together with resource constraints faced by providers.	Limited evidence to suggest that patient choice is a substantial lever of quality improvement in primary care (GP services). Few studies have investigated this since the focus of choice-based competition has been on hospital services. Little systematic empirical evidence of the effect of competition in other out-of-hospital (community) care.

Source: Santos et al. (2017), Gaynor et al. (2016), Monitor (2015a), Gaynor (2013), OECD (2018a); OECD (2018c), Croes et al. (2018).

International academic research on the merits of different forms of competition has found that patients and commissioners seem to be "*significantly more reactive to price than they are to quality*".[46] In general, where providers are allowed to compete on price as well as on quality, price reductions can come with quality deterioration, although the merits of

46 McGuire A. Costa-Font J. (2012), The LSE Companion to health policy. Page 89.

price competition depend significantly on the type of service in question.[47] Where prices are fixed, however, there is evidence of competition-driven quality improvements, such as those witnessed in the English NHS, as reported in Table 2.

In Chapter 3, we shed further light on what lies behind these findings. Notably, the outcomes of different health (and social care) systems depend on the design of the market-based systems and approaches to commissioning.

47 Propper (2008).

Chapter 3. The role of commissioners: making markets work for patients in practice

Having discussed the 'building blocks' of well-functioning health and social care markets in Chapter 2, in this Chapter, we review the available evidence from our focus countries of how the market mechanisms have played out in practice. We explain how governments, municipalities, local and regional authorities and other commissioner bodies have engaged in the design of the market mechanisms. We investigated:

1. Which **type of services and geographic areas** lend themselves to competition.
2. What the **form of competition** is – e.g., whether providers compete for patients' choices and/or for service contracts, and whether they compete on quality and/or on price.
3. How patients and commissioners make decisions based on **evidence of provider performance**.
4. How rigorously commissioners **specify the services** they open up for competition, striking the balance between securing patient safety whilst offering room for innovation.
5. How commissioners monitor performance and **create opportunities for new entry** where the incumbent provider fails to meet patients' needs.

We discuss our findings regarding each of these questions below.

3.1 The services where markets play a role vary considerably across countries

The circumstances under which the market is used by the commissioners and when, for example, the use of tendering procedures is justified (and when not) differ between and sometimes within countries. Factors such as the level of specialisation, costs of necessary

equipment and the demographic composition of the population are important for determining what kind of market mechanism(s), if any, are likely to be successful.

As confirmed by our review of selected countries, the decisions regarding whether and where markets can play a role in health and social care appear to be often dictated by politics rather than analytical appraisals of the costs and benefits of different options. Generally, the role of private and charitable sectors tends to be stronger in primary care, types of community care (e.g., physiotherapy etc.), care homes and other social services. These types of service exhibit relatively low barriers to entry (e.g., limited fixed costs associated with buildings and medical equipment) and do not require as large a scale as hospital-based services. Furthermore, our example countries (and many others) have witnessed private sector entry in certain medical specialties such as ophthalmology and orthopaedics. On the other hand, owing to the specialist skills and resource and equipment needs, emergency care (with some exceptions), intensive care and highly specialist services are typically operated exclusively by public hospitals.

We examined the types of service our example countries have opened wholly or partly for the private sector.

3.1.1 Sweden: choice-based competition has been introduced in primary healthcare

In Sweden, we observe interregional differences, with Stockholm as the main outlier both when it comes to what is offered to the market and how reimbursements are arranged.[48] The regions are responsible for organising primary and specialised care, and most private provision in healthcare financed by the regions is within primary care due to patients' legal right to choose their primary care provider, see Figure 9. In care additional to primary care, patient choice and implementation of other market mechanisms such as procurement is optional and whether to implement it is decided by each individual region.[49] Some health and social care services are procured[50], and some are not available to private providers.

48 Swedish Agency for Health and Care Services Analysis (2017).

49 Swedish Act of Choice (2008:962).

50 Under the Swedish Public Procurement Act (2016:1145).

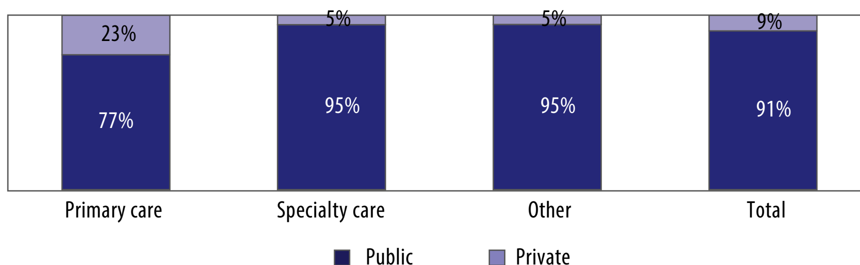

Figure 9. Most private provision in healthcare financed by Swedish regions is within primary care. Percentage of expenditures in 2018

Note: 'Other' includes dental services and other healthcare expenditures such as disability and assistive technology activities.

Source: Statistics Sweden (2019).

The Stockholm region is by far the main user of private providers in specialist care, applying patient choice to several specialist care services, such as palliative care, gynaecology care and urology.[51] Most regions do not have a sufficiently large patient base to need or attract additional providers other than the public provider or a procured private provider.

While the use of the private sector is limited on the whole in Sweden (compared to the overall health expenditure, similarly to most countries), the Stockholm region has tendered a contract to run a hospital with emergency services. Capio S:t Görans Hospital in Stockholm is the only emergency hospital run by a private provider. The provision is procured by the Stockholm region, and the contract is valid until January 2026. The private provider, Capio, was awarded an extension of the contract in 2018. The decision to extend the agreement was based on an evaluation of the care provided at the hospital. The evaluation showed that Capio S:t Görans Hospital performs well in both quality and availability as well as productivity and production control. **The overall conclusion from the evaluation was that Capio S:t Görans offers good quality healthcare at a price advantageous to the region.**[52]

We notice that patient choice is applied differently across regions; however, Stockholm is the clear outlier. With a relatively large number of inhabitants, Stockholm applies patient choice to not only primary care but also several specialty-care services and hospital care. It is apparent that the characteristics of Stockholm differ significantly from the rest of the Swedish regions and that the region has a larger demand for healthcare and social services, which is suitable for patient choice and substantial entry from private providers.

51 Swedish Association of Local Authorities and Regions (SALAR) (2019c).

52 Capio (2018).

3.1.2 England: competition and choice have focused predominantly on community, mental health and elective hospital services

The UK, and England more specifically, has used market-based mechanisms both by incentivising competition between public providers and by allowing the private and third sector to provide NHS-funded services and hence compete for patients and for contracts. However, while choice is in principle a right across a wide variety of services, the extent to which it serves as a lever of quality improvement varies by service. Notably:

- Choice and competition have been found to play a negligible role in **emergency services** (where many patients are not able to exercise choice) and **specialist hospital-based services** (where choice is not possible).

- In **primary care**, choice has been enshrined in the NHS Constitution since the inception of the NHS. However, as confirmed by Monitor (the health regulator), few patients make active choices based on information on service quality at different GP practices. Monitor also found that the resource (e.g. workforce) and financial constraints limit GP providers' incentives to compete for patients. Thus, the capitated payment attached to each patient may not give an incentive to attract additional patients in many areas.[53] Further, around 96 per cent of GP contracts are held by GPs, GP partnerships or other NHS providers with contracts that have no end date.[54] The remaining minority of contracts are tendered out to the market and often held by the private sector chains or not-for-profit organisations.

- Choice-based competition has played a more significant role in **elective (non-urgent) secondary care** services.[55] Patients can access services provided by private hospitals either by paying for diagnosis and treatment themselves (either through out-of-pocket charges or an insurance policy), or they can access NHS-funded care subject to a referral from their GP. Private providers offer a range of elective services; around 21 per cent of all NHS gastroenterology, trauma and orthopaedic patients are currently treated by independent providers.[56] The array of services provided by the

53 Capitated payment (or capitation) means that GP practices receive funding based on the number and characteristics of the patients registered with the practice.

54 Monitor (2015). More specifically, the majority of the GP contracts are either General Medical Services (GMS) contracts or Personal Medical Services (PMS) contracts that can be held by GPs, GP partnerships, healthcare professionals involved in the provision of NHS services and, in the case of PMS contracts, NHS Trusts and Foundation Trusts. Alternative Provide Medial Services contracts (APMS) which constitute a small minority of all contracts, can be held by any person that meets the relevant requirements (e.g. publicly traded healthcare companies).

55 See section 2.2 for a summary of the relevant literature.

56 NHS Partners Network (2019).

private sector does not extend to similar levels of coverage as their NHS counterparts (they do not provide, for instance, emergency, intensive care and highly specialised services).

– Further to services where markets have been opened to a variety of providers through patient-choice schemes, **especially mental health and community service contracts have been tendered out with both the NHS and private providers bidding for contracts**. As summarised by The King's Fund, a health think tank:

  "The extent of private sector-commissioned services varies between different areas of care. For example, evidence suggests that spending on private providers increased more quickly in community services and mental health than in other services. This may be, for example, because of contracts being more frequently retendered in these services and because more non-NHS providers are operating in these service areas."[57]

Further, private providers' role is generally significant in social care services, although there is no established definition of social care, nor are there precise figures on the market shares across the different social care services.

However, as explained above, the competitive landscape is changing somewhat and there is an ever-increasing policy move towards greater collaboration. As we were told by the NHS Partners Network (and as confirmed by evidence)[58], the use of the private sector continues to be steady in elective surgery, as the NHS providers are facing capacity constraints. However, it is currently unclear whether and under what circumstances commissioners will contract new non-NHS providers in other aspects of healthcare, such as community services, where the private sector has increased its presence over the recent years.

3.1.3 The Netherlands: the universal insurance-based competition covers hospital services; limited competition in primary care

Hospital services in the Netherlands are covered by the 'managed competition' system described in Chapter 2. The system builds on the notion that insurers can assess which hospitals provide the best value for money and the highest quality across the different services their patients might need, from basi to more specialised services. The mandatory insurance cover (funded by the state) covers all universal (essential) health services;

57 The King's Fund (2019), Is the NHS being privatised? Available from: https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised

58 Copenhagen Economics interview with NHS Partners Network.

customers can opt for additional supplemental services subject to market-based conditions.[59]

While policymakers and regulators have developed the insurance-based competition in the Dutch hospital sector through various reforms, regulatory actions and interventions, there has been significantly less emphasis on promoting competition in primary care. Indeed, the Dutch health regulator told us that there is limited competition for patients in primary care, notwithstanding patients having the right to choose.[60]

3.2 The form of competition depends on the policy objectives and local circumstances

Organisers have different reasons for why they decide to open a market up for competition and, depending on the objective, there are different types of competition they may use, as illustrated in Table 3 below.

Table 3. How can competition manifest itself?

FORM OF COMPETITION	CONSIDERATIONS FOR POLICYMAKERS AND COMMISSIONERS
Competition for contracts or patient choice?	Is there a sufficient number of patients to make the market viable for more than one provider? Is there a realistic prospect that patients can make informed choices based on transparent information?
Competition on price or competition on quality and service innovation?	Can the commissioner secure a good standard of quality through contract management and supervision, or is there a risk that price competition leads to a 'race to the bottom' and deterioration of quality?
Who competes?	Does competition mean entry of private and third-sector providers, or can competition play a role in driving improvements amongst public providers?

Source: Copenhagen Economics.

As Table 3 illustrates, commissioners (and policymakers) face a range of questions on how to design markets. There are important trade-offs between different choices, in particular:

- whether to allow any qualified providers, whether public or private, to enter and compete for patients' choices, or whether competitive mechanisms make more sense through competitive tenders of service contracts;

59 ACM (2016).

60 Interview with The Dutch Healthcare Authority, 21 November.

– whether to allow providers to compete on price, or whether payments should be fixed, and the only factor of competition should be service quality[61];
– whether public providers, too, could be incentivised to improve their services through allowing (or incentivising) them to compete.

We found that the approaches are often dictated by health and social care policy and politics, not always evidence-based appraisals of different options. Nevertheless, especially on regional and local level, commissioners have used different tools to meet the needs of their populations. Furthermore, the need to increase availability of services and cut waiting times by encouraging the private sector to bring more capacity has been a national-level motive (e.g., in England and Sweden).

Below, we describe the main aspects of commissioning approaches in our focus countries.

3.2.1 Safeguarding competition neutrality is a fundamental principle in the Swedish model of patient choice

Swedish primary care[62] is exposed to competition and has been since 1 January 2010, when the patient choice system was made mandatory for all regions. The purpose of introducing patient choice in primary care was mainly to increase patients' choices. The power to choose provider was handed over from the region to the patient. Furthermore, a patient choice system with free entry makes it possible for more providers to enter the market. Because the financing follows patient choice, the system is premised on the notion that providers have an incentive to improve services to attract and retain patients. Individual providers will not endure if they are not selected by a sufficient number of patients.[63]

To ensure competition neutrality between public and private providers, all providers within one region receive compensation based on the same reimbursement model within the patient choice system. Safeguarding competition neutrality is a fundamental

61 "Service quality" is used as a generic term here and can mean clinical quality, waiting times or other aspects that matter to patients.

62 In practice, there is no clear definition of what primary care is in the Swedish context. In the Health and Medical Service Act (2017:30) it is defined as *outpatient care without any limitation in terms of disease, age or patient groups. It should provide basic medical treatment, nursing, preventive care and rehabilitation that do not require the hospital's medical and technical resources or other special skills. (Swedish: 6 § Med primärvård avses i denna lag hälso- och sjukvårdsverksamhet där öppen vård ges utan avgränsning när det gäller sjukdomar, ålder eller patientgrupper. Primärvården svarar för behovet av sådan grundläggande medicinsk behandling, omvårdnad, förebyggande arbete och rehabilitering som inte kräver sjukhusens medicinska och tekniska resurser eller annan särskild kompetens.).* See SOU 2018:39, p. 56–57.

63 SOU 2008: 37.

principle in the Swedish patient choice model.[64] The Swedish Competition Authority (SCA), however, finds it unclear whether private and public providers compete on equal terms. Private providers often criticise Swedish regions for carrying deficits at public primary care units without compensating private providers.[65] That said, they highlight that the roles and prerequisites for public and private providers differ and should be, and to some extent are, reflected in the reimbursements. For example, in contrast to private providers, public providers are obliged to adhere to the Public Procurement Act when purchasing materials – i.e., they are not allowed to provide services outside their own region, and they are not allowed to offer supplementary services. These obligations may entail that public providers are entitled to higher or different reimbursement due to more complicated processes and sometimes an inability to take advantage of economies of scale and revenues from supplementary services.

At the same time, private service providers in Sweden may also have special conditions which are disadvantageous, which the public service providers do not have. For example, companies that provide healthcare and social services conduct VAT-exempt activities. When they invoice their services, they do not add any outgoing VAT to the sales value and when doing purchases, they are not allowed to deduct VAT. Therefore, input VAT is an accounting cost not recognised by the public service provider. This is a known relationship and municipalities and regions therefore compensate for this in the renumeration to the private service provider. The supplement to private performers varies slightly between different regions and municipalities but is usually between three to six per cent.[66]

Local characteristics in focus when deciding which market mechanisms to apply

Other types of care than the care provided at primary care units, such as hospital care and outpatient specialty care, are also possible to tender out or to include in a patient choice system. Municipalities and regions are autonomous and while they are obliged to follow governmental frameworks, they can make independent decisions and collect taxes from residents to finance their duties. This includes how to finance their health and social care, except primary care.

Regional officers investigate, make assessments and prepare suggestions on which local politicians then base their decision to apply patient choice or public procurement to a certain service or their decision to not make it available to private providers at all[67]. The National Board of Health and Welfare publish national regulatory documents and

64 SOU 2008: 37, p. 111.

65 Swedish Competition Authority (SCA) (2018), page 208.

66 Interview with SALAR, 20 November 2019.

67 Interview with Stockholm Region on 3 December 2019.

define what is good and equal care, but there are no national guidelines on how to make assessments, and decision rules vary between regions.

Stockholm, for example, usually includes the following aspects in their assessment of a certain service:

- Current accessibility to the service;
- Cost efficiency;
- Quality of care;
- Patient safety;
- Demand and need of the service; and
- Equal access to care throughout the region.

For example, patient choice is preferred if demand is high, while public procurement is preferred and sometimes necessary if demand is low and costs are difficult to assess.[68] When choosing a specialty care provider, patients may be unable or unfit to make an informed choice. If this is the case, their general practitioner acts as their agent.[69]

Patient choice is less efficient in areas with small patient populations

Like regions, municipalities are free to decide how to finance their activities, whether through patient choice or procurement or by providing services themselves. They are responsible for organising social care for elderly and people with disabilities, personal assistance for people in need of no more than 20 hours of assistance per week and healthcare for schoolchildren.[70]

Whether and how to introduce patient choice varies considerably across Sweden. So far, it is mainly applied in municipalities with many inhabitants. 162 out of 290 municipalities apply patient choice to one or more services, 54 per cent apply it to domestic care services. Many municipalities and regions are sparsely populated and struggle with attracting private providers; see an example from Mora municipality in Box 1. This implies that patient choice is less efficient and, in some cases, not viable in areas with small patient populations.

68 Interview with Stockholm Region on 3 December 2019.

69 Swedish Competition Authority (2013) Beslut 10 July 2013 Dnr 62/2013 Valfrihetssystemet för privat psykoterapi Uppsala läns landsting.

70 OECD (2018a).

BOX 1. NO PRIVATE PROVIDERS WITHIN DOMESTIC CARE SERVICES FOR ELDERLY IN MORA

Mora municipality in Dalarna opened up for patient choice within domestic care services in early 2019 but are yet to receive any applications from private providers. Mora has about 20 thousand inhabitants and about 380 users of domestic care services of which some would likely stay with/choose the municipality as provider if private providers would enter the market.

Mora will continue to offer patient choice but may consider switching over to procurement if no private providers decide to enter the market. There are private providers supplying residential care to disabled or elderly in Mora. This has proven more efficient and the municipality representatives believe this may be due to the fact that the market share of each provider, although small, is well defined and predictable over time.

Source: Interview with Mora municipality on 2 December 2019.

The SCA suggests that efforts to decrease potential entry barriers for private providers should be made.[71] SALAR, however, points out that the main entry barrier for private providers is a lack of sufficient patient base.[72] The patient base and population varies a lot across regions; see Figure 10. The primary care in Stockholm had 12.5 million patient visits in 2018, compared to 200 thousand in Gotland.[73] An alternative is that the regions procure private providers to run entire primary care units in addition to those enrolled under the patient choice.

71 Swedish Competition Authority (2018), page 208.

72 Interview with TSALAR, 20 November 2019.

73 Swedish Association of Local Authorities and Regions (SALAR) (2019d). Note that regions define primary care differently which may complicate comparisons of patient visits. However, a very large difference between Stockholm and Gotland is expected.

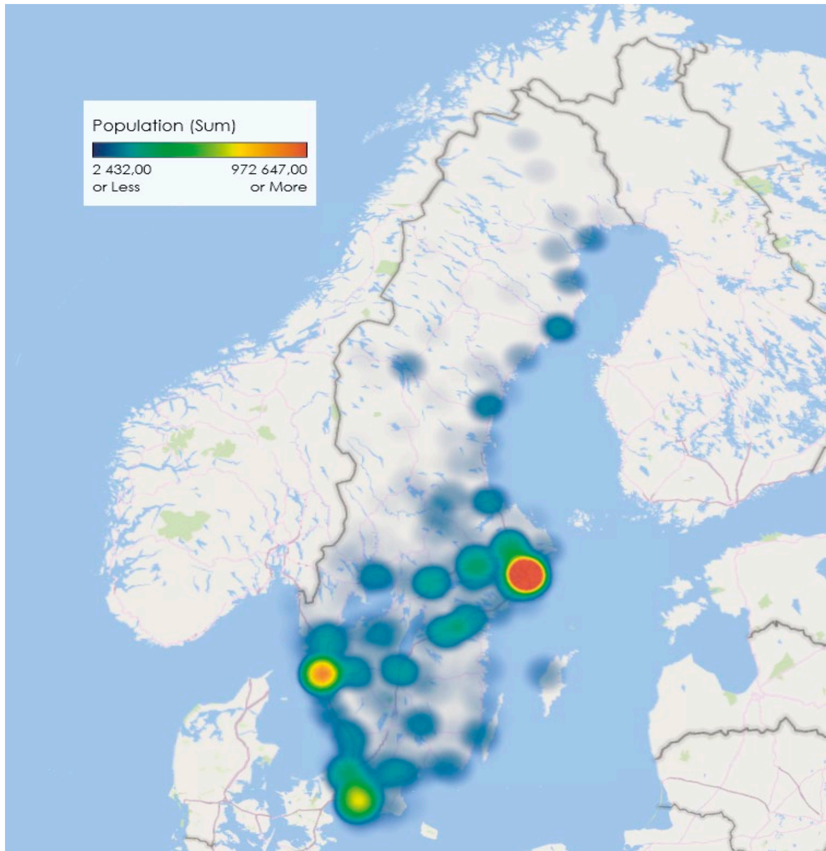

Figure 10. Figure 10 Many municipalities and regions have low patient numbers. Distribution of inhabitants in Sweden

Source: Data extracted on 2019-11-22 from Statistics Sweden. Total population in the country, counties and municipalities, 30 September 2019.

Some regions have gained availability while others have lost availability

Patient choice has been found to contribute to an increased supply of primary care services in Sweden, although this development has been uneven between regions. The number of available primary care units increased by eight per cent in 2010 after the patient choice system was made mandatory, but the increase then wore off, steadying at about five per cent compared to 2009; see Figure 11. It is primarily private healthcare providers that have established new primary care units, and they mainly enter regional markets with a large population base, although there are some examples of new establishments in sparsely populated areas. Between 2009 and 2018, the number of primary health units increased most in Södermanland, from 21 primary health units in 2009 to 28 units in 2018, an increase of 33 per cent, despite a fairly small population of almost 300 thousand people. Jönköping have seen the second-largest increase of 31 per cent, followed by Västernorrland at 23 per cent. In Gotland, Kalmar and Norrbotten the number of primary

care units have decreased by 25, 20 and 15 per cent respectively. Gotland had two units less in 2018 compared to 2009, Kalmar had nine, and Norrbotten had five.[74]

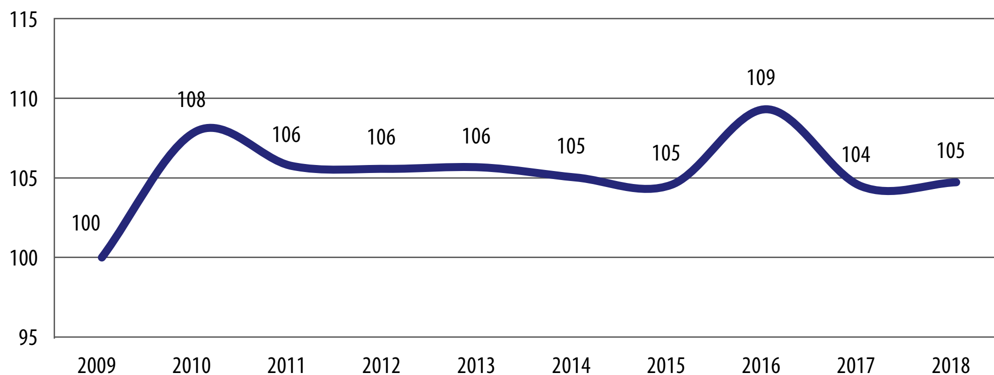

Figure 11. Available primary care units increased after the introduction of patient choice. Index, 2009=100

Note: Three regions (Stockholm, Halland and Västmanland) already applied patient choice to primary care before 2010, which may deflate the effect in 2010. Halland implemented patient choice in 2007 and Stockholm and Västmanland implemented patient choice in 2008. (Source: Ministry of Health and Social Affairs (2008)).

Source: Swedish Association of Local Authorities and Regions (SALAR) (2019d)

Thus, while overall availability has increased since the introduction of mandatory patient choice in primary care, there are regions where the opposite is true. This suggests that private providers are more inclined to establish themselves in areas with a large patient base, making it less attractive to enter the primary care market in, for example, Gotland with a total population of about 60,000 people.[75]

Price competition or quality competition

As has been mentioned, it is possible to compete on price and on quality. Swedish regions and municipalities are free to decide how to finance their services, regardless how they are provided. However, all regions have decided to apply a combination of a fixed and flexible reimbursement where the fixed part is dependent on the number of patients listed at the primary care unit and the flexible part is paid out in relation to each patient visit/treatment. The renumeration is fixed in the sense that all providers, both public and private, receive remuneration according to the same model. This ensures competition neutrality between providers, as mentioned above, and incentivises competition on

74 Swedish Association of Local Authorities and Regions (SALAR) (2019b).

75 Data extracted on 22 November 2019 from Statistics Sweden. Total population in the country, counties and municipalities, 30 September 2019.

quality rather than price.[76] As mentioned previously, the renumeration does take into account systematic differences between public and private providers, supplementing the renumeration to private providers that have to carry the cost of VAT when doing purchases, which the public providers are not required to do.[77]

There are some instances where price competition is used within the healthcare system. For example, laboratory services are procured through price competition. The cost of laboratory services has successfully decreased in regions with procured laboratory services, although it is unclear how and if quality and delivery times have been affected. Also, procurement for materials etc. is likely to be subject to price competition given a set of requirements to functionality.[78]

3.2.2 Patient choice continues to be inherent in the English NHS despite policies aimed at scaling back competition

There have been two main forms of competition in the NHS:

Providers can **compete for service contracts** where commissioners put contracts out for competitive tender (or engage in other forms of competitive processes to choose providers). For example, NHS and independent sector providers can bid for contracts to provide certain community, specialised and mental health services. The use of competitive tendering tends to take place at a local level based on the choices of the local commissioner. According to the relevant regulations, commissioners need to assure themselves that patients' needs are met by the best possible provider.[79] However, there are considerable variations between commissioners' approaches. For example, Monitor (the regulator) found that some commissioners opted for rolling over community service contracts with existing providers without exploring whether alternative providers would provide better, more cost-effective services.[80]

While decisions to put services out for competitive tenders are taken largely by local commissioners, the patient-choice policies apply across England. Patients have been able to choose their provider for **elective hospital care** since 2006. Under 'Payment by Results (PbR)'-based payment, the payment 'follows the patient' – i.e., the provider of the patient's

76 OECD (2018a).

77 Interview with SALAR, 20 November 2019.

78 OECD (2018a).

79 Monitor (now part of NHS England and NHS Improvement) published guidance on the procurement rules for heath services: https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance.

80 Monitor (2015b); Copenhagen Economics interview with NHS Partners Network, December 2019.

choice receives payment, the level of which is, in most cases, determined nationally and is intended to cover the cost of the care received by the patient. **Since payments are fixed and not determined by providers, this system was envisaged to give providers financial incentives to maintain and improve quality in their hospital services.**[81] As we reported in Chapter 2.2, there is academic research to suggest that patient choice and competition have had a positive impact on patient outcomes and on the quality of management.[82] Alongside other reforms[83], the choice-based system in elective care helped alleviate the pressures and long waiting times at public providers, especially with respect to high-volume services, such as hip and knee operations.[84]

While patients have had a legal right to choose their **primary care** provider, few patients make active choices between providers. Indeed, the available evidence suggests that choice and competition play a limited role as levers of quality improvement in England. This is primarily due to patients not engaging with published information on quality of different providers (despite this information being readily available) and due to financial and resource constraints which mean that providers do not have a strong incentive to attract more patients.[85]

We note that commissioners have also been able to introduce choice for certain community services through the **Any Qualified Provider (AQP) scheme**.[86] The AQP required CCGs to put in place arrangements for selected services that enable patients to choose from a range of private, charitable and NHS providers, as long as conditions set by the commissioner and the Care Quality Commission are met, without being contracted through a competitive tender (the AQP providers must be licensed by the Care Quality Commission). The mandatory use of AQP for selected community services was removed in 2014/15, however, and its use was generally limited and applied to sub-set of services with relatively low barriers to entry. A concrete example of an AQP service with high take-up is adult hearing aid, the use of which is briefly summarised in Box 2 below.

81 Department of Health Payment by Results Team (2012).

82 For example: Bloom et al. (2015).

83 These included an increased supply of doctors, increased funding and rigid waiting times targets. Cooper Z. et al (2009) BMJ 2009;339:b3264.

84 See, for example, Cooper Z. et al (2009) BMJ 2009;339:b3264

85 Monitor (2015).

86 The British Medical Association (2019).

BOX 2. OPENING THE PROVISION OF ADULT HEARING SERVICES TO ANY QUALIFIED PROVIDERS

As set out by Monitor, the NHS regulator (now part of NHS Improvement), in 2015 around half of commissioners in England had taken up the any qualified provider approach for adult hearing services. This enables providers from the private and third sectors provide services that were traditionally provided by (NHS) hospitals.

The introduction of AQP was found to significantly enhance access to adult hearing services with these services being provided in various settings, including at GP practices and private clinics on the high street. Monitor found evidence to suggest that patients where generally satisfied with the services provided by these 'new entrants'.

The expansion in the provision came with an increased take up of NHS-funded adult hearing aid services, and consequently with an increased expenditure; hearing aid is a service that is not always used by patients even if their quality of life would improve if they did so. To manage costs some commissioners had determined prices that were 20–25% lower than the national (non-mandated) tariff (the price being the publicly funded payment paid to which ever provider treating the patient). Further, to address concerns over the clinical quality of new provision, commissioners required providers to report their service outcomes to commissioners, who could levy penalties for underperformance.

Source: Monitor (2015) NHS adult hearing services in England: exploring how choice is working for patients.

As reported above, the policy-focus in the NHS is to integrate care and facilitate collaboration, rather than competition, between providers. Notwithstanding these developments, patient choice continues to be central to the NHS. **Indeed, there is an increasing impetus to accelerate patient-centred personalised care.** This means, for example, personal health budgets (PHBs) whereby patients with multiple needs can choose together with the commissioner where and how they use health and social care services. PHBs are used by select group of patients the national objective being 50,000 – 100,000 patients by 2020/21. Again, central to the national steer to deploy PHBs is active collection of data and quarterly monitoring of how well the PHBs used by patients in different areas meet the targets (financial and clinical) set to them.[87] This enables national-level evaluation and learning across the different areas.

87 https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/personal-health-budget-phb

3.2.3 The Netherlands

Patient choice applies in the Dutch primary care (GPs) but, according to NZa, the health regulator, choice plays a negligible role in driving up quality.[88] This is because there is limited information available about quality of care provided by different providers. Patients choose predominantly on the basis of distance and convenience.

The insurance-based model in the Netherlands, on the other hand, introduces competition both between national insurance companies (contracting with hospitals) and between providers (for contracts with insurance companies for patient choice). Insurance companies are acting as patient 'agents' and are expected to have the capability of bargaining affordable prices and to put pressure on providers to compete on quality. There is some evidence to suggest that competition between providers has resulted in lower prices paid by insurers and (based on available indicators) better quality of care.[89]

3.2.4 Denmark

Denmark does not generally use traditional market mechanisms. Most hospital services are publicly provided, about 97 per cent of hospital beds are publicly owned. Private providers are, however, present in different parts of the healthcare system – e.g., almost all GPs are self-employed and are paid by the regions via capitation and fee-for-service.[90] The service-based fees are used as financial incentive to prioritise service, as people can register with any available local GP. Moreover, citizens in need of hospital care may, within certain limits, freely choose any public and some private hospitals. If the region is not able to ensure treatment within 30 days, the patients have the right choose to go to a private hospital in Denmark or to a public or private hospital abroad. Additionally, the municipalities are responsible for social psychiatry and care and can choose to contract with a combination of private and public service providers, but most providers are public.[91] We did not find any evidence of whether the ability to choose contributes to providers' incentives to improve services.

3.3 Specification of requirements for providers

Commissioners define the services they need providers to supply and the requirements they must fulfil to ensure that the societal need of healthcare and social services is met.

88 Interview with the Dutch Healthcare Authority (NZa), 21 November 2019.

89 Sauter et al. (2019).

90 Karsten Vrangbaek (2016).

91 Ibid.

3.3.1 Swedish municipalities and regions formulate a programme outlining needs and requirements at the beginning of every term

Swedish municipalities and regions are responsible for contracted activities.[92] In practice, the council of each municipality and region formulate a programme at the beginning of every term. The programme outlines goals and guidelines for the contracted activities, a well-defined structure for governance and continuous monitoring with defined responsibilities. The programme applies to all contracts with private providers.[93]

BOX 3. VÄSTMANLAND FORMULATES CLEAR COMPETENCE REQUIREMENTS IN ITS PROGRAMME

Västmanland clearly defines in its 'Primärvårdsprogram 2019' what is required from a private provider of primary care. Regarding competences and staffing, they write that:

> *"The care provider is responsible for ensuring that all personnel in the primary care unit have adequate expertise, credentials and specialist expertise where required and that staffing is enough to provide good and safe care. The primary care unit's healthcare staff should be able to speak, understand and write good Swedish corresponding to C1 level on the Council of Europe's language scale. (…) At the request of the Region Västmanland, the provider must submit a certificate confirming the staff's language skills. At the primary care unit, there must be a legitimised doctor with specialist expertise in general medicine, legitimised district nurse, legitimised midwife, legitimised BVC nurse, legitimised occupational therapist, legitimised physiotherapist, dietitian as well as legitimised psychologist and/or legitimised psychotherapist and/or social worker. The social worker should have basic psychotherapy training in KBT (formerly step 1)."*

Further, they clearly specify the indexes under which the private provider will be evaluated. For example, their main index for measuring primary care quality is the Continuity of Care index (COC).

Note: Translation by Copenhagen Economics.
Source: Region Västmanland (2019b).

3.3.2 In England, continuous monitoring is central to regulatory and commissioning decisions

The Care Quality Commission (CQC) is the independent regulator for health and social care in England. The CQC monitors, inspects and rates health and adult social care services. All health and social care providers in England must be registered with the Care

92 Swedish Local Government Act (2017:725), chapter 10 8–9 §§.
93 Swedish Association of Local Authorities and Regions (SALAR) (2019a).

Quality Commission (CQC).[94] This applies to public, private and third-sector providers. CQC assesses the 'fitness' of the applicants in terms of whether they meet the relevant regulations of each service. The registration itself does not dictate the specifics of the service but sets the minimum requirements and makes the provider subject to CQC's supervision and inspections.

Providers' contracts with commissioners stipulate where services are delivered and how they are configured (typically CCGs and NHS England for health and local authorities for social services). Furthermore, regarding hospital services, NHS hospitals providing mental health, acute care or community services have been divided into so-called NHS Trusts and NHS Foundation Trusts. The key difference between the two is that NHS Foundation Trusts have greater autonomy, subject to their performance. Foundation Trusts can retain any surpluses they generate and borrow to invest in services[95]. They therefore have a degree of flexibility to provide services in innovative ways. There does not appear to be a systematic evaluation of the merits of the Foundation Trust system in encouraging innovative service provision through greater autonomy. Indeed, the performance of Foundation Trusts has varied considerably, with some rated 'Outstanding' by the CQC and others as 'Inadequate', leading to a regulatory intervention. **The current direction of development is moving towards a more harmonised regulatory approach governing all secondary care providers, both the NHS Trusts and NHS Foundation Trusts**[96]. This may be indicative of a need for stronger centrally led regulation to avoid variations in quality of care and financial performance.

Similar variations exist in the English primary care where, again, the ways in which services are provided stem from the relevant regulations (as above), as well as the national GP contract, agreed annually by the trade association British Medical Association, BMA, and by NHS England (the commissioner of primary care services). In 2015, Monitor, the regulator, found that GP practices varied in terms of their take up of technologies, staff-mix (e.g. use of nurses) and other, likely efficiency enhancing, ways of working such as phone consultations.[97] GP practices can provide additional services over and above the core services, such as out-of-ours services or certain vaccination programmes.[98] They can also invest any surpluses in, say, more advanced digital services. Some of the digital innovations

94 Care Quality Commission (2019).

95 More specifically, they can acquire and dispose property, generate, retain and reinvest surpluses, borrow to invest in new and improved services and engage in private patient work.

96 Specifically, regulation of these two types of providers has been integrated since the establishment of NHS Improvement, which brought together several NHS bodies and regulators, including Monitor (the regulator of NHS Foundation Trusts) and the NHS Trust Development Authority (NHS Trusts).

97 Monitor (2015).

98 For most recent enhanced service specifications, see: https://www.england.nhs.uk/publication/gp-contract-2019-20-nhs-england-enhanced-service-specifications/.

(online booking, electronic prescriptions) are stipulated by the GP contract, but there is room for GPs to innovate and invest, subject to the financial resources available to them.

While all GPs are effectively private partnerships, only around five per cent are owned by private chains. As reported by Monitor, the contracts held by the private sectors tend to have a relatively short contract length and strict requirements.[99] A notable, relatively recent development is the entry of a digital 'GP at Hand' service by Babylon, a health tech company. GP at Hand service is approved by the Care Quality Commission (i.e., it meets the necessary quality requirements) and the service is also available from the NHS without any out-of-pocket expense to the patient who opts to use the service. Box 4 provides an overview.

BOX 4. GP AT HAND – DIGITAL PRIMARY CARE SERVICE FUNDED BY THE NHS

'GP at Hand' is an artificial intelligent based service providing patients with access to a 'chatbot' and a smartphone video consultation. Similar technology has been available for those paying at the point of use – i.e., paid-for online consultations or as an employment benefit. Notably, 'GP at Hand' has been made available as an NHS (publicly) funded service by a commissioner in London.

GP at Hand offers GP appointments online 24 hours a day at no extra cost to the patient. Patients are triaged through the service and, based on their symptoms, directed to an online consultation which may be followed by physical appointments. The services cover standard GP services such as repeat prescriptions and specialist referrals.

The London-based commissioner that entered into a contract with Babylon, as well as NHS England, the national body accountable for the commissioning of primary care, have been undertaking economic evaluations of the service. To date the evidence suggests that patients and doctors are broadly satisfied with the service. Further evidence will be needed to understand the impacts of the service on the wider system, including how it impacts on the need for physical appointments or emergency attendances. An evaluation by Ipsos MORI also found that the capitation-based funding needs adjusting to fund the costs of GP at Hand patients. These patients tend to be younger and more affluent but use health services more than patients of their age generally (the funding formula is based on patient characteristics such as age). The quality regulator CQC has given Babylon the rating 'Good' (second highest on a four-rung overall rating system) overall. Whether more local commissioners will take up this (or similar) service is likely to depend on the emerging evidence of its effectiveness, including that obtained from planned clinical trials.

Source: NHS (2019a), Ipsos MORI and York Health Economics Consortium with Prof. Chris Salisbury for NHS Hammersmith and Fulham CCG and NHS England (2019).

99 Monitor (2015a).

The above example highlights that, notwithstanding the health policy in England moving away from competition towards greater collaboration between (public) NHS providers, the system continues to enable innovative private-sector entrants to provide publicly funded services. Again, **central to the NHS's take-up of this innovative service is continuous evidence gathering and evaluation.** Whether and to what extent these types innovative service will be deployed and funded at a larger scale, depends on the evidence of their effectiveness.

3.4 Transparency and access to information

As established above in Chapter 2, for any use of market-based mechanisms necessitates that information is available to patients, commissioners steering the market and to providers themselves. Patients and users in healthcare and social services cannot make informed decisions without information that is accessible, focuses on the quality of care and is easy to understand. Commissioners need transparent, comparable evidence to monitor performance and, when needed, to find alternative providers that fare better in the light of reliable evidence. Providers and healthcare professionals use transparent information for benchmarking and identifying opportunities for improvement.

We found a wide variation in the use and publication of information in our focus countries, summarised below.

3.4.1 In Sweden, Quality Registers support providers and commissioners but patients would benefit from more information

The Swedish Competition Authority estimates that about 95 per cent of Swedish residents are aware that they can freely choose their primary care unit and two thirds believe to have made an active choice.[100] Few patients, however, change their initial choice other than in connection with moving away from their previously chosen primary care unit.[101]

Regions and municipalities are obliged to provide patients with relevant information when choosing a provider. This, however, is not executed efficiently in all regions/municipalities, making it difficult for patients to make informed decisions[102]. Until recently, 1177 Vårdguiden[103] administered an online comparison service called Compare Care (in Swedish:

100 Swedish Competition Authority (2018), page 208.

101 Interview with SALAR, 20 November 2019.

102 Interview with SALAR, 20 November 2019.

103 1177 Vårdguiden collects relevant healthcare information and offers healthcare guidance online and via phone. It is funded by the regions.

Jämför vård) covering all regions in Sweden. This service is, however, no longer available, and the available information patients can easily access is in general limited across regions.[104]

The implication of this is that, while the patient choice policy has led to an increase in capacity and availability of services, it is not clear how choice has improved clinical quality in Swedish primary care, as was intended. As mentioned above in Chapter 3.2.1, patients are expected to choose a primary care unit based on the quality of the care provided. However, if there is no easily available information on quality, patients are unable to make an informed decision, nor are commissioners able to judge whether competition between providers is contributing to service improvements. This may undermine the effectiveness of quality competition, as each patient must experience the care of a primary care unit and then opt out of that unit instead of directly acquiring previously collected and aggregated information on quality of care at different units and choose a high-quality primary care unit. Indeed, the Swedish Competition Authority further reports that "*the data concerning quality before and after the introduction of the system of choice is limited*" and it therefore appears to be difficult to draw definitive conclusions about the extent to which patients' choices have driven up clinical quality in Sweden.[105]

Sweden has however a long tradition of developing quality registries. The Swedish National Quality Registries collect individualized data on medical interventions, procedures and outcomes within different treatment areas. Some examples of treatment areas are acute, anaesthesia and intensive care, children, obstetrics and gynaecology, cancer, and the circulatory system and others. The purpose of the registers is to develop and secure the quality of health and social care and to contribute to continuous improvement. The registries make it possible to follow up the care provided throughout the country, sometimes on a per unit level. The indicators are intended for professionals and academic researchers, but some data is publicly available and may therefore be used as a quality indicator also by patients.[106] While it is thus unclear whether and how this evidence can help support patients' choices, the National Quality Registries can inform commissioners, health professionals and provider management in identifying opportunities for improvement through continuous monitoring of outcomes and benchmarking.

3.4.2 Evidence from England shows the importance of comparative information

As reported above, patient choice has been central to the NHS in England over the last two decades. Notably, patients can choose their GP practice for their primary care needs.

104 Vårdföretagarna (2019), p. 18.

105 OECD (2018a).

106 Nationella kvalitetsregister (2020).

For (non-urgent) secondary care, at the time of referral, patients have a legal right to choose the provider of their first outpatient appointment. GPs provide patients with information about choices available to them. To help inform their choice, patients can also access comparative information online, for example, via NHS website.[107] There is evidence available on patient satisfaction, on key clinical indicators and on more holistic inspection results by the Care Quality Commission. Providers are further required to display their 'quality rating' visibly at the hospital or GP practice and on their website.[108] Figure 12 illustrates an example of how patients can access information about (in this case) hospital services near their area (this illustrative screenshot displays only 'key facts', patients can readily access further evidence on the same online service).

Topics: Key Facts; Sort by: Mortality rate (in l; Update results	NHS.UK users rating	Care Quality Commission inspection ratings	Recommended by staff	Mortality rate (in hospital and up to 30 days after discharge)	Food: Choice and Quality
Western Eye Hospital — Add to shortlist					
Tel: 020 3312 6666 153-173 Marylebone Road London NW1 5QH **2.6 miles away** NHS	74 ratings **Rate it yourself**	n/a Not yet rated	OK Within expected range with a value of 73%	Lower number of deaths than expected	96.08% Among the best
St Mary's Hospital (HQ) — Add to shortlist					
Tel: 020 3312 6666 Praed Street London W2 1NY **2.6 miles away** P NHS	183 ratings **Rate it yourself**	Requires Improvement **Visit CQC profile**	OK Within expected range with a value of 73%	Lower number of deaths than expected	87.46% Among the best
Hammersmith Hospital — Add to shortlist					
Tel: 020 3313 1000 Du Cane Road London W12 0HS **3.1 miles away** P NHS	79 ratings **Rate it yourself**	Requires Improvement **Visit CQC profile**	OK Within expected range with a value of 73%	Lower number of deaths than expected	91.49% Among the best
Queen Charlotte's & Chelsea Hospital — Add to shortlist					
Tel: 020 3313 1111 Du Cane Road London W12 0HS **3.1 miles away**	63 ratings **Rate it yourself**	Outstanding **Visit CQC profile**	OK Within expected range with a value of 73%	Lower number of deaths than expected	95.39% Among the best

Figure 12. An illustration of how patients can access comparative information for the treatment they need

Source: NHS website: https://www.nhs.uk/service-search/other-services/Hospital/nw61jx/Results/3/-0.192296400666237/51.5532569885254/7/0?distance=25&sortBy=96&ResultsOnPageValue=10&isNational=0 Accessed 28 February 2020.

107 See NHS website: https://www.nhs.uk/pages/home.aspx.

108 Care Quality Commission provides detailed guidance on how different types of provider need to display their ratings: https://www.cqc.org.uk/guidance-providers/ratings/ratings-what-you-have-display-where

Notwithstanding the abundance of published information, there is room for more patients to engage with the evidence available to inform their choices. Around 40 per cent of patients say they were offered a choice of hospital or clinic for their first outpatient appointment (the most recent survey results are from 2015).[109] While the proportion of patients is not as large as it could be, it nevertheless suggests that a large number of patients make active choices over secondary care together with their GP.

This does not hold for primary care, however. While there is comparative information available, few patients use comparative information to inform their choice. In 2015, Monitor, the regulator, found that **when choosing their provider, a small fraction (2–3 per cent) of patients had used published information about how different practices would meet their needs.**[110]

In all, it the NHS has advanced data collection processes in place and that the collected information is actively brought to patients and healthcare professionals. It appears that patients themselves may not engage with the information but are more likely to do so when prompted and assisted by a professional. This may in part explain why competition and choice appear to have contributed more to patient outcomes in settings where patient choice is facilitated by GPs rather than where patients choose on their own (we reported some of the key findings of the relevant research in Chapter 2.2).

The collection and transparent sharing of performance information can help drive up quality in different ways. The model whereby patient choice coupled with an activity-based funding system creates incentives to compete on quality is not the only mechanism through which providers can respond to each other's performance.

- First, once information is available, it can be used for benchmarking between providers, and individual doctors and nurses to identify variations in quality and therefore opportunities to take action where needed. To that effect, he the NHS is increasingly making good use of data on provider performance. Notably, NHS Improvement's Model Hospital tool enables trust management and staff to access data on their performance and compare it to national performance or closest peers. **Providers are thereby encouraged to identify opportunities for improvement through the increased use of comparative data across the sector.**[111]

109 NHS England (2015).

110 Monitor (2015a).

111 For further information, see NHS Improvement (2019a).

- Second, measuring and collecting performance data can inform commissioning decisions. Systematically and frequently collected evidence can provide commissioners and regulators with the necessary first indications of variations in outcomes. Indeed, in England, both the quality regulator CQC and NHS England and NHS Improvement use broad sets of indicators and analytics.[112] Further, performance data underlies many of the financial incentives built into the payment models in the NHS.

Finally, there is generally less information available on social care services, although the quality regulator CQC also publishes reviews on social care providers and the NHS Choices website covers certain indicators for services (e.g., care homes). The information gap was noticed recently by the Competition and Markets Authority (CMA). The CMA investigated the care homes market and advised care home providers, both public and private, "*what upfront information they should give to potential residents, their families or other representatives and when (through websites, over the phone and when people visit) to help them make informed choices.*"[113]

3.4.3 Consumers may find it challenging to observe differences between insurance policies in the Netherlands

In the Netherlands, a factor inhibiting competition from driving quality improvement in primary and social care is a lack of published information about quality of service.[114]

In hospital care, which is where market mechanisms play a central role in the Netherlands, there is information available for insurance companies and patients. However, in its review in 2016, the Dutch Competition Authority, ACM, found that, despite the large number of insurance policies available to consumers (e.g., 71 basic insurance packages), and hence the availability of choice, it was less clear whether patients were making decisions on the basis of quality. This is because, on the basis of the information marketed to consumers, insurances actually hardly differ from one another and the "differences between health insurers may thus be primarily based on non-objective characteristics, which stifles competition between health insurers."[115] This adds to the evidence that consumer choice may not in itself (or alone) direct providers' efforts on quality improvements, given the inherent difficulty of observing quality in health and social care services.

112 We discuss these further in Section 4.

113 The Competition and Markets Authority (2018).

114 Copenhagen Economics interview with the Dutch Healthcare Authority.

115 Copenhagen Economics interview with the Dutch Healthcare Authority.

3.5 Commissioners’ and regulators’ oversight and interventions

Commissioners of health and social care services are accountable for monitoring the performance of providers with whom they have contracts. There must be a credible response system in place to incentivise providers to perform in line with defined requirements in line with the wider societal objectives.

3.5.1 Follow-up on service quality is set to improve operations and to make sure Swedish care meets existing requirements

Joint responsibility for quality of care

Swedish municipalities and regions are obliged to monitor and follow up on all contracted municipal and regional activity.[116] Reasons for contract termination and termination clauses are entered in the tender documents and regulated in the contract. Often, ‘sanction stairs’ are used, meaning that the provider first receives a warning which entails monitoring of activities at regular intervals and execution of a suitable action plan. Possible measures if a provider continues to perform poorly are to lower the compensation or terminate the contract, see example from Västmanland in Box 5.[117]

116 Swedish Local Government Act (2017:725), chapter 10 8–9 §§.

117 Interview with SALAR, 20 November 2019.

BOX 5. VÄSTMANLAND REGION CAN TERMINATE CONTRACTS AND/OR REQUEST COMPENSATION

When signing contracts with private providers under patient choice, the region enters clauses that will allow them to efficiently act if any defects are detected. The below text is an example of how the Västmanland region formulates its clause 'Deficiencies in operations and financial penalties':

"If the provider fails in the fulfilment of his or her undertaking, the provider shall immediately notify the region after the provider has, or must be deemed to have, been aware of the defect and present a plan showing how the deficiencies should be rectified.

If the region discovers, or suspects, deficiencies in the provider's fulfilment of the undertaking, the region must immediately notify the provider in writing, as well as specify requirements for measures and reporting. The provider must immediately reply to the region.

The provider should rectify any deficiencies as soon as possible. In the event of essential deficiencies, correction must be made within 30 days, unless the region is entitled to

terminate the agreement. If the defect is not rectified under this section, the region has the right to terminate the agreement until early termination in accordance with the terms.

In the event of a defect which the region considers to be non-minor, the region has the opportunity to notify the provider of a fine in Swedish kronor that the provider shall pay if the defect has not been rectified within the time stipulated in the penalty payment. (...)

The region unilaterally decides on the size of the fine. The level of the fine is proportionate to the significance of the deviation. The fine can be paid as monthly reduction of invoiced amount or with repeated monthly reduction until the deficiency is corrected. The fine can also be paid as a lump sum. Payment, according to the alternatives above, is made primarily by deduction of the monthly financial compensation to the care provider.

Examples of deficiencies that are considered non-minor:

- *The supplier does not carry out the operations to an agreed extent.*
- *The supplier does not staff the business with the skills and the dimensions stated in the tender documentation.*
- *The supplier does not achieve operational and quality goals in accordance with current legislation and in addition what is stated in the rule books.*
- *The supplier does not register business information in accordance with current instructions.*
- *The supplier lacks the equipment required for the performance of the contract.*
- *The premises where the business is conducted do not meet the requirements of the program or the rule books for premises for the business."*

Note: Translation by Copenhagen Economics.
Source: Region Västmanland (2019).

The follow-up on service is meant to improve operations and to make sure they meet existing requirements. The extent of commissioners' control depends on how a service is organised. When supplied by the region themselves, they are better able to act by, for example, dismissing the management of a malfunctioning business, compared to when a service is supplied by a private provider. In that case, the region is completely dependent on the contract and its terms.[118]

In addition to the supervision exercised by municipalities and regions, there are other regional and national authorities working with assuring the quality of the care provided to Swedish citizens. Below we summarise their roles and indicators of the size of their operations:

- **The Regional Patient Boards** support patients and their relatives with their complaints regarding all publicly funded healthcare in Swedish regions and municipalities. The patient board is not an actively supervisory body and has no disciplinary powers, but its main functionality is to inform patients and caregivers and to passively observe.[119] The Regional Patient Board in Stockholm employed 25 persons consisting of officers (nurses, occupational therapists, social workers), administrational personnel, one analyst, one statistician, one lawyer and one person responsible for marketing and communication. They received 7,710 cases during 2018 and the total cost amounted to 31 mSEK.[120]

- **The National Board of Health and Welfare** develops binding rules in the form of regulations as well as knowledge support and guidelines that help caregivers develop practices and working methods. It may be national guidelines, recommendations and indicators. Their patient safety work is cross-governmental and takes place in collaboration with several different authorities and parties. It is the National Board of Health and Welfare that examines and issues credentials for healthcare professionals.[121] In 2018, the authority employed 776 persons and they administered 33,024 cases and 178 government assignments. The personnel costs in 2018 amounted to 589 mSEK.[122]

- **The Health and Social Care Inspectorate, IVO**, oversees all healthcare in Sweden by investigating complaints and inspecting healthcare operations.

118 Interview with SALAR, 20 November 2019.

119 National Board of Health and Welfare (2019a).

120 Region Stockholm (2019) and interview with representative from the Regional Patient Board of Stockholm on 16 December 2019.

121 National Board of Health and Welfare (2019a).

122 National Board of Health and Welfare (2019c).

IVO is responsible for the supervision of legitimised healthcare personnel. The results of the supervision are returned to the caregivers and the public, both in individual cases via decisions and through national and regional analyses.[123] In 2018, the authority employed 708 persons and received 5,691 complaints regarding social services, 741 complaints regarding healthcare and 105 complaints regarding both social services and healthcare. The personnel costs for 2018 amounted to 528 mSEK.[124]

– **The Public Health Agency of Sweden** is responsible for public health issues and works for good public health. They are responsible for issues related to health-related infections and hygiene, and they collect, analyse and disseminate knowledge on issues related to antibiotic resistance. They develop a knowledge base and action programmes that can be used in healthcare and also function as an expert support.[125] In 2018, the authority employed 536 persons (public health researchers, political scientists, former health care professionals/medical experts, lawyers, economists, microbiologists etc.), presented 30 finalised assignments to the government and answered 193 referrals and surveys. The personnel costs amounted to 378 mSEK.[126]

There are examples of contracts being terminated due to poor performance. In July 2018, the Stockholm region terminated their contract with *Veritas vårdcentral Väsby* outside Stockholm, and in November 2017, the Västra Götaland region terminated their contract with *Angered Care*. The two cases are described in Box 6.

123 National Board of Health and Welfare (2019a).

124 Health and Social Care Inspectorate (2019).

125 National Board of Health and Welfare (2019a).

126 Public Health Agency of Sweden (2019) and interview with representative from HR department at the Public Health Agency on 16 December 2019.

BOX 6. THE CASES VERITAS VÅRDCENTRAL VÄSBY AND ANGERED CARE

Veritas vårdcentral Väsby

In the spring of 2018, the health centre Veritas vårdcentral Väsby was damaged by a fire and had to close. The reconstruction was supposed to be finished in June the same year, but in July it was still ongoing. Region Stockholm, responsible for all publicly financed healthcare in Stockholm County, estimated that the health centre's business would not be up and running within the specified time frame, and thus decided to terminate the contract with the supplier, Swefi Care U-V AB. Region Stockholm also stated in its announcement that the parts of the business that the caregiver had been able to carry out outside the premises, i.e., telephone counselling and home care, had been poor. As a result of the termination of the contract, the health centre had to shut down its business immediately and all its current patients were informed about the free choice of health centre in the Stockholm area. In the surrounding area, there were already four other health centres, thus no further action was taken.

Angered Care

In the autumn of 2017, Region Västra Götaland, responsible for medical care in the territory Västra Götaland, became aware of deficiencies in the medical care at health centre Angered Care. The deficiencies were reported by The Health and Social Care Inspectorate, a government agency responsible for supervising healthcare, after insufficiencies in patient safety was found. Therefore, Region Västra Götaland decided on an in-depth follow-up of the operations at the health centre. The follow-up examined the quality of care and staffing at the childcare centre. The review also applied to the quality of the care centre, including patient safety and the evening and full-day reception with doctors in readiness. The in-depth follow-up showed such serious shortcomings in staffing, journaling and care that patients' safety had been compromised. The deficiencies found were considered so serious, especially regarding patient safety, that Region Västra Götaland decided in November 2017 to terminate the agreement with Angered Care with immediate effect. The owner of Angered Care was later also found guilty of accounting fraud by the Swedish district court and sentenced to three years and nine months in prison and banned from business activity for five years. The health centre's current patients were all transferred to the health centre closest to their home with the option to freely change centre in accordance with the free choice.

Source: SLL (2018), Cision (2017), GP (2019).

3.5.2 In England, regulatory oversight has evolved but there have been variations in commissioning practices

NHS providers operate under regulatory oversight in terms of the quality of care they provide, and their financial performance. CQC monitors and inspects all health and social care providers regularly (see above 3.2.2). Further, NHS providers are overseen by NHS

England and NHS Improvement. The NHS Oversight Framework is the basis for monitoring of health systems, both providers and commissioners.[127] It covers the following themes:

1. New service models
2. Preventing ill health and reducing inequalities
3. Quality of care and outcomes
4. Leadership and workforce
5. Finance and use of resources.

Each theme consists of several quantitative and qualitative indicators ranging from clinical indicators such as *cancers diagnosed at an early stage and appropriate prescribing of antibiotics in primary* care to measures of organisational performance such as *expenditure in areas with identified scope for improvement and probity and corporate governance*. Put briefly, providers and health systems that perform better have greater autonomy while those with room for improvement are supported closely by regulators.

When serious problems are evident and there are concerns that the existing leadership cannot make the necessary improvements without support, the CQC and NHS England and NHS Improvement may place the trust in special measures.[128] When a provider is placed in special measures, the regulators assess the causes of provider's persistent underperformance and design a support package accordingly. In some cases, it is necessary to introduce changes in the management of the provider. The regulators may also identify structural issues that warrant longer-term solutions such as service reconfigurations, management arrangements or transactions (merger or acquisition).

There are further, economic regulations steering commissioners to consider which organisation, whether public or private, should run the services in their area. The Health and Social Care Act 2012 brought a new regulatory package aimed at ensuring that commissioners assess the needs of their local populations and make sure that patients' interests are met by the best possible providers.[129] These 'Patient choice and competition regulations' set out how commissioners should make choice and competition work for patients. Contrary to the common misconceptions surrounding these regulations, they do not oblige commissioners to use competitive tenders. Rather, they seek to ensure that commissioners consider different options and that the provider of choice is best placed to meet the needs of their local populations.[130]

127 NHS Improvement (2019b)

128 NHS Improvement, Guide to special measures Available from: https://improvement.nhs.uk/resources/special-measures-guide-nhs-trusts-and-foundation-trusts/.

129 Monitor (2013).

130 See guidance on the use of Procurement, choice and competition regulations: Monitor (2013).

To ensure that competition, choice and procurement rules are complied with and enforced where necessary, the 2012 reforms introduced new powers to the economic regulator of healthcare services, Monitor. Monitor has, among other duties, a role in determining prices for health services and in enforcing competition rules. In practice, Monitor's role on competition was (and still is, albeit to a limited extent) to support commissioners and providers and steer the markets without many formal interventions.[131] There are, however, notable exceptions where informal engagement with commissioners and providers did not suffice and where Monitor opened investigations into commissioners' practices. Box 7 provides an example of such an investigation, which resulted in a commissioner revisiting its approach.

BOX 7. MONITOR INVESTIGATION INTO ALLEGED BREACH OF COMMISSIONING REGULATIONS

After a complaint from a private healthcare provider chain, Care UK Clinical Services Ltd, Monitor commenced an investigation into the North East London commissioner's process of securing services to meet the needs of the local population and proposed pricing arrangements for elective care services in North East London. Care UK's concerns related to how the local commissioner had selected a public NHS Trust (Barking, Havering and Redbridge University Hospitals NHS Trust) to operate the North East London NHS Treatment Centre. The services provided at the centre were elective services such as general surgery, ophthalmology and ear, nose and throat services.

The complaint covered a range of issues from the selection criteria and commissioner's bid evaluation process to pricing arrangements associated with the contract. Monitor found, for example, that the commissioner "failed to take into account relevant information about the Trust's ability to deliver on its bid and that the CCGs did not do enough to ensure that the bid they selected was the best option for patients." Specific issues related to the provider's performance difficulties identified by the Care Quality Commission and, for example, the provider's failure to comply with certain important waiting time targets.

The case was settled through undertakings proposed by the commissioner and eventually accepted by Monitor. Care UK retained the contract for an extended period.

Source: Monitor (2016).

Quality of care provided, and therefore the interest of patients, was central to the outcome of the case presented above. **The regulatory approach was underpinned by evidence of**

131 Interview with NHS England and NHS Improvement, 4 December 2019.

the provider's performance. It is not clear that the same view would have been reached in the absence of such objective evidence.

3.5.3 Supervision mechanisms are in place in the Netherlands and Denmark

In the Netherlands, the quality requirements for healthcare are stipulated nationally by the Quality, Complaints and Disputes in Care Act. The Health and Youth Care Inspectorate (IGJ) oversees compliance with legislative regulatory requirements.[132] The IGJ has developed indicators it applies to the monitoring of hospital performance which need to be reported to the IGC (not published). Since 2014, it has been mandatory to also publish standardised mortality rates, and further published indicators are being developed. Insurers, who in the Netherlands act as akin to commissioners, monitor performance, too, and impose their requirements although with "significant resistance" from hospitals.[133] Further to clinical quality, hospitals are also obliged to comply with maximum waiting times standards (e.g., four weeks for a visit to an outpatient clinic), which can in turn impact on the terms agreed with the insurers, and (at least in principle) on patients' choices.

Notwithstanding the quality requirements and oversight, we are not aware of any hospital closures or acquisitions due to inadequate performance, although hospitals have closed due to financial reasons. Further to the secondary hospital care, the Dutch Health Authority informed us that there are very few (if any) examples of regulators intervening and replacing a provider due to inadequate performance in primary care.[134]

In Denmark, the general regulation and supervision of healthcare, including cost-control mechanisms, take place at a national level. Regions oversee hospital services and supervision and payment of GPs and other private specialists. Municipalities primarily handle prevention, health promotion and long-term care. To enable users to compare performance at hospital department level, benchmark data related to service, quality and number of treatments performed are provided on a national website.

To ensure quality and efficiency within the healthcare system, the Danish Health Authority monitors pathways and the speed with which patients are diagnosed and treated. In case of poor results, the regions are obliged to act. If the regions fail to comply with the standards, the authority can step in. The regulatory interventions (if needed) would manifest themselves as a turnaround of services, rather than opening the services to alternate providers through a competitive process.

132 Sauter et al. (2019).

133 Ibid.

134 Copenhagen Economics interview with the Dutch Healthcare Authority.

Chapter 4. Resources and capabilities: what does it take to make markets work for patients?

The functioning of health and social care markets relies on commissioners securing mechanisms for choice and on provider-side incentives to compete on quality and (in some cases) price. Making these 'building blocks' work for patients is, however, easier said than done. Indeed, the success of markets is not only contingent on the design of the systems but often on the rigour of the way the systems are implemented and operated. For example, the UK and the Netherlands have very different set-ups, yet in both countries there is evidence to suggest that market-based systems have contributed to improved outcomes.

In this Chapter, we examine the determinants of success in health and social care commissioning. There are few systematic evaluations of commissioning practices and resource requirements. Our review of the available evidence and interviews suggest that the critical resource and capability factors influencing the functioning of commissioning boil down to the core 'building blocks' introduced in Chapter 2:

1. Evidence-based understanding of how providers meet patients' needs;
2. Financing models to ensure incentives for efficient and effective care;
3. Resources and scale needed for active commissioning based on local health needs;
4. National-level steering to ensure consistency and support for local commissioning.

We discuss these in turn below.

4.1 Evidence-based understanding of how providers meet patients' needs

Whether commissioners decide to use patient choice or to tender a health and/or social care contract, they need transparent evidence of how different providers are performing.

Patient choice cannot be expected to be a lever of quality improvement if patients are not making informed choices. Similarly, commissioners cannot effectively run tenders where providers compete on quality, unless they have sound evidence of the quality of services provided by different tenderers. Contractual obligations to secure a high standard of care are necessary, but often not enough to give commissioners sufficient assurances. A provider's historical performance can be a useful proxy for its future performance.

There are opportunities to increase information enabling patients or commissioners to make informed decisions about the quality of care:

- The Dutch Healthcare Authority told us that, in the Netherlands, there has not been any assessment by the authorities of the case for introducing more transparency in primary and social care services.[135] There is more information available on the quality of hospital care, which is where competition is set to play a key role in the Dutch health system.

- In Sweden, where patient choice is introduced nationwide for all primary care, easily accessible information about the quality of care provided at different primary care units is very scarce. Previously, a publicly available and easy to use database was available for patients. This database is however no longer accessible. On the other hand, for some health and social care services provided by municipalities, patients and users have more information at hand. For example, through the database The Elderly Guide (Äldreguiden). The Elderly Guide is aimed at the elderly and their relatives and provides information on home care services and elderly housing throughout Sweden. It is possible to compare provider performances within the municipalities, which is useful when choosing a provider and allow them to make informed decisions.[136]

England has well-established practices for monitoring of provider performance, both to help local commissioners and national regulators and to facilitate patient choice. This

135 Copenhagen Economics interview with the Dutch Health Authority (NZa).

136 National Board of Health and Welfare, Äldreguiden, https://www.socialstyrelsen.se/lattlast/aldreguiden/, accessed on 6 December 2019.

applies especially to healthcare services; social care services are also inspected by the CQC (and their performance ratings are published), but there are fewer quantitative indicators available to the public or commissioners (i.e., local authorities).[137]

The resource requirements underlying the NHS data collection and publication are significant. The NHS involves a myriad of national and local organisations that lead or contribute to the collection and processing of data on, for example, patient outcomes, access to care, operational performance and patient satisfaction. This evidence is widely used across the sector by (a) providers, who can benchmark their performance against each other, (b) commissioners, who can monitor how providers perform and (c) patients, who can use published information to inform their choice of provider (although relatively few patients engage in using evidence, as explained above). Box 8 presents key organisations and ongoing initiatives.

BOX 8. NHS INTELLIGENCE INFRASTRUCTURE: KEY ORGANISATIONS

NHS Digital is the leading national NHS organisation responsible for data collection and processing and for the digital transformation of the NHS. With a workforce of more than 3,000 employees, NHS Digital operates an annual total expenditure of around £440 million.

The Care Quality Commission, as reported above, is the quality regulator inspecting and overseeing the performance. The CQC runs a systematic data collection and processing unit, CQC Insight, which incorporates data indicators, monitors them, identifies risks of quality deterioration and monitors changes over time.

National Institute for Health and Care Excellence (NICE) produces guidance for health and social care practitioners, information services for commissioners and clinical practitioners and managers and develops quality standards and metrics that are closely followed and complied with within the NHS.

NHS England and NHS Improvement (NHSE & NHSE), as one of their many roles, assess NHS providers' performance drawing on data on various aspects of financial, operational and clinical performance. Model Hospital is an online tool that enables acute hospitals to compare their performance against their peers across several dimensions of quality, productivity, operational performance and financial performance. Model Hospital is developed through an ongoing programme of work, involving statisticians, clinicians, data scientist and economists.

137 As we explained above, health and social care services tend to be separately commissioned, although some regions have taken steps to integrate the organisation of the two.

Public Health England collects, processes and publishes many public health data and analysis tools and resources. Most tools can be accessed by anyone, although the main users of this data are local governments and health professionals who seek to address any unwarranted inequalities in their areas.

Source: Websites of NHS England and NHS Improvement, CQC, NICE, Public Health England and NHS Digital. NHS Digital Annual Report and Accounts 2018/19.

Given its longstanding history of data collection and processing, the NHS offers several useful lessons with regards to the practical implementation of evidence-based steering.

First, patients may need support in making informed choices. As the above-explained examples demonstrate, even if published information was available, patients do not necessarily engage with it when making choices. One way of facilitating choice in primary, community and social care is through supporting patients in deciding where to receive care, especially when the patient suffers from comorbidities or needs a combination of health and social care services. By way of an example, while the English NHS currently places less emphasis on choice as a lever of competition, choice is still inherent in the current focus on personalised care. Personal Health Budgets, for example, are notional sums of money a patient can use through the pathway and where the patient's treatment plan is made jointly with a clinical and/or social care practitioner arranged by the commissioner.[138]

Second, no indicator is a perfect measure of performance, and effective commissioning necessitates evidence of the different aspects of healthcare. It is widely accepted in the literature and by UK practitioners that any quality monitoring will require a range of indicators capturing different aspects of healthcare. For example, the CQC Insight, the framework used by the quality regulator, includes indicators for hospital care, mental health, community care and primary care (CQC Insight does not cover social care even though social care is within the CQC's remit).[139] Similarly, the NHS Oversight Framework used by NHS England and NHS Improvement draws on a several domains from leadership to clinical quality. As the English experience demonstrates, outcomes indicators and monitoring frameworks evolve constantly and require an ongoing engagement between providers, commissioners, independent clinical experts and patient representatives.

138 More information available from: NHS (2019b).

139 Care Quality Commission (2018).

Third, regulators and commissioners need to exercise caution when publishing information to avoid misinterpretation by the public. As we explained in Chapter 2, an inherent feature of health and social care services is patients' difficulty in observing and assessing quality of care. This means that any published indicators are easily misinterpreted, or they may not adequately capture what matters to patients (such as clinical quality). By way of an example, the UK Care Quality Commission started to inspect GP practices (providers of primary care) in 2014 and launched a comprehensive review, based on data on quality indicators, labelled '*CQC Intelligent Monitoring*'. The publication received a strong rebuttal, as it was seen to judge GP practices merely based on certain quantitative indicators, some of which had not been adequately reviewed before publication. The CQC had to rectify errors and stressed the risk of miscommunication in its public statements that followed.[140]

Fourth, where evidence is used to create incentives to improve performance, the focus should be on outcomes, not just outputs. In its review of community services, Monitor, the health regulator in England, found that commissioners are using a variety of resources and working with stakeholders to understand what is most important to patients and to develop outcome indicators. The tendency in England is towards a reduced number of KPIs and a greater focus on "outcomes instead of activity or processes."[141] One challenge identified was to craft indicators that were robust and relevant to the objectives for patients and were also intrinsically valid, meaning they measured what they claimed to measure. Similarly, in the Netherlands, The National Healthcare Institute has since 2014 played an important role in developing guidelines for quality monitoring. Manen (2019) found, however, that the work on developing informative indicators is still in progress and at present, quality indicators play a limited role in competition between insurers and between providers. These authors report that the problem is not the lack of indicators, rather their usefulness for patients.

Sweden has a similar tradition of systematically collecting data, organised within the Swedish National Quality Registries. The data is mainly used by (a) providers, who can benchmark their performance against each other, (b) commissioners, who can monitor how units and their municipality/region perform in certain treatment areas and (c) academic researchers. Much of the data is not publicly available due to its sensitive character but contributes to improved care throughout the country.[142]

140 Care Quality Commission (2017).

141 Community services are defined to include "community matrons, district nursing, continence services, podiatry, physiotherapy, diabetes care, specialist nurses, tissue viability, heart failure services, wheelchair services, rehabilitation services, falls, palliative care, neurology, respiratory and stroke services". Monitor (2015b).

142 Nationella kvalitetsregister (2020).

4.2 Financing models to ensure incentives for efficient and effective care

Where universal health (or social) care services are publicly funded and payments regulated, commissioners need to be able to compensate providers adequately to encourage new, innovative entry. In principle, providers should be able to recover their *efficiently incurred* costs while preserving a high standard of services. We found that designing payment models is far from straightforward and there are useful learnings from other countries:

1. In England, NHS hospitals have been facing significant financial pressures under the recent level of payments, which has in part diluted providers' incentive to compete. There are examples where the funding constraints have led commissioners to transferring the volume risk to providers by introducing fixed-sum contracts (so called 'block contracts'). These types of fixed-sum payments can undermine any incentives to compete, to the extent funding does not follow patient choice.[143] In mental health and community care services, the payment models have been less advanced and often not based on the underlying costs of services. Furthermore, primary care providers are largely paid based on the number of registered patients, while hospitals are funded on the basis of activity (HRGs, see above). This means that the payment model does not as such encourage keeping the patient out of hospital through more effective primary and/or preventative care.[144]

2. Similarly, in the Netherlands, one observed problem is the diagnosis and treatment combinations (DTC) funding model focuses on activity, not on the quality of services provided. Further, the payment model has been criticised for offering "too few opportunities to encourage substitution between secondary and primary care".[145] In other words, similarly to the English NHS, the payment model does not align incentives between the two care settings.

3. In Sweden, the Swedish Competition Authority's review in 2012 (two years after the inception of the choice legislation) found that of the 1065 healthcare centres included in the SCA's survey, four out of ten were running a deficit. The financial difficulties were particularly prominent in areas with

143 Competition and Markets Authority (2019).

144 See, for example, The Health Foundation and NHS Providers (2017).

145 The DTCs are "compensation bundles" capturing the total cost of an episode of care, akin to DRGs and HRGs. Manen J. (2019) in Sauter J. et al. (2019), p. 378.

low availability, with around 67 per cent of the healthcare centres running a deficit. This was found to indicate that the capitation funding, which by design should take into account the needs of different patient populations, was not adequate. Furthermore, the remuneration over and above capitation payments varies considerably between county councils with no common established rules or guidance for determining payments.[146]

Notwithstanding the fact that no country offers a perfect blueprint for determining a payment system that encourages efficient entry, there are important lessons to be learned. Notably:

Understanding of costs is an important prerequisite of quality competition with fixed prices. As established, commissioners often fix the payment associated with a service, whether as a capitation payment, and activity-based payment or as a ceiling in a public tender. Irrespective of the payment model, understanding underlying costs remains essential. A commissioner will not be well-placed to determine an appropriate "cost-reflective" payment (ceiling) without an understanding of the underlying costs.

In the NHS, with its longstanding history of developing costing and payment models, the direction of development is towards more outcomes rather than activity-based payment schemes. Notwithstanding that, the NHS continues to develop ever more granular patient-level costing systems (patient level information and costing system, PLICS).[147] PLICS represents an advanced costing approach to the case-based health resource groups (HRGs[148]). In summary, rather than reflecting average costs, PLICS seeks to capture how resources are used at patient level (e.g. staff, drugs, equipment costs).[149] **Thus, the need to understand costs along the patient pathway prevails irrespective of the way in which the cost information is used in determining payments.**

In concrete terms, rigorous costing means a range of functions, including multidisciplinary groups, including clinicians, accountants, economists and statisticians developing standardised approaches to record activities and collect data on associated costs and regular quality assurance (audit) of the cost data. In practice, different providers have tended to apply different costing approaches, which means that the processing of the data can be burdensome, even if necessary.

146 OECD (2018a).

147 NHS Digital (2019).

148 See above, e.g. footnote 21.

149 For further information about PLICS, see, for example: https://www.hfma.org.uk/our-networks/healthcare-costing-for-value-institute/what-is-plics. See above, e.g. footnote 21.

It is widely recognised that payments should focus on outcomes rather than outputs and encourage prevention. Where providers are paid by activity (e.g., the number of operations or appointments), they will have a financial incentive to maximise the volume of those activities. The above experiences, especially from the Netherlands and the UK, suggest that they may not be conducive to providing care at the most efficient setting – e.g., if primary and community care is paid for on a fixed-sum basis (irrespective of volume) and hospital care payment is based on activity, there is a risk of incentivising providers to refer patients to hospital care, and for hospitals to maximise activity.[150] Incentives to improve services can be created through additional payments associated with good performance and innovation. Box 9 sets out examples from the English NHS.

BOX 9. EXAMPLES OF PAYMENT MODELS USED TO INCENTIVISE QUALITY IMPROVEMENTS

Best Practice Tariffs (BPT) are designed to incentivize quality and cost-effective hospital care. The aim of BPT is to reduce unexplained variations in clinical quality and encourage best practice. In practice, this may mean including a description of the activities that most closely correspond to the delivery of certain outcomes for a patient. The financial incentive is created by a price differential between agreed best practice and regular care.

Quality and Outcomes Framework is a model applied in primary care to reward good practice. On average GPs are estimated to receive around 10 per cent of their income based on how they perform against a wide range of outcomes indicators. The number of indicators was 77 in 2018/19 consisting mostly of clinical indicators (e.g. chronic kidney disease, heart failure) and public health measures (cervical screening and contraception).

Source: NHS England and NHS Improvement (2019b); https://qof.digital.nhs.uk/

The examples in Box 9 are outcomes-based financial incentives built as "add-ons" to the existing payment systems: HRG-based system in hospital care and capitation in primary care. As such they do no represent entirely new, "value based" payment models. Owing to the concerns that current payment models are not conducive to aligning incentives and integrating care between providers in different settings, both in England and in the Netherlands national regulators are in the process of designing what can be referred to as *population-based* payment models. Rather than paying providers for volumes

150 This risk of misalignment and potential ways to address it have been explained by Monitor (now part of NHS England and NHS Improvement); see Monitor and NHS England (2015).

of treatments these types of payment models would reimburse providers "for making available specified services and possibly delivering specified outcomes for a defined target population, drawing on services that cross different organisational boundaries to meet individual patient needs".[151] This type of capitated payment could be weighted, or risk-adjusted, to take into account of the fact that some patients in the groups require more complex care than others. These types of model are widely used in, for example, primary care in the English NHS. That said, they tend not to cover other care settings, notably hospital care, and as such not thus far widely used as enablers of integrated care.[152]

There are further examples of more 'value based' funding models in Sweden. These are typically implemented or experimented on a regional level. By way of an example, Stockholm has introduced payment models that reimburse providers for full episodes of care and tie part of the payment on patient outcomes. These models have been introduced for spinal surgery and hip replacements, not yet across wider sets of services. The 'backbone' of these models is the evidence on patient outcomes collected through Quality Registries. The development towards better use of data in designing payment models is a gradual process. Some of the practical challenges include integration of IT systems across the country and addressing variations in the quality of the data collected.[153]

In terms of **resource needs**, developing a sound financing framework for publicly funded services requires time and expertise. To give an indication of the scale of the resource needs, NHS England and NHS Improvement told us that only the team developing prices and costs centrally in the NHS has a headcount of over 70 divided into different business units from producing (modelling) the prices to developing more innovative payment systems for future. In addition, there are significant resources developing pricing inputs at regional and local levels (local commissioners, providers) as well as staff at NHS Digital (see above) involved in the processing of data.[154]

151 Monitor and NHS England (2015).

152 Monitor and NHS England (2015); NHS England (2017); Sauter et al. (2019).

153 The Economist Intelligence Unit (2019).

154 To give an idea of the scale of pricing and costing supported by that national infrastructure, NHS England and NHS Improvement told us that the tariff has around 9,000 prices covering around £76 billion of NHS healthcare, and an annual submission of patient-level costs amounts to some 16 billion healthcare records covering some £100 billion of care. Information provided to Copenhagen Economics by NHS England and NHS Improvement.

4.3 Resources and scale needed for active commissioning based on local health needs

International examples suggest that active engagement with providers and gathering accurate information about patient needs across different areas are key ingredients of 'best practice' commissioning. Commissioners' ability to engage in active commissioning may be limited by resources available to them – e.g. small commissioners may not have staff to actively monitor health needs, to assess providers' performance and, for example, to plan alternative ways to provide preventative and/or integrated care. Further, providers may have a better understanding of the patient needs in the area, the true costs of services and the standard of care.[155]

Recent developments in England suggest that the country is moving towards organising the provision and commissioning of care into larger areas covering different types of health service. In 2013, the NHS in England was divided into 211 Clinical Commissioning Groups (CCGs). The average population size of a CCG is around 250,000 with the numbers ranging from under 100,000 to around a million.[156] There is however an ongoing tendency for CCGs to merge (in April 2019 there were 191 CCGs). Further, the new NHS structure divides the country into 44 regions covering all types of healthcare from primary care to specialist hospital services, with an average population size reaching well above a million inhabitants. These areas are called sustainability and transformation partnerships (STPs), which have been formed to bring together local providers, commissioners and local councils to facilitate planning at a regional level. The STPs are intended to be a key vehicle for agreement on the allocation of resources in the NHS. They are not statutory bodies (the underlying legislation did not change when STPs were introduced), but rather collaborative vehicles developed through central steering from NHS England. In some areas, STPs are forming integrated care systems (ICS). An ICS will take "collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve."[157] It is envisaged that ICSs will bring together healthcare providers as well as local councils and charities with the aim of keeping people out of hospital by providing more care in the community. Thus, STPs and ICSs not only increase the scale of patient populations under each of them, but also bring together commissioners of different types of service that have traditionally been reimbursed from separate budgets and through different payment models. **In all, these developments suggest that CCGs have in many cases been considered too small, and to cover too few**

155 Copenhagen Economics interview with NHS England and NHS Improvement.

156 https://www.nhscc.org/ccgs/ ; CCG data available from: Office of National Statistics: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualsmallareapopulationestimates/2013-08-15

157 NHS England (2019).

services to run the organisation of integrated care. We note that the move towards STPs and ICSs has commenced relatively recently and is still in its infancy when it comes to, for example, development of payment models for integrated care.

Some local commissioning areas have been considered too small for patient choice in Sweden. There are examples of municipalities opening entry through patient choice systems in various services that never receive any applications from private providers; see example of Mora municipality in Chapter 3.2.1. Due to how responsibilities for health and social services are distributed between state, regions and municipalities, there are no consolidations of commissioners. However, municipalities are able to combine patient choice with procurement, which may be more attractive to private providers in small commissioning areas.

Finally, when the English NHS was divided into 211 local commissioning areas, Commissioner Support Units were established. The role of CSU is to help commissioners with analytics, strategies and payment approaches, for example. CSUs are thus effectively public sector 'consultancies' providing local commissioners with expertise they may not have in-house.[158]

In all, these examples suggest that commissioning can benefit from scale, scope and resources of the commissioner while it is still considered important to preserve local-level knowledge. More resources are likely to enable more rigorous contract management, and more specialised resources available for assessing new ways of delivering services and identifying best placed providers to run (some of the) services. The ongoing development in England provides an example where the scaling up of commissioning resource is largely undertaken through nationally steered collaboration, rather than legislative changes or formal mergers between commissioning bodies.

4.4 National-level steering to ensure consistency and support for local commissioning

Different countries, including those under our review, vary considerably in terms of how health and social care policies are governed and enforced. As reported above, at one extreme, the Dutch healthcare system is regulated by national bodies, while in Sweden, regions and local municipalities operate with significant autonomy. In the English NHS, the local commissioners

158 For example, North East London CSU employs over 2000 staff, manages over 8 per cent of the NHS budget covering a population size of 16 million. For more information about their role and remit, see: http://www.nelcsu.nhs.uk/

have been accountable for organising care in their area, however with the support of strong national leading organisations (notably NHS England and NHS Improvement).

There are significant differences in the institutional set-up of different countries, which are often dictated by historical developments. We therefore focused on the specific aspects where national-level steering has contributed to the functioning of the markets. In particular, the following features can support local commissioners, both in terms of adding to the capability needs, which might not be available to small local commissioners and in terms of ensuring consistency and transparency throughout each country.

Reliable evidence of outcomes, performance and costs is a prerequisite for any health and social care system that seeks to promote transparency, comparability and evidence-based decisions by patients and by commissioners. **Central bodies have played a role in ensuring consistency in determining what information is collected and why, and how the data is processed.** Continuous evaluation of what works and why, knowledge sharing and benchmarking between regions are typically centrally led (where they happen). For example:

- As demonstrated above, national bodies run information and evidence gathering in the NHS. While local commissioners can (and do) also collect specific types of information, there are hundreds of nationally monitored indicators for different aspects of operational performance), waiting times, financial viability, clinical quality and patient satisfaction. Changes to existing or establishment of new indicators is subject to a national-level engagement with stakeholders (commissioners, providers, patient representatives, regulators) led by national bodies. As a concrete example, the need for nationally standardised data collection was stressed by Monitor, the regulator in England, in the context of a review of community health services. Unlike many other primary and secondary care services, community services had not been subject to similarly rigorous data collection. Specific data need stressed by Monitor included: (i) activity data (e.g. number of contacts specified by service line); (ii) information on the costs of services provided; (iii) data to measure quality of care, including outcomes and experiences of patients; (iv) staffing and other human resource information; (v) information on the state of premises and facilities; (v) data to benchmark their own services.[159]
- The Swedish National Board of Health and Welfare is often involved in, and sometimes responsible for, the collection of performance data. Similarly, they publish national guidelines that support municipalities and regions

159 Monitor (2015).

> in prioritising and efficiently allocating resources. However, the municipal autonomy is protected with the purpose of being able to meet local needs. National guidelines are therefore often vaguely formulated to allow for regional and local differences. For example, staffing in elderly care should be on par with local needs (not stipulated by national regulations). Further, to address silo-working and scale up the development of 'value based' payment models in the largely decentralised Swedish health care system, a collaboration vehicle called "value-based reimbursement and monitoring of health care (SVEUS)" was implemented. SVEUS is a useful example of brining together private and public sector providers, commissioners and academics to develop innovative payment models with a national-level (rather than just local) focus.[160]

Further, developing an efficient financial architecture that rewards providers for outcomes (not just activity) requires reliable data on costs, on patient outcomes and on the effectiveness of different incentives that can be built into the payment model. **This requires consistency in information gathering and comparability of cost data between providers.** Again, costing programmes are led by national bodies with significant resources and expertise in, for example, the UK (see above).[161]

Both in the Netherlands and the UK, competition authorities (ACM and CMA) have specific roles in healthcare markets. Both countries have also established economic regulators with competition-related powers, choice and procurement-related matters, although in the UK, the role of the regulator has diminished with the general trend of scaling back competition in healthcare (as reported above). In both countries, the healthcare-related roles of competition authorities and sector regulators have been divided between the two authorities. For example, in the context of merger control, the regulators Monitor (England) and NZa (The Netherlands) focus on health aspects while the respective competition authorities have the responsibility of assessing the potential implications of a merger on competition.[162]

National bodies can also develop resources, such as guidelines, to help local commissioners and providers. This type of guidance can help commissioners and providers ensure their approaches to procurement and collaboration with other providers are in line with the relevant procurement regulations and with the competition law. This type of guidance (and associated support) has proven particularly useful in the context of the need for providers to collaborate. The central message of the English and Dutch authorities is

160 The Economist Intelligence Unit (2019).

161 Information provided to Copenhagen Economics by NHS Improvement.

162 Sauter et al (2019). For example, Monitor (now part of NHS England and NHS Improvement) advises the CMA on the assessment of patient benefits of NHS mergers.

that competition rules are not a barrier to collaboration insofar as the collaboration can be shown to benefit patients. However, providers contemplating collaboration, and commissioners contemplating integration of services into bigger, all-encompassing contracts, should be mindful of the potential cost associated with any loss of competition. Box 10 sets out some concrete advise provided by the Dutch and English regulators.

BOX 10. COOPERATION AND COMPETITION

Collaboration and integration of providers is not necessarily incompatible with competition. *Vertical integration* between providers across different care settings (e.g. primary and secondary care, or social-care and primary care) can be effective in enabling seamless patient pathways without the patient having to use (and search) different providers for their multiple needs. The effect of horizontal integration, in turn, depends on the benefits additional scale and service integration brings relative to any loss of competition. Recognising the potential costs and benefits of Monitor (England) and the ACM (Netherlands) have published guidance to help providers and commissioners to ensure their arrangements are indeed designed to benefit patients and do not run the risk of being anti-competitive. Notably:

a) Monitor published several pieces of guidance on the application of procurement rules (including substantive guidance, case scenarios). This included, for example, help for commissioners to determine the circumstances under which an integrated provider "alliance" could be in the interest of patients, if it meant that the number of competitors would be lower than it would be if all services were contracted separately. At the heart of this guidance (and its application in enforcement) was a thorough assessment of patient needs and the care model that best meets those needs. Further, commissioners were told to "ensure they still hold levers to improve care and hold providers accountable" – e.g. ways to terminate contract if performance was found inadequate or financial incentives attached to good performance.

b) Monitor published guidance on the circumstances under which primary care providers can collaborate through a publication of selected practical scenarios. This included scenarios from what providers should consider when contemplating joint bidding for service contracts to cooperation between primary care and hospital services.

c) The ACM published guidance for so called "first line providers" (GPs, physiotherapists, pharmacies etc). The guidance essentially clarifies that providers are allowed to cooperate to improve clinical quality, accessibility and innovation. However, collaboration should not limit choice of patients, lead to collective bargaining with insurers (e.g. boycotting contracting), market share division, or sharing information about prices.

Source: The ACM's guidance is available from: https://www.acm.nl/nl/publicaties/publicatie/14734/Uitgangspunten-toezicht-ACM-op-zorgaanbieders-in-de-eerste-lijn. Monitor's guidance documentation is available from: https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance Monitor (2013), and https://www.gov.uk/government/publications/improving-gp-services-commissioners-and-patient-choice/choice-and-competition-toolkit-scenarios-for-gps-working-together; Monitor (2015).

Finally, in the English NHS, the role of Monitor (the regulator with competition powers in healthcare) was strongly focused on providing the market participants, both commissioners and providers, with informal advice. This consisted of hands-on advice to both sides and support to settle any concerns of anti-competitive commissioning practices and to find acceptable arrangements without formal investigations.[163]

163 Copenhagen Economics interview with NHS Improvement and NHS England.

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