The Governance of Primary Care Quasi-markets:
A Case Study of the Stockholm Region in Sweden

Mirja Sjöblom

Name of degree: PhD
The University of Edinburgh
Year of Presentation: 2021
Abstract and Lay Summary

Background: In the latter part of the 20th century, several European countries introduced quasi-markets in their public healthcare systems. The introduction of quasi-markets is designed to give patients a choice of the service provider that meets their needs, among competing providers, including, in some cases, privately owned providers. In quasi-markets, as “money follows the patient”, often in the form of fee-for-service payments, providers have an incentive to increase technical efficiency (to generate higher surpluses from the payment they receive) and service quality (to attract more patients and therefore generate more revenues), in comparison to a traditional planned resource allocation structure. Whether these improvements in efficiency and quality occur in practice, however, depends on the “rules of the game” in the market: what we in this thesis label the quasi-market’s governance system. The thesis aims to provide an analysis of a specific quasi-market — the primary care quasi-market in Stockholm, Sweden — from the perspectives of key stakeholders who work in or are affected by the relevant governance arrangements. The focus is on how the governance system operates and performs, with specific reference to the achievement of fair competition among providers with different ownership characteristics and the attainment of quality of care for patients.

Methods: A literature review was conducted to identify the existing base of knowledge to which the thesis aims to contribute. The main body of the thesis consists of an embedded case study that analyses how the regional authorities in Stockholm seek to exert influence on primary care providers, publicly and privately owned, and how, in the perception of key stakeholders, the mechanisms deployed impact on the achievement of fair competition and service quality. Key informants included those with the formal authority to govern (e.g. officials/employees of the region’s Health Committee and Health Care Office) alongside those who are subject to the resulting governance arrangements (the accredited service providers). Data was generated from 39 semi-structured interviews with senior professionals in relevant organisations, undertaken between February and November 2018. In addition, a documentary analysis of nine strategic/policy documents
was carried out to further understanding of the governance system, and its impacts on the main outcomes of interest (competition/quality), with triangulation across sources.

**Results:** The results were organised to address the three key objectives of the thesis, as follows:

(i) **What mechanisms are used to govern the quasi-market and how do these influence the incentive environment in which primary care providers operate?**

According to the key informants interviewed, a range of specific mechanisms have been employed by public authorities to exert performance pressure on accredited providers. These include the payment mechanism, market entry/exit criteria, performance monitoring, the use of knowledge management, and a range of sanctions. Of these mechanisms, many informants perceived the payment mechanism to have the greatest impact on incentives. However, they also perceived the effect of this to be moderated by other variables. Primary care providers tended to perceive their actions as being shaped by the actions of different principals — e.g. public authorities, organisation owners, and their professional ethics — resulting in different (and sometimes competing) pressures. When reflecting on the resulting complexity of performance pressures, care providers tended to emphasise the pre-eminence of their values and professional ethics in determining their actions. Care providers also expressed frustration with those who set the rules of the game in the market because of limited opportunities for policy dialogue, and often found command and control-style directions from public authorities to be unhelpful and, in their view, contrary to the advancement of the patient/public interest.

(ii) **How do stakeholders perceive the impact of the governance system on the achievement of competition across providers in a context of diverse ownership characteristics?**

The “rules on paper” (manifested in a standardised contract and an associated rulebook) are designed to ensure that all providers — public and private — operate within the same market conditions, i.e. to ensure that there is fair competition. Yet, according to key stakeholders, the rules in practice lead to a situation in which
providers with different ownership characteristics (a) serve different segments of the market (with publicly owned providers serving as providers of last resort) and (b) operate in different market conditions. Providers with small private owners perceived market conditions to be unfair to them, while public authorities expressed concern over the performance of providers with small private owners. Indeed, the results highlight the extent to which ownership matters in quasi-markets. This is not simply a matter of public versus private, but also the types of private ownership. In particular, larger private owners (often private-equity companies), for whom short-term profit maximisation is a key goal, are perceived to more often pursue profit maximisation strategies that could be inimical to patient welfare, such as unnecessary referral of patients to associated business units in secondary care facilities. These findings highlight the importance of considering ownership characteristics, and particularly the nature and scale of the owner, as determinants of providers’ behaviour in the primary care quasi-market and thus an important variable for governance systems to recognise and regulate.

(iii) How do stakeholders perceive the impact of the governance system on the quality of primary care services? Service providers tended to be sceptical that the outcomes from primary care services are appropriately measured by public authorities. There is a widespread perception among managers of provider organisations that public authorities focus on the “wrong things” — especially those things that are easy to measure (e.g. rapid access to care), as opposed to factors that are less easily measured but are more important from a quality perspective (e.g. continuity of care). In addition, in the absence of robust data on outcomes, public officials tended to perceive the governance of quality to be weak, and highly dependent on trust — in other words, a reliance on providers not engaging in opportunistic behaviours to maximise surpluses/profits at the expense of patient welfare.

Conclusion: This thesis provides critical insights into the governance of primary care quasi-markets and the challenges involved. Key challenges include: (i) the creation of appropriate incentive structures in the context of multiple (and sometimes competing)
accountability relationships; (ii) the complexities and risks of establishing and maintaining fair competition in the context of diverse ownership characteristics; and (iii) establishing accurate measures of service quality and the limitations and risks of reliance on trust. In future reform efforts (in Sweden and elsewhere), health policymakers who wish to achieve the benefits of choice and competition can learn from the Stockholm experience to generate a more granular understanding of the costs and risks involved, and how to mitigate them in practice, noting the additional challenges in governing to achieve public interest objectives in the context of widespread ownership of large for-profit providers.
Acknowledgements

I wish to express my deepest gratitude and thanks to my supervisors, Dr. Mark Hellowell (first supervisor) and Prof. Richard Freeman, at the University of Edinburgh, who have been a constant source of great ideas, support, and inspiration throughout the process of writing this thesis. Your positive and encouraging attitude was very important to me and made it enjoyable to take this project to completion.

I wish to express my thanks to everyone who participated or otherwise supported the research, particularly the interviewees who took valuable time out of their busy schedules.

I also wish to express my infinite appreciation to my family for your enduring support throughout. I particularly want to mention my mother Prof. Yvonne Sjöblom, whose academic career and research are great sources of inspiration to me, and my father Robert Sjöblom, who is always encouraging me and contributes with new and insightful perspectives. Without your support while writing this thesis, it would not have seen the light of day!

I would like to express my sincerest gratitude to my teacher Ronit Singer, who taught me the importance of using my voice.

I am also grateful to many colleagues at the World Bank, faculty of the Managing Markets for Health Course and policymakers I have worked with, who encouraged me to embark on this journey. Amongst them, I’d like to mention Dr. April Harding and Ms. Barbara O’Hanlon, whose passion for thinking about private sector engagement in the health sector has been inspiring, Dr. Monique Vledder, who saw my bigger vision and gave me the flexibility that allowed me carry out this research project while working at the World Bank, and Dr. Tania Dmytraczenko who allowed me time in the end to complete the project.

Special thanks are also due to all staff at the University of Edinburgh for providing resources as well as such an open and supportive academic environment. I have truly enjoyed being a student again! I also would like to express my gratitude to Ms. Sylva M. Caracatsanis, who skilfully and diligently edited and formatted the final manuscript.
Finally, I want to thank many friends and other supporters, who appeared along the way of the journey and generously shared ideas, articles, books, and introductions to experts, or just some words of support when I needed it the most. I am sincerely grateful to you and feel blessed to have you in my life.
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1 Introduction to the Thesis

1.1 Introduction

On September 1, 2020, a privately owned predominately digital primary care service provider, Kry, opened the doors of its first two physical primary health care centres in Stockholm. Their objective was to combine digital and physical (in-person) primary care, thereby increasing patient access (Kry, 2020). A politician from the Stockholm Region\footnote{As of January 1, 2020, the name County Council was replaced with Region. Henceforth, County Council and Region are used synonymously in this thesis. Source: Government of Sweden (2019).}, the government entity responsible for the governance and implementation of all publicly financed health care in the Stockholm Region, was present to cut the ribbon (DN, 2020b).

In October, only a month later, and to widespread surprise, market shares in the primary care market had shifted drastically. In a short space of time, over 10,000 patients had chosen to register with Kry (DN, 2020c). As each registered patient generates a capitation payment for their chosen care provider, this rapid transfer of patients to Kry meant that some of the existing providers lost a large fraction of their main revenue source in just a few weeks.

The primary care service providers that had lost patients were furious and claimed that Kry had used dubious means to encourage patients to transfer to Kry — for example, by using their own digital application for transferring patients rather than a neutral platform (Cederberg, 2020). These providers, mostly small privately owned providers, also expressed concerns as their ‘patient mix’ shifted towards more costly patients (i.e. those who were sicker and older, and less likely to seek digital care), and they stated that left with these patients only they risked going bankrupt.

Kry, on the other hand, stated that they had not broken any rules, and that patients had made their choice for a better service (digital and physical services combined).

A researcher from Lund university in Sweden stated that “Kry is phenomenal at finding small loopholes in the system that they can take advantage of” (Forsberg, 2020). A representative from the Stockholm Region said that while Kry had not necessarily broken
any rules of the market, its actions had exposed a lack of clarity on what information should appear when registering patients, and noted that the Stockholm Region would now produce clearer guidelines (Cederberg, 2020). But the market shares had already changed in Kry's favour. With the new guidelines, was there a way back now?

1.2 Introduction to the Theory of Quasi-markets

The events described above were reported to have occurred in the primary care market in Stockholm in the fall of 2020. This is a market characterised by public funding of primary care (raised primarily through taxation), which is used to provide revenues for public and private sector primary care providers, who compete with one another to attract patient-related per capita (capitation) payments, such that revenues “follow the patient” (Anell & Glenngård, 2012).

Le Grand (1991, 2003) called this type of market a quasi-market, i.e. one in which the state is a funder but not necessarily a provider of services of public interest (Le Grand 1991). In such a quasi-market, there is competition between service providers for market share and the associated revenues (as in a regular market), but the services provided are publicly funded, and the markets are heavily regulated — including, in many cases, through fixed consumer prices set by the government, which means that providers compete on quality of services (rather than price) to attract patients (Brekke et al., 2014).

This means that there are incentives for service providers to bring down costs and thereby drive efficiency, as the revenue generated by the providers for a specific treatment is fixed regardless of the cost of care, and the provider can keep the difference between the reimbursement rate and the actual cost (Propper et al., 2006). Importantly, the incentives associated with a fixed price do not necessarily drive quality of care, and this is where patient choice comes into the picture — as patients generate revenue, the free choice of service providers by the user is a key feature in the quasi-market.

It is relevant to mention first that health care markets differ from regular markets because the product is differentiated (each user/patient gets a slightly different product) and there are information asymmetries between buyers (users/patients) and sellers (service
Because of these market failures, health care markets require government regulation (e.g. through entry barriers in the form of licensing of medical staff to guarantee a minimum quality of care) (Propper et al., 2018). As Arrow stated already in 1963, given the asymmetric information in medical care, and since the customer cannot test the services offered by the providers before consuming it, there is an important element of trust in the patient–provider relation, where the provider’s behaviour “is supposed to be governed by a concern for the customer’s welfare, which would not be expected by a salesman [in a regular market]” (Arrow, 1963, p. 949).

Within the framework of the quasi-market, however, the user is seen as best placed to determine how best to maximise their utility, and by having a choice of provider they will be able to choose what is best for them (Fotaki, 2007). This view is anchored in basic precepts of neo-classical economics, with its emphasis on the value of property rights, competition, and individual choice (e.g. Friedman & Friedman, 1980) (Fotaki, 2007).

Reforms to create quasi-markets were introduced in several wealthy countries, including Sweden, in the latter part of the 20th century (Gingrich, 2011). These reforms were, in many cases, introduced in response to rapidly growing concerns about health care costs in the context of budgetary constraints and certain quality of care issues, including long waiting times, becoming higher-profile political issues (Le Grand, 2007, 2009).

Views concerning the desirability of these policies are highly polarised. Advocates have linked the implementation of quasi-markets to a range of performance improvements, where important aspects of service quality, including better access, greater efficiency, and superior quality, are emphasised (e.g. Gratzer, 2006; Le Grand & Bartlett, 1993). It has also been argued that quasi-markets benefit the citizens, as they are given a greater choice to access services from a diverse range of providers rather than only the state (Le Grand, 2007). In contrast, opponents have claimed that the introduction of the profit motive creates undesirable incentives, which may come at the expense of social objectives, such as ensuring the availability of high-quality services for all citizens, including the poor and marginalised, with adverse impacts with regard to equity in access and financial protection (e.g. Dahlgren, 2008; Gingrich, 2011).
As mentioned above, economic theory predicts that quasi-markets will deliver on public interest objectives, including technical efficiency and service quality, by creating an incentive for providers to compete for patients and thereby maximise their net revenue (Brekke et al., 2014). In the absence of price competition, achieving high service quality is the only way to encourage existing users to retain their services and new users to select them (Le Grand & Bartlett, 1993; Le Grand, 2007; Propper et al., 2006).

However, theorists also stipulate that quasi-markets only operate this way if certain conditions are in place (Brekke et al., 2014) and stress the importance of institutions of the market being appropriately designed to create a conducive incentive environment for users/patients and providers (Propper et al., 2006). For instance, quasi-markets may not deliver on public interest objectives if patients’ choices are not driven by quality of care. This may be the case if patients do not have good information about differences in the quality of care offered by different providers (Le Grand, 2009). This may be the case for patients in general, in which case providers have no incentive to treat them. More likely, it may be the case for some specific categories of patients, e.g. those who have severe illnesses and are therefore more costly to treat. In such cases, providers have an incentive to focus on low-cost patients (‘creaming’) or eliminate the supply of services to high-cost patients (‘dumping’), or give such patients reduced quality of care (‘skimping’) (Ellis, 1998), rather than compete to retain or win their business.

These risks exist in a medical market without competition, but competition, as in a quasi-market, is likely to sharpen them (Propper et al., 2006). Further, the extent to which quasi-markets will serve public interest objectives is uncertain if provider organisations’ preferences and behaviours do not respond to competition pressures in the ways that economic theory predicts — which may be the case if, for example, senior staff working in such organisations respond less strongly to financial incentives than anticipated, and/or their behaviours are more strongly influenced by professional norms and/or altruistic concerns for patients’ health (e.g. Brekke et al., 2011; Vengberg et al., 2019). Finally, and as shown in, for example, employment services quasi-markets, there is also a risk that providers will respond to competitive pressures not by enhancing quality and reducing
production costs, as predicted by theory, but by gaming the system in ways that are non-conducive to the maintenance of efficiency and quality (Considine & O'Sullivan, 2015).

Therefore, in quasi-markets of this form, key aspects of market governance — the “rules of the game” established by public authorities, the mechanisms through which these rules are implemented, enforced, and monitored, and how and the extent to which these efforts actually influence the incentive and accountability environment faced by service providers in the market — are critical. If the rules of the game are inadequately comprehensive, poorly implemented, or unevenly observed, or (for some reason) are failing to drive the incentives and behaviours of market players as intended, then the public interest implications of quasi-markets are uncertain. There is, then, a pressing need to understand how (and how well) governance regimes work in practice.

This is the focus of the thesis. It examines how the primary care quasi-market in the Stockholm Region, Sweden, is governed, focusing on the perceptions of key stakeholders across the organisations involved as providers in the market and the governance system established for it.

1.3 Primary Care Choice Reforms in Sweden

In Sweden, several of the 21 regions, that are responsible for financing and managing primary care, began to experiment with quasi-market reforms to introduce both competition and patient choice in the primary care market as early as 2007. The Stockholm Region was a front-runner in these reform efforts and prior to the enactment of a national law that cemented the reform nationwide, Stockholm adopted patient choice and competition in primary care markets in 2008, hereafter called the Primary Care Choice Reform (PCCR).

Based on the experience in Stockholm and other front-runner regions, an official government report titled ‘The Freedom of Choice Act’ (Swe. LOV att välja – lag om valfrihetssystem) (Government of Sweden, 2008, p. 15) recommended a new national law to allow for competition between providers and user choice for a number of welfare services (including primary, disability, and elderly care). Accordingly, the government
introduced the new law in 2010 that made freedom of establishment for primary care providers (regardless of ownership status) with public payment and patient choice mandatory for all 21 regions in the country (Anell, 2015). Following the new law, and in accordance with how the health sector is governed in Sweden (described in Chapter 2), each region promulgated or changed regulations to establish a primary care governance system that complied with the national directive.

These reform efforts represented a fundamental shift in the governance of primary care where the regions changed the management and control of providers to fit the Choice model (Anell, 2011). They set in place arrangements whereby public agencies and officials governed a market of public and private providers to achieve public health objectives, and they involved the development of a complex set of relationships and accountability mechanisms congruent with ‘steering’ a mixed economy of independent organisations in primary care provision. The arrangements also involved balancing many potentially conflicting objectives, interests, and preferences of various actors in support of health care policy goals (Glenngård, 2016).

A growing body of empirical literature documents the impact of these reforms on various facets of primary care performance, including accessibility, equity, cost efficiency, clinical quality, productivity, patient satisfaction, and effectiveness (see Annex A for a summary of the literature). There are also a number of studies (e.g. Anell et al., 2012b; Berg & Ingre, 2013; Glenngård, 2019; SOU, 2017; Swedish Agency for Health and Care Services Analysis, 2017) that examine what governance mechanisms exist through which the regions seek to ‘steer’ primary care providers. However, detailed analyses of the mechanisms and processes through which providers are regulated and how they are perceived by the providers themselves are rare. Moreover, few studies have reported how the governance system is perceived by different types of providers, with different ownership characteristics (public/private, small, and large owners). Yet, the example above of the establishment of a new provider, Kry, in Stockholm, shows that the governance system matters for the functioning of this market and for its ability to deliver on public interest objectives.
What did it mean, in practice, to establish this new way of governing primary care? How do you govern for high-quality health care in a quasi-market when providers may skimp on quality to maximise profit? And how do you create an equal playing field between all providers in a primary care market, with both public and private providers? Most importantly, what was the thinking behind the establishment of the rules of the market and how are these rules perceived by those who operate in the market? These were some of the questions that I wanted to explore when I embarked on this research project to study the governance of the primary health care quasi-market in the Stockholm Region.

Sweden is an excellent laboratory for study of the governance of quasi-markets for several reasons. First, it is one of the few countries of the Organisation for Economic Co-operation and Development (OECD) that quite recently transitioned from primarily publicly provided primary care to more private delivery. Most OECD countries already had predominately private sector ownership and market forces present in primary care when Sweden went through this transition (OECD, 2016). Second, patient choice has been a critical political trend in recent decades in Sweden (Winblad et al., 2021). Third, the transition to the PCCR occurred about a decade ago; thus, the quasi-market governance system is not new but has settled and is therefore mature enough to study. Fourth, Esping-Andersen (1990), in his classic classification of systems of modern welfare states, categorised Sweden as a social democratic welfare state, with a strong role of the government in the welfare state. Thus, I speculate that if there is anywhere that a government would have the capacity to govern a market well, it would be in this type of welfare system, where the state is already strong. Hence, it provides an interesting country to study.

1.4 What This Thesis Will Do

Following from the above, this thesis explores how primary care quasi-market–style governance mechanisms have been operationalised after the PCCR in the most populous region in Sweden, Stockholm. It examines how public authorities and both public and private providers perceive the rules of the game established by public authorities, the mechanisms through which these rules are implemented, enforced, and monitored, and
the incentive environment the governance system gives rise to, from the perceptions of those who govern and those who are being governed.

As mentioned above, quasi-markets are different from regular markets because there is an inherent contraposition in the quasi-market between quality and competition. On the one hand, the market regulator wants to place some entry barriers for providers to guarantee that providers fulfil minimum standards with regard to quality of services. On the other hand, the market regulator wants to create competition in the market to ensure quality competition by ensuring that many providers can enter the market (SOU, 2016). To study in practice how the Stockholm Region is balancing these acts through regulation therefore becomes the focus of my thesis. I examine how key aspects of policy formulation, with regard to achieving quality of care and competition, are realised and managed through the governance system.

In doing so, this thesis’ overarching aim is to explore the governance system of the primary care quasi-market in the Stockholm Region, Sweden, and examine how this system is perceived by different stakeholders.

To achieve this, it answers the following research questions:

1. What mechanisms are used to govern the quasi-market and how do these influence the incentive environment in which primary care providers operate?
2. How do stakeholders perceive the impact of the governance system on the achievement of competition across providers in a context of diverse ownership characteristics?
3. How do stakeholders perceive the impact of the governance system on quality of primary care services?

The thesis will first discuss the research setting and then outline my structured narrative review of the existing literature on governance of primary care quasi-markets, discuss important research gaps, and clarify how this thesis contributes to addressing them. The thesis then outlines how I designed a qualitative embedded case study to explore stakeholders’ perceptions of the mechanisms put in place to govern the primary care quasi-market in the Stockholm Region. The case study was taken forward through:
(1) semi-structured in-depth interviews with regional-level politicians/market shapers/regulators; (2) semi-structured in-depth interviews with individuals (chiefly heads of units) in purposely selected primary care facilities; and (3) documentary sources, including strategies, policies, and plans related to primary care in the Stockholm Region. The findings of the case study contribute to knowledge of the mechanisms that are used to govern primary care quasi-markets — and provides an example of a context in which there are multiple “hybrid” forms of accountability at different levels (micro, meso, and macro) of the governance system — in addition to how they work and why they work as they do.

The thesis seeks to contribute to knowledge about aspects of the governance of quasi-markets that are currently under-studied yet crucial for competitive fixed-price regimes to deliver on public interest objectives — including how public authorities balance the promotion of distinct, and sometimes competing, objectives. Finally, by bringing in the perspectives of the heads of units, I seek to shed light on how health care providers perceive the governance system and its effect on provider behaviour. I bring in the views of providers with different type of owners; those that are publicly owned by Health Care Services Stockholm County (SLSO), a large state-owned organisation that manages the public units in the Stockholm Region, and those privately owned providers owned by large corporations, which are sometimes owned by holders of private equity, as well as those private facilities that are owned by one or a few professionals who often work in the primary health care units.

With the empirical data on how governance is conducted in practice, I hope to provide data and analysis that is valuable for policymakers (defined generally as government authorities and their interlocutors amongst non-state actors, international organisations, and development actors) who are implementing or advising on reforms to establish or expand competition in core public service areas.

I am myself one of these interlocutors within the World Bank, where I work as a Senior Economist in the health, nutrition, and population practice. Based on over 15 years of experience advising policymakers on health system reforms, I know, from first-hand experience, that practical evidence on how to govern health care markets and particularly
quasi-markets is limited. The lack of knowledge and expertise in this area comes at great cost for social welfare in many countries that are struggling to devise the right policy to create governance systems, inclusive of private and public providers, that deliver on public interest objectives.

As I will explain in Chapter 4, my research questions are inspired from inquiries I have gotten by government officials in my professional career, and my motivation for doing this thesis originates from my own search for knowledge about how to best answer these questions in the future. For years, I have been troubled by the fact that we do not have sound knowledge when it comes to governing health care markets. I am sincerely hoping that this thesis will be one amongst many other current and future contributions that will help us to create a more solid foundation to stand on regarding how to govern health care markets, as I believe this is a key pillar in the quest to expand universal health coverage globally.

My research was conducted between 2017 and 2021, a period that includes one of the worst public health emergencies, the COVID-19 pandemic, in modern history. As a result, there is growing realisation of the importance of primary care in the ability of countries to prepare for and respond to health emergencies, and there are renewed efforts to increase the priority afforded to primary care as the single most (cost-)effective mechanism to obtain equitable and resilient health systems and accelerate progress towards universal health coverage (World Bank, 2021). In this context, it is both desirable and probable that primary care will receive growing attention as governments and health systems seek to manage the longevity of the current pandemic and “build back better” in its wake.

As primary health care systems are strengthened in Stockholm, Sweden, and globally, I am hopeful that the insights from this research project can enrich and inform the policy dialogue concerning how to govern primary care systems, most of which are “mixed” (both public and private owners) in terms of their ownership characteristics (Grépin, 2016; Paris et al., 2010) and, often, at least in OECD countries, contain some elements of patient choice and competition (OECD, 2016) for the achievement of social objectives.
1.5 Definition of Key Concepts

This section defines key concepts in the thesis.

1.5.1 Defining Governance

This section discusses the concept of governance as it has been defined in the existing health systems literature. It then clarifies how the concept will be deployed in this thesis.

Governance has been an important concept across many areas of public policy (e.g. Ostrom, 1990). In the health sector, the concept began to be used around the turn of the century, with an early example being Moran’s conceptualisation of “governing in health” as incorporating the making of authoritative decisions, creation of the means to put those into effect, and mobilising support for them (Moran, 1999, p. 5). This was followed in the World Health Organization’s (WHO) landmark ‘World Health Report 2000’, in which the concept of “stewardship” was introduced and placed among three other “core” health system functions (the others being financing, resource generation, and service delivery) that drive performance.

It is worth mentioning here that in the literature in general, governance and stewardship are often used as synonyms (Barbazza & Tello, 2014). In this thesis, I mostly refer to governance, not stewardship. In accordance with the ‘World Health Report 2000’, I perceive “stewardship” as the role of the state in ensuring sound governance of the health system. The report defines stewardship as “defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information” (WHO, 2000, p. xiv), and focuses on the government’s pre-eminent responsibility for ensuring the well-being of the population by fulfilling the “core” health system functions (Brinkerhoff et al., 2019).

To further develop the hitherto vague concept of “stewardship”, WHO et al. (2002) emphasised the importance of the process of governing as well as the functions of governance. They further defined six domains or “sub-functions” of stewardship, namely: (1) generation of intelligence; (2) formulation of strategic policy direction; (3) ensuring
tools for implementation (powers, incentives, and sanctions); (4) building coalitions/partnerships; (5) ensuring a fit between policy objectives and organisational structure and culture; and (6) ensuring accountability, each of which were discussed in detail in their seminal work.

This elaboration of the concept of stewardship is helpful as it highlights the relationships between stewardship and other related concepts. In their structure, stewardship/governance is the overarching system that is composed of different sub-functions, including tools for implementation. These tools (e.g. incentives/sanctions, regulations) and other functions, such as partnership building, are subordinates of the function of stewardship.

WHO et al. (2002) also stressed the existence of several common challenges associated with the exercise of stewardship/governance, including: (a) the fact that setting objectives is not enough as it is also necessary to act on these (e.g. through necessary adjustments in budget allocations); (b) the fact that the modern state is often decentralised such that the “stewards”’ powers are not always commensurate with their explicit responsibilities; and (c) that many issues of critical policy interest are outside of the scope of the existing regulatory framework.

Drawing on the practical elaboration of stewardship of WHO et al. (2002), the WHO reframed stewardship in 2007 as leadership and governance, describing this as “ensuring [that] strategic policy frameworks exist and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability” (WHO, 2007, p. 5). This version of the concept was included as one of seven health system “building blocks” that, it was asserted, are required for a health system to function well (WHO, 2007). This descriptive framework has been extremely influential in global health research and practice in the succeeding years.

However, if governance is a health system function, its content remains vague and there are no established indicators for measuring it. In their review of health governance, Barbazza and Tello (2014) found that studies on governance in the health sector tend to be characterised by normative biases, conceptual misunderstandings, and a general lack
of clarity on how relevant sub-functions should be defined, assessed, and operationalised. Despite this, this function is often considered to be the most important function of the state in relation to the health system, as well as the most complex one to get right (Smith et al., 2012).

Outside of the WHO, academics have attempted to understand and operationalise the concept of leadership and governance in the health sector. Veillard et al. (2011) conducted a multidisciplinary review of the literature on health system stewardship—which they used explicitly as a synonym for governance. Based on this review, they developed an operational framework of six key sub-functions, namely: (1) to define the vision for health and the strategy to achieve better health; (2) to exert influence across all sectors for better health; (3) to govern the health system in a way that is consistent with prevailing values; (4) to ensure that system design is aligned with health system goals; (5) to better leverage available legal and regulatory instruments; and (6) to compile, disseminate, and apply intelligence.

It can be seen that the various frameworks are similar in terms of substance, even if the presentation and lexicon differ slightly. For this thesis, I find Smith et al.'s (2012) description of governance the most useful, as, in addition to identifying sub-functions, it clarifies the different roles of the state in various governance “modes”. While Smith et al. (2012) state that “governance can [generically] be defined as social coordination” (p. 3), they describe three different modes of governance — hierarchy, market, and network (Bouckaert et al., 2010; Thompson et al., 1991) — and argue that each of these calls for different actions by states.

Hierarchies, as in the classical bureaucratic model (Weber, 1922/1983), are characterised by a formal structure, rules-based management with clear procedures and objectives, specialised human resources with clearly defined areas of responsibility, and promotions based on technical qualifications and skills. In such a hierarchical structure, the state defines rules, allocates resources and responsibilities, and exercises top-down direct control (Smith et al., 2012).

Markets, on the other hand, involve the interaction of demand and supply, these variables determining the prices and quantities of goods and services produced and consumed,
with the state’s role being primarily one of designing and enforcing regulation, and (re)shaping incentives through subsidising “buyers”, or purchasing from “sellers”, in the market (Smith et al., 2012).

*Networks* are characterised by reciprocal patterns of communication and exchange and are less dependent on the top-down exercise of power compared to bureaucratic structures. This form of governance is portrayed as an alternative to both markets and hierarchy, and it is characterised by horizontal collaboration, decentralisation, fluid decision-making structures, joint learning, and competition. In such structures, the state establishes common values and knowledge, and it manages these through strengthening of professional norms and information (Smith et al., 2012).

Hierarchy was the most prominent governance model for public administration in the 20th century (Hughes, 2003). However, in the early 1990s, scholars began to describe a shift from bureaucratic and hierarchical governance to network governance, reflecting in part the larger number of non-state actors involved in policy implementation — including in the form of service delivery to the population (Sørensen & Torfing, 2007). In both the market and the network modes of governance, the state relinquishes control compared to that of the traditional hierarchical form of governance. In the United States (US), this shift is expressed in Osborne and Gaebler’s (1992) classic book *Reinventing Government* that discussed the role of a catalytic government in steering rather than rowing in public policy.

Smith et al. (2012) define the functions of governance in the form of a “cybernetic model” with three fundamental functions: priority setting, performance monitoring, and accountability arrangements. While Smith et al.’s model is not fundamentally different from the previous conceptualisations, it is more fully elaborated, especially in terms of capturing and distilling the complexity of governance into these three core sub-functions, as follows.

*Priority setting* involves setting clear goals, and translating them into targets and operational actions. This may involve defining benefit packages that citizens are entitled to as well as targets — e.g. related to waiting times, access guarantees, or standards for patient safety. *Performance monitoring* involves capturing reliable, accurate, and timely data on inputs, activities, and outputs of the health system. It involves analysis and
dissemination of data to inform stakeholders, create transparency, and help steer the health system to better outcomes. *Accountability arrangements* can be described as mechanisms that allow stakeholders to express their judgement of service providers and, if needed, take corrective action. These mechanisms may take different forms and several may be used simultaneously, including in markets where users of the system vote with their feet (as in the primary care quasi-market in Sweden), through a democratic process where voters pass judgements on political leaders, or through incentives/sanctions in payment or accreditation systems (Smith et al., 2012).

To depict the governance system and organise my empirical data on the mechanisms of governance used by public authorities, I drew on Smith et al.’s (2012) conceptualisation alongside the seven elements for “market organisation” developed by Ahrne et al. (2015) and Andersson et al. (2017). I use this framework as it provides a more detailed account (beyond the functions of governance) to describe the actual governance mechanisms (e.g. rules, sanctions [or incentives], etc.) used to exert influence on a market system and carry out the functions described in Smith et al.’s “cybernetic model”. A more detailed account of Ahrne et al.’s (2015) framework is given in Chapter 4.

As mentioned above, governance is a central concept in this thesis that I explore through my empirical data. While I ask about governance in my interviews, I do not define the term for the interviewees. Thus, the interviewees have interpreted the concept of governance according to how they understand it. I am interested through this examination to understand how governance is understood and perceived by my interviewees and to explore, from their perspectives, what is governing their actions. Thus, I am using the concept in an open way and through the actors in the market I am exploring how they understand and see governance of the primary care quasi-market in Stockholm, Sweden.

I use the terms “governance arrangements”, “governance system”, and “governance regime” synonymously as well as the terms “mechanism”, “instrument”, and “control” — as phenomena used by public authorities to influence the governance system and the operation and performance of the quasi-market.
1.5.2 Defining Competition

As mentioned, in Section 1.2, competition is important in the theory of quasi-markets, and it is included in my research question and therefore a key concept in my thesis.

Stigler (2008) defines competition as what “arises whenever two or more parties strive for something that all cannot obtain” (para. 1) and notes that classic economists felt no need for a very precise definition of competition because they viewed monopoly as highly exceptional … [and] the concept of perfect competition emerged as the standard model of economic theory and as first approximation in the concrete studies of applied microeconomics. (Stigler, 2008, para. 1)

More recent work (Listra, 2015) shows, based on an overview of the concept of competition in the literature, that although the concept “competition” is used regularly in both public and business discussions about economic units, conceptual clarity of the term is lacking and the concept is dependent on the problem being analysed.

Listra (2015) defines a unified framework for analysis on competition (and competitiveness) that focuses on six dimensions, namely, defining:

1. The focal unit of competition (i.e. the competitor that could be bound in a group, e.g. an organisation or a firm).
2. The objective of competition (the underlying variable of competition, e.g. price, quantity, and quality, the aimed level of achievement, and the competitive process).
3. The internal and external determinants of competitiveness (the focal unit’s internal structure such as the resource base of the firm).
4. The relationships influencing the competitive process (market exchange, networks, hierarchies, institutions).
5. The internal and/or external competition environment (e.g. static, stationary, or changing).
6. The purpose of the modelling (how analysis of competitive environment is carried out and for the benefit of whom).
I see competition in accordance with the theory of quasi-markets described in Section 1.2. Using Listra’s (2015) framework and Stigler’s (2008) definition, for the purpose of this thesis, competition is defined as what arises whenever two or more parties, here primary care units, strive for something that all cannot obtain (market share that is associated with revenue). Thus, in this thesis the focal unit of competition is the primary care unit in the Stockholm Region. Since the price is regulated, the underlying variable of competition is quality of care, which is to some extent linked to quantity as timely access to health care services is one component of quality of care. The objective of competition is for primary care units to compete for market share and associated revenue. Other dimensions included in Stigler’s unified framework, such as internal and external determinants of competitiveness, the relationships influencing the competitive process, and the internal and/or external competition environment, are explored in the thesis as it examines the incentive environment, in the quasi-market that the governance mechanisms give rise to. Lastly, the aim of the analysis of competition is to explore the governance system of the primary care quasi-market in the Stockholm Region and it is not for the benefit of any particular stakeholder.

Other key concepts related to competition that I use in the thesis are competition neutrality and level playing field. These are key concepts because in the quasi-market a role of the governance system is to create a situation where all providers in the market, regardless of ownership and size, compete on an equal footing. This, in turn, would ensure that the competitive environment creates incentives for providers to compete for patients and thereby maximise their net revenue (Brekke et al., 2014).

In this thesis, I define competition neutrality as a situation where no advantage is shown to any focal unit of competition in the market. This in turn creates a “level playing field” that is defined, in this thesis, as a situation in which everyone has the same chance of succeeding in the market, or in this case, in gaining market share or revenue.
1.5.3 Defining Quality of Care

My research includes an examination of how public authorities “govern” to achieve quality of care.

According to the WHO (2022), “quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes” (para. 1), and this is also how I define quality of care in this thesis.

Quality of care encompasses various dimensions including the provision of effective care that is evidence-based and provided to the target population in need, safe care where harm is avoided, and people-centred care that responds to the individual’s preferences, needs, and values (WHO, 2022).

I find the Donabedian (1988) conceptual model for evaluating quality of care useful for the purpose of this thesis and when discussing how public authorities govern to achieve quality of care and I use it throughout the thesis. It proposes that data on quality of care can be drawn from three categories: “structure”, “process”, and “outcomes”. Structural indicators collect information about the context in which health care is provided (e.g. infrastructure, equipment, health care workers, financing, etc.). Process indicators focus on collecting information on the transaction between the patient and the provider (e.g. if providers follow stipulated clinical guidelines when delivering care), and outcome indicators focus on information about the effects of health care on the users of services or populations (e.g. changes in health status).

As described in Section 1.2, the quasi-market theory predicts that in a fixed-price regime (regulated by the government) with competing providers where revenues follow the patient, providers will compete on quality of services to attract patients (Brekke et al., 2014). Thus, in theory, provider behaviour will drive improved quality of care. However, and as will be discussed in the literature review, this theoretical prediction may not hold in practice, and it depends crucially on the institutional environment (and especially the quality of information that is held by market actors). This is something that will be elaborated on in the literature review and the thesis, and Chapter 7 in particular will explore the mechanisms used by public authorities to govern with regard to achieving
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quality of care and how these mechanisms are perceived by public authorities and service providers.

1.5.4 Defining Ownership

Another key concept used in this thesis is ownership of primary health care units, as I examine health care centres with different ownership characteristics.

In their seminal work, exploring why one firm would ever buy another firm rather than conduct business with that firm through a contract, Grossman and Hart (1986) define ownership as “the power to exercise control” (p. 694), where the shareholders could have control, or it could be delegated to the board of directors (i.e. management).

Grossman and Hart (1986) discuss that granting ownership implies the residual right to control (or decision rights), which is the right that is not possible to regulate in a contract because contracts are incomplete (since events will always occur that could not be foreseen when a contract was signed). They develop their definition of ownership and conclude that “ownership is the purchase of these residual rights” (Grossman & Hart, 1986, p. 691). I am mentioning the concept of residual rights here as I will come back to it in the literature review in Chapter 3.

In the literature on primary care, Crampton (2005) defines ownership as “governance responsibility (ultimate control) for an organization and accountability for its actions” (p. 2). I find this definition less helpful as it blurs ownership and governance (another key concept in my thesis) as well as control and accountability in one definition.

For this thesis, I use Grossman and Hart’s (1986) definition of ownership, i.e. “the power of exercise control” (p. 694) through the purchase of residual rights useful, because they specify that there are pressures or controls that can be exercised on an organisation/firm beyond what can be specified in a contract (e.g. between a purchaser and a service provider of health care). This is what I explore in the thesis when I study the impact of the governance system in the context of providers with diverse ownership characteristics.
My sample of providers has different types of owners. Primary health care facilities in Stockholm are either government-owned and operated or privately owned and operated. In Sweden, the share of not-for-profit private actors in the primary care quasi-market is very small (SOU, 2016), and I was therefore not able to include any units with this ownership characteristic in my thesis.

Amongst the privately owned group, there are those that are owned by smaller owners, for example, a group of health care professionals, who often are engaged in the daily operations of running a primary care clinic. These are small and medium-sized enterprises. But I also include privately owned organisations that are owned by large investor-owned businesses. These large organisations are owned by shareholders or a private-equity company, that is, an investment firm that invests in a business with the goal of increasing its value over time before eventually selling the company at a profit (Pitchbook, 2021).

Henceforth, I refer to private units that are not owned by large corporations as “small private units” and those that are owned by large corporations as “large private units”. Thus, the size is not a reflection of the size of the unit but rather the size of the owner(s). Public units are those that are owned by SLSO.

I want to explore if providers with these different ownership characteristics perceive the impact of the governance system differently. My hypothesis is that the different owners may have different objective functions and thereby exercise different controls on their providers. For instance, an owner who is under pressure to generate strong revenue flows for a potential buyer of the company (i.e. a private-equity owner) may run the health care unit in a different way than a public facility that is not under the same pressure to generate profit.

1.5.5 Defining Incentives

For the purpose of this thesis, incentives are defined as “something that encourages a person to do something” (Cambridge Dictionary, n.d., para. 1), where the person could also be several people or an organisation. It can be a rule or regulation that motivates or
drives a primary care provider to do something or behave in a certain way (see Box 1). Incentives, or sanctions, is one instrument that policymakers use to govern the quasi-market.

There are different types of incentives discussed in this thesis. Incentives can be extrinsic (i.e. created by a desire to get something, such as a material reward, additional status, or prestige) or intrinsic (i.e. created by a sense of personal fulfilment and satisfaction that comes from “a job well done”). Thus, the scope of this incentive definition is wider than financial incentives — which are only a subset of extrinsic incentives.

The term “incentive environment” is the combination of multiple incentives, rules, and other instruments used by policymakers to govern the market, which give rise to an incentive environment or incentive structure (I use these terms synonymously), recognising that there is rarely only one incentive at play, but multiple ones. In essence, I see the public authorities as carrying out different functions of governance (priority setting, performance monitoring, and accountability arrangements) by using different mechanisms or instruments (e.g. incentives, rules), which together result in an “incentive environment” that is recognised by the actors that operate in the market.

According to previous literature, which I will give an account of in Chapter 3, theory predicts that ownership affects incentives and behaviour in response.

1.5.6  Defining Primary Care

The general definition of primary care used in Sweden, and the one I use in this thesis, is:

health care activities where outpatient care is provided without delimitation in terms of diseases, age or patient groups. Primary care is responsible for needs of such measures in the form of medical assessment and treatment, nursing, preventive work and rehabilitation that do not require special medical or technical resources or any other special skills. (Sveriges Riksdag, 2017, para. 6)

Sweden has a decentralised governance system, which means that the exact package of medical services provided in primary care settings varies by region. In the Stockholm
Region, the subject of this study, there were 46 patient choice domains in April 2019 (areas of care where patients can choose providers), of which nine belonged to primary care. These were: (1) general practice with basic homecare; (2) child welfare centres; (3) maternity care centre/midwife clinic; (4) footcare; (5) speech therapy; (6) medical interventions in special accommodations; (7) primary hearing rehabilitation; (8) primary care rehabilitation; and (9) specialised physiotherapy (SRHCO, 2019).

In this thesis, primary care concerns the first of these patient choice areas, namely general practice with basic home care, which is the largest area with regard to patient volume in Stockholm. According to the SRHCO, the general assignment for this choice area is:

1. **The general practice**, which includes reception activities and home visits. The health centre should function as the coordinator of care for patients in the overall health care system and give the patient knowledge and support to self-care.
2. **Basic home care** including assessing, planning, and coordinating the entire home care needs of the patient throughout the day, and to perform home care throughout the day as well as home interventions during the day on the weekend.
3. **Psychosocial care** provided by staff with special competences and including mild to moderate mental illness such as anxiety, depression, and stress as well as crisis support.
4. **General practice emergency service**, which is a complement to emergency care at the hospital level, where medical assessment and counselling by phone and in the health care unit is provided during weekends from 8 am to 5 pm.
5. **Local infection control and partnership against antimicrobial resistance**.

There are also some primary care units (at least 13% of primary care units in Stockholm had these in 2019) that have additional tasks than the ones listed above. These are defined in four areas and include: “health-promoting population-oriented initiatives, first-line mental care for children and young people with mental illness, rehabilitation for long-term non-specific pain and health examination for asylum seekers” (SRHCO, 2019, p. 17). I was informed during the interviews with primary care health care units whether
they had the general assignment and/or additional tasks and at least one facility had the special task of providing psychosocial care.

1.6 Thesis Outline

Chapter 2 gives a short introduction to the research setting. It introduces the Swedish health care system and the overall political system, as well as the regional governance structure in the Stockholm Region, where the case study takes place. Subsequently, this chapter provides an account of the historical reform context in Sweden and the background to the introduction of the PCCR in the Stockholm Region. Chapter 3 reviews relevant literature and presents the systematic search strategy that underpins my structured narrative literature review. It contains the key findings of the literature review, identifies gaps, and presents the contributions of this thesis to the existing body of knowledge on the governance of primary care quasi-markets. Chapter 4 presents the research design pursued to examine the governance system in the primary care quasi-market and to answer the research questions. To achieve this objective, this chapter first explains the underpinning philosophy of science of this research and various sources of theoretical inspiration for this thesis. Thereafter, the research design and method are presented, including the data generation approach, data collection method, approach to analysis, ethical considerations, and conclusions.

Chapter 5 is the first of three empirical chapters. It examines the mechanisms that are used by the public authorities to govern the primary care quasi-market in Stockholm and analyses how these influence the incentive environment in which primary care providers operate (research question 1). Building on this chapter, Chapter 6 analyses how this primary care quasi-market is governed to create a competitive environment, i.e. what mechanisms are used by public authorities to govern for competition, with particular focus on competition neutrality, in a context of diverse ownership characteristics (research question 2). It also gives an account of the incentives the governance system gives rise to with regard to competition, from the perspectives of both public authorities and service providers. Chapter 7 drills down on governing a primary care quasi-market to achieve quality of care. It focuses on how public authorities oversee that primary care providers
deliver quality care. It also focuses on how managers of primary care units perceive the existing governance system with respect to how it assures quality of care and explores challenges and opportunities for improvements (research question 3).

Following the three results chapters, **Chapter 8** includes a concluding discussion. It synthesises the thesis as a whole, integrates the main findings of the thesis, and highlights their contribution to existing literature. In this chapter I also reflect on the key findings and the policy questions that they give rise to. I discuss broader themes such as the interest holders in primary care quasi-markets, whether quasi-markets with patient choice models ultimately can limit choice, and the importance of clearly defining the objectives of quasi-market reforms. Lastly, the chapter considers implications for future research and policy practice.
2 Introduction to the Research Setting and Historical Context of the Primary Care Choice Reform

2.1 Introduction

The purpose of this chapter is to give a short introduction to the research setting and the historical context of the primary care market in which the PCCR was introduced.

A reform never takes place in a vacuum but is a series of policy shifts embedded in a context both in time (reforms that happened before and after PCCR) and space.

To understand policy considerations and decisions with regard to the governance system for the quasi-market, it is important to understand the timing of the reform and building blocks that led to the introduction of the shift in governance arrangements introduced with the PCCR in the Stockholm Region. Therefore, part of this chapter gives an account of the history of primary health care reform context in Sweden and the background to the introduction of the PCCR in the Stockholm Region.

The PCCR was also introduced in a particular context. To understand the governance system in the primary care quasi-market in Stockholm, it is critical to gain knowledge of the overall political system and the decentralised system of governance in Sweden. It was also important to gain familiarity with the institutions for governing the Stockholm Region, where the case study takes place, to design the study. To develop an understanding of the research context, I drew from a range of publications, government websites, policy documents, and legislation as well as my empirical data from the interviews.

The chapter’s subsequent section (2.2) discusses the Swedish national health care system and the national governance context. Section 2.3 turns to the Stockholm Region and discusses key governing bodies in the health sector. Section 2.4 sheds light on the temporal context in which the PCCR was introduced by giving an account of the national history of primary care reforms and private primary care service provision in Sweden. Section 2.5 describes the history of choice reforms in primary care in the Stockholm Region, as well as how the choice reforms, including the PCCR, were depicted when they
were introduced. In the final section (2.6), I reflect on my findings of this introductory chapter in a concluding discussion.

### 2.2 The Swedish Health Care System

There are three levels of government that are involved in health care in Sweden: national, regional, and municipal. At the national level, the Ministry of Health and Social Affairs is responsible for government health care regulation, legislation, and new proposals for parliament. However, the Swedish health care system is highly decentralised from an international perspective (Saltman et al., 2007) and governed primarily by 21 relatively autonomous regions, which are locally elected every four years (Anell, 2015), where the Stockholm Region is one of them. These governance bodies decide on many policy issues, including the financing of health care services and the organisation of the local health care system. The third level, the 290 municipalities, is responsible for nursing home care and help in the delivery of services to older people (Smith et al., 2012).

While national laws can be passed to introduce national policy changes at the regional levels, such as the introduction of the national law on patient choice in primary care in 2010, the regional authorities decide how such policy changes are introduced in terms of organisation and financing. Thus, the three levels of governance are in charge of priority setting for health system action and standards (Smith et al., 2012).

Health care is primarily financed from local income tax (around 80%) (the regions levy taxes), funding from the national government (15-20%), and user fees (0-5%) (Isaksson, 2016).

The Swedish Association of Local Authorities and Regions (SALAR) plays an important role between the national and regional levels, as it is a coordinating political agency for all regions. It initiates new policy changes and recommends them to the regions. This way of governing the health system is quite unusual in a European context, not because there are several layers of governance but because of the level of decentralisation of power to the local and regional governments (Fredriksson & Winblad, 2018). The main rationale behind the local autonomy is that elected leaders at the local level have better knowledge
about the local context and are therefore in a better position to adapt national policies to local circumstances (Winblad et al., 2021).

The national level governs and monitors and evaluates whether the regions produce health services of equal quality and terms to the population through, for example, law, supervision, and agreements (Fredriksson, 2012). The National Board of Health and Welfare (Swe. Socialstyrelsen) is the government’s central advisory and supervisory agency that evaluates if the services provided correspond to the goals laid down by the national government. ‘Open Comparisons’ (Swe. Öppna jämförelser) is an important ongoing effort to provide transparent cross-regional comparative performance indicators (both quality and clinical) to allow comparison of performance indicators across regions (Smith et al., 2012).

While the national government could in principle hold the regions accountable for the delivery of health care according to the Health Care Act, this does not happen in practice (Smith et al., 2012). The main accountability mechanism for the regional elected officials is through votes in local elections every fourth year (Smith et al., 2012).

The decentralised nature of the Swedish health care system, with local autonomy for the regions, means that local policies are influenced by the elected political majorities at the regional level. The Left party as well as the Social Democrats have focused more on equity as a goal of health policy (Winblad et al., 2021), whereas the centre right-wing coalition has traditionally emphasised pro-competition policies and privatisation. The Stockholm Region has since 2018 been ruled by a centre right-wing coalition (Valmyndigheten, 2018).

The Health and Medical Service Act (Swe. Hälso- och sjukvårdslagen (1982:763)) (Sveriges Riksdag, 1982) is the principal legal framework regulating health care provision in Sweden. It stipulates that the most important goal for Sweden’s health care is good health for the entire population on equal terms with respect and dignity of all human beings (WHO, 2017). Furthermore, the National Board of Health and Welfare developed ethical principles for prioritisation in health care in 1995 (SOU, 1995) that were adopted by Parliament in 1996/97, these include:
• the *human value principle*, i.e. that all people have the same right to health care regardless of talent, social status, income, age, ethnicity, or any other factor;

• the *need and solidarity principle*, i.e. that those patients in most need should be given priority and that special attention should be given to weak groups that have difficulty making their voice heard; and

• the *cost-effectiveness principle*, i.e. that the health care system has an obligation to use its resources as efficiently as possible.

The legal framework stipulates that the *cost-effectiveness principle* is subordinate to the *human value* and *need and solidarity principles*, which in practice means that serious illnesses and important deterioration in quality of life should be prioritised over minor illnesses, even though the care of the serious illness is more expensive (SOU, 1995).

### 2.3 The Governance of the Stockholm Region

The Stockholm Region is responsible for the management, governance, and implementation of all publicly financed health care in the Stockholm Region, where 2.3 million people live (https://www.sll.se/).

Politically elected representatives make decisions about the general strategy for the region, the budget, and the size of the tax rate in the Regional Assembly (*Swe. Regionfullmäktige*), which is the second to largest parliamentary assembly in Sweden with 149 representatives. Once the budget has been agreed upon, the Assembly delegates the governance of health care to the Health Committee (*Swe. Hälso-sjukvårdsnämden*), a political body responsible for ensuring that the supply of health care corresponds to the population’s needs. Certain decisions by the Health Committee are delegated to subordinate health committees (*Swe. Sjukvårdsutskott*) that cover a specific geographical area in the Stockholm Region (https://www.sll.se/).

The health sector at the regional level is organised according to a purchaser–provider model where the politicians and civil servants, at the Stockholm Region Health Care Office (SRHCO) (*Swe. Hälso- Sjukvårdsförvaltningen*), are purchasers and public and private health care organisations provide health care services. Each political party has
access to the expertise from the SRHCO, which is composed of apolitical civil servants with expertise in health care system and management (Falkenström & Höglund, 2018).

The SRHCO is responsible for ensuring that residents in the Stockholm Region have access to good and safe health care and dental care, based on the assignment it receives from the Health Committee, the political body. The SRHCO analyses the needs of the population, and based on these analyses proposals are made, within the existing financial resources, to the Health Committee, which purchases health and dental care for the population (https://www.sll.se/).

The SRHCO also monitors the results of services provision and oversees implementation of policies. Thus, the SRHCO executes the political decisions by, for example, managing local health care provision through contractual relationships, and it also supports the elected representatives in their decision-making functions. Thus, the SRHCO plays a dual role of interacting with both purchaser and providers (Johansson Krafve, 2015).

2.4 The History of Reforms in Swedish Primary Care

Already since the 1940s there has been a political wish to strengthen primary care, as the Swedish health care system has traditionally been hospital-heavy (Stockholm Region, 2020). In the 1960s, the responsibility for primary care moved from the national level to the regional level.

Until the beginning of the 1970s primary care in Sweden was mainly provided by physicians who were publicly employed in the hospitals and who worked part-time in private practices. During this time, there was choice of providers as patients paid out-of-pocket for outpatient care and were reimbursed by the national sickness fund (Swe. Försäkringskassan) (Immergut, 1992).

In 1970, a subsidised nominal seven crowns fixed patient fee was introduced, and medical staff became publicly employed with a fixed salary as opposed to the previous fee-for-service payments for outpatient visits (Dahlgren, 2018). The Seven Crown Reform meant, in practice, that private providers became less attractive to patients because it
was more expensive to visit a private clinic where patients paid the full fee (although some services were reimbursable), compared to outpatient care that was provided in the hospitals virtually free of charge (Immergut, 1992). With the Seven Crown Reform, choice in primary care became more restrictive and patients belonged to a nearby public hospital or primary care clinic for outpatient care.

In the late 1970s, the National Board of Health and others defined primary care as all health care that takes place outside hospitals. Words that came to characterise primary care include holistic perspective, primary responsibility, proximity, accessibility, continuity, quality, safety, and collaboration (Svartling, 2006). It was also during this period that the larger primary care teams started to evolve in Sweden. In contrast to other OECD countries with individual General Practitioners (GPs) practices, Swedish primary care centres have a multidisciplinary team of health professionals, typically consisting of 4–10 GPs, nurses, physical therapists, and dieticians (Isaksson, 2016).

In the 1980s, primary care gained more prominence in the health care system. In 1981, general medicine became its own specialty within the medical profession. The objective of the above-mentioned new Health and Medical Service Act (Swe. Hälso- och sjukvårds lag (1982:763)) (Svartling, 2006), which was introduced in 1982, was to provide good needs-based care on equal terms for the entire population. During this time, an agreement between the government and the federation of county councils opened the doors for patient choice of provider, first within the county of resident but then also beyond (Dahlgren, 2018). However, with the Dagmar reform, introduced in 1984, private practice was restricted (Immergut, 1992). Physicians who conducted dual practice with public reimbursement now needed a special permission from the county council.

In the late 1980s and 1990s, the public health care system was increasingly criticised for low productivity and limited choice for patients (Dahlgren, 2018). With the election of the centre right-wing coalition government in 1991, a new law (Swe. Husläkarlagen) was introduced in 1993 with the objective to improve access and continuity of primary care (Socialstyrelsen, 1992). With this new law each citizen could choose and register (either passively or actively) with a GP, to whom the citizen could turn.
This reform was an important precursor for the PCCR, although *Husläkarlagen* was reversed in 1994 when the Social Democratic government regained power. However, the registration with a GP was never abolished (Svartling, 2006) and this reform increased the number of private GPs by 12% (Anell, 2011).

2.5 Introduction of the Choice Reform in Primary Care in the Stockholm Region

In the Stockholm Region, patient choice was first introduced in the 1990s, when patients could choose a provider in another region, at the expense of the Stockholm Region, if they did not get access to a primary care clinic within a reasonable time frame. Furthermore, in the 1990s, the Stockholm County Council started to contract out service provision to private providers through the Swedish Public Procurement Act (*Swe. Lagen om Offentlig Upphandling*). Individual contracts were negotiated with each provider. This was also an important precursor to the introduction of the PCCR.

In the 1990s and early 2000s, the SRHCO was divided into six different health care areas (*Swe. Sjukvårdsområden*), each one with a purchasing agency (interview, former SRHCO staff member). The extent of private provision varied between the different health care areas. For instance, the South part of the Stockholm Region had privatised all primary care units by contracting out through the Swedish Public Procurement Act, while public provision was more prevalent in other health care areas. One area (Nacka) had also started to experiment with patient choice for home-based care (interview, former SRHCO staff member).

After the general election in 2002, there was a political decision to centralise health care management and in 2003 the six health care areas merged into three different organisations with one purchasing agent with different departments for the North, Stockholm, and the South. As the health care areas merged into one purchasing agent, a discussion commenced about the need to standardise contracts with providers across the Stockholm Region, which initiated the process of contract harmonisation (interview, former SRHCO staff member).
Prior to this standardisation, the contracts with individual providers did not just have different reimbursement levels but the definition of the content of primary care also varied. For instance, in one part of the region, called Södertälje, psychosocial services were included in the definition of primary care, whereas this was not the case in the rest of the region (interview, SRHCO staff member). The first harmonised and standardised contract was available in 2005 and thereafter it was agreed that all new contracts with providers should use the standard contract (interview, SRHCO staff member).

With the election victory of the centre right-wing coalition in the Stockholm Region in 2006, patient choice was immediately discussed and several steps to move towards the PCCR were introduced in 2007. This political coalition, Alliansen, traditionally put the ability of each individual to thrive at the centre of its politics and the job agenda was seen as the basis for the welfare state (Alliansen, 2014). The PCCR was in line with this ideological philosophy. At the time, patient choice in primary care had already been introduced in another region in Sweden, Halland, and the centre right-wing coalition in Stockholm wanted a similar model (interview, SRHCO staff member).

Consequently, in 2007 the three purchasing units, which managed contracts, were merged into one unit, called the primary care department (Swe. Närsjukvårdsavdelning), under one manager (interview, SRHCO staff member). In 2007, the Stockholm Region also set-up a ‘spin-off office’ (Swe. Avknoppningskansli) to prepare for the PCCR and support health care staff who wanted to acquire the public unit where they worked for a subsidised price and turn it into a privately owned unit (interview, SRHCO staff member).

In June 2007, there was a decision in the County Council Assembly that the patient choice reforms would start in January 2008 and at first include primary care, including basic home-based care, childcare centres, maternity care centres, paediatric care, and speech therapy. These first choice reforms in these health care areas would later be named Health Care Choice Stockholm (HCCS) (Swe. Vårdval Stockholm). The PCCR was one of the Choice Reforms included in the HCCS.

The budget (Stockholm Region, 2008) for the Stockholm Region that was adopted by the County Council Assembly in November 2007 gives an insight into the objectives of and perceptions about the HCCS by the ruling politicians when the reform was introduced.
The budget states: “freedom of choice, diversity and security are key words that will make the county council develop into an open and a development-oriented organization with the task of providing good service to the inhabitants of our county” (cit. Stockholm Region, 2008, p. 6).

Furthermore, the reform, HCCS, is described as per below in the budget document:

the freedom reform “Health Care Choice Stockholm” means that power over healthcare is shifted from politicians to patients. It is a historical reform that will lead to increased accessibility, greater diversity and freedom of choice as well as improved service. Increased diversity gives positive effects in the form of clearer organization, goals and leadership. This is needed to be able to attract the healthcare workforce in the future. But also to increase residents’ freedom of choice. Competition and procurement stimulate to increased dialogue about the quality of care, which provides better conditions for creating the care services the population is in need of, while the taxpayers’ money is used in the best way. (cit. Stockholm Region, 2008, p. 4)

The budget document includes one section about principles for governance of health care services, which states:

Healthcare in Stockholm County Council must put the patient’s choice in the first room. At the same time, it is important to find ways to fulfil the county council’s planning needs. With the provider-purchasing model as the basis, there are preconditions to be able to award both good quality of care and low costs through financial instruments.

... A variety of health care providers is necessary to provide citizens with good and accessible care without queues. The remuneration systems must both be competition neutral and stimulate healthcare producers to deliver good quality care at a good price. The County Council’s procurement [procedures] should be developed so that the tenderer is judged on both price and quality. The quality requirements must be so clear that they enable early termination if the provider does not meet the requirements. (cit. Stockholm Region, 2008, p. 35)

The budget document puts “the patient’s choice in the first room” (Stockholm Region, 2008, p. 35), with ‘first room’ given to mean top priority, and there is overall a strong emphasis on choice. The document also stresses key features of the mechanics of the choice reform, namely the importance of linking financing of care to results and to have clarity around quality requirements, such that providers that do not live up to the required
quality standards are excluded from the market. Further, with regard to quality of care, the document stipulates:

The population should be given the opportunity to simply and easily be given comparisons between different caregivers so that they can choose the caregiver they trust. This means that the information should be of such a nature and presented in such a way that it helps citizens to make informed decisions about which care they want to choose. This applies, for example, to accessibility and patient-perceived quality in care. This also applies to medical quality indicators that describe which treatment results are achieved. It is also about democratic transparency. Citizens have the right to know how their taxes are used and what results they produce. Comparative information is also an important tool for healthcare providers’ own quality development. Information on accessibility, patient perceived quality and medical quality indicators should be published so that citizens and patients can compare caregivers and choose the caregiver they feel they trust. (cit. Stockholm Region, 2008, p. 36)

This shows that transparency around quality of care to the population was considered essential to help patients to choose providers. The document explicitly states that patients need access to information about accessibility, patient-perceived quality in care, and medical quality indicators that describe treatment results to make informed decisions.

As mentioned in the Introduction, opponents to patient choice reforms often raise the increase of inequity in access to care as a major concern. With regard to equity and equality, the budget document puts the onus on the population to promote equality and equity in care through their own choices, as per below:

Equity and equal care are a very important parts of the quality development of care and is a perspective that should be integrated into all decisions, procurement and contracts. ... Through “Health Care Choice Stockholm”, the population is given the opportunity to promote equality and equity in care through their own choices ... (cit. Stockholm Region, 2008, p. 38)

Thus, the main instructions with regard to ensuring equity and equality are that this perspective should be mainstreamed into all decisions, procurement, and contracts and promoted through the choices of the population.
2.6 Concluding Discussion

This chapter has provided a short introduction to the research setting and the historical context of the primary care market in which the PCCR was introduced in the Stockholm Region. It also explores the history of the PCCR in Sweden in general and in the Stockholm Region in particular, where it is clear that the PCCR had several precursors, including Husläkarlagen that was introduced in 1993 and later reversed, as well as the experience in the 1990s, when the Stockholm Region started to contract out service provision to private providers through the Swedish Public Procurement Act.

I have started to uncover the different levels of governance in the regional health care system, with the political level making decisions and the experts in the SRHCO supporting the purchaser of care, while also interacting directly with the provider. To understand these relationships was critical for the design of my research project as well as to orient my readers.

With regard to the introduction of the reform, the PCCR (which was part of the HCCS), in Stockholm was introduced immediately when the centre right-wing coalition took power in the Stockholm Region. Its political view put emphasis on the importance of giving the individual more power over their everyday life by strengthening choice for the individual (Alliansen, 2014) and was grounded in classic liberal values. The introduction of the PCCR is very much in line with this political coalition’s ideological view.

Sensitive topics such as ‘privatisation’, which may not have been popular in Stockholm, are rarely used in the budget document but replaced by words that are more ambiguous and perhaps have a more positive connotation, such as ‘diversity’. For instance, in the budget document (Stockholm Region, 2008) the word ‘privatisation’ is not mentioned a single time, although it is a key feature of the PCCR, evidenced by the fact that the spin-off unit was set up in the SRHCO to support divestiture (sales of public assets). The word ‘private’ is used 7 times in the budget document, whereas the word ‘diversity’ is mentioned 20 times. Wisell et al. (2019), in their study on how policymakers in Sweden understood and defined the word ‘diversity’ during the national reforms to liberalise the community pharmacy and primary care sectors, found that policymakers held “vague and unclear definitions” of the concept (Wisell et al., 2019, p. 457).
The timing of the introduction of the reform and the language in the budget document indicate that the introduction of the HCCS was politically and ideologically driven, rather than driven by providing a solution to a prevailing problem. For instance, the budget document shows that there was a conviction amongst politicians that certain features, such as increased diversity of providers, would automatically generate a certain outcome, exemplified by sentences such as: “Increased diversity gives positive effects in the form of clearer organization, goals and leadership” (cit. Stockholm Region, 2008, p. 4). However, it is unclear exactly how and why there would be this causal link and no evidence is referenced. Thus, it appears as if the introduction of the HCCS was based in a normative rather than a technical domain.

The budget document states that “patient choice is in the first room” (cit. Stockholm Region, 2008, p. 35). Thus, the public interest objective is “choice” rather than, for example, patient outcomes or reducing waiting time or some critical outcome measure. These observations confirm previous research that shows that although policy concerns, such as long waiting times, were important for the timing of the introduction of choice reforms, the concerns appear to have been less important in the design of the choice reform (Vrangbaek et al., 2012). Similarly, Wisell et al. (2015) showed in their analysis of the political argument for the privatisation (or so-called reregulation) of the pharmacy market in Sweden that the purpose of the reform was to introduce private ownership, rather than to solve any general problems or to enhance patient outcomes.

Furthermore, the budget document communicates the HCCS in a skilful way that makes it difficult to oppose it. For instance, few would disagree with statements such as “the power over healthcare is shifted from politicians to patients” (cit. Stockholm Region, 2008, p. 4).

The budget document also contains a number of statements that connect concepts such as ‘competition’ with other ideas such as ‘taxpayers’ money used in the best way’, without explaining why competition would lead to money being better used. This is one example: “Competition and procurement stimulate increased dialogue about the quality of care, which provides better conditions for creating the care services the population is in need
of, while the taxpayers’ money is used in the best way” (cit. Stockholm Region, 2008, p. 4).

Given that the Swedish Health and Medical Service Act gives priority to the human value and the need and solidarity principles, it is also noticeable that the budget document is largely silent on how the reform impacts (or considers) the ethical principles for prioritisation in health that regulate health care provision in Sweden. This shows that, in practice, in Sweden’s decentralised governance system, the national-level authorities have limited influence over the authorities at the regional level, as the regional authorities do not address the main principles of the national legal framework in their reform efforts.

I will explore some of these issues further in subsequent chapters. The next chapter focuses on the relevant body of literature that the thesis aims to contribute to and I present a structured narrative literature review on the governance of primary care quasi-markets.
3 Literature Review

3.1 Introduction

This chapter provides an overview of existing literature on the governance of primary care quasi-markets, focused on the research questions posed in this thesis. It presents a structured narrative literature review, underpinned by a systematic search strategy, including qualitative, quantitative, and mixed-method studies.

The objective of the chapter is to contribute to the empirical investigation by reviewing the existing literature on governance of primary care quasi-markets, give an account of relevant strands of the theoretical research, and provide a more comprehensive overview of the empirical research on the topic. This approach underpins the aim to gain insights into the literature, including mapping key findings and identifying the gaps in existing literature, and explains how this thesis contributes to the existing body of knowledge.

The chapter is structured as follows. Section 3.2. describes the methods used for the literature review, Section 3.3 presents the main findings of the review, and Section 3.4 summarises the main conclusions of the literature review and the contribution of this thesis to the existing body of evidence on governance of primary care quasi-markets.

3.2 Methods

Since the main purpose of this literature review is to map the available literature and key findings, examine existing research and analyse knowledge gaps, and identify how this thesis contributes to the literature, I decided to do a structured narrative literature review, underpinned by a comprehensive search strategy. This stands in contrast to a systematic review focused on uncovering international evidence, confirming current/new practice, or producing statements to guide decision-making (Munn et al., 2018). It was neither possible nor appropriate to conduct a systematic literature review since I had a broader topic (rather than a narrow research question) and because it was important for me to
review different branches of literature, within different subject areas, as the subject of study, the governance of primary care quasi-markets, does not sit within one discipline.

The method used for the literature review was inspired by a framework originally developed by Arksey and O’Malley (2005) for conducting scoping reviews. I used the five stages presented in their framework to ensure I used a comprehensive search strategy and to structure this chapter. In the following sections, I describe the method, outlined according to the framework’s five stages: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; and (5) collating, summarising, and reporting the results (Arksey & O’Malley, 2005, p. 22).

3.2.1 Identifying the Research Question

Prior to choosing the research questions of focus in this literature review, I conducted a structured literature search focused on the research questions posed in this thesis primarily using Google’s advanced search function and searching the database of Swedish government websites. This exercise provided a preliminary idea of the literature and informed the focus of the review. Based on this preliminary search, the focus of the review is to explore: (i) What is known from the existing literature about the governance of primary care quasi-markets? Within this research question, I decided to also explore a second research question: (ii) What is known from existing research on the effect of ownership of primary health care facilities?

Research question (i) is the primary focus of the thesis and research question (ii) on ownership was included since there is literature comparing public and private providers, which was critical to be aware of given the focus of the thesis.

Initially, I also included a third research question (iii) What is known from the existing research, in the Swedish context, about quasi-markets? But I decided to drop the literature review I conducted on this question to narrow the scope of the literature review and better tie it directly to the research questions of the thesis. However, the work conducted on research question (iii) was useful to get an overview of the quite large body of literature on quasi-markets in various welfare sectors in Sweden developed in tandem.
with the last decades’ reform efforts (e.g. Hartman et al., 2011; SOU, 2016) and gain insights into the policy debate on quasi-markets. It allowed me to familiarise myself with a broader set of ideas related to the management of quasi-markets, beyond the primary health care sector and the ongoing policy debate in the country. This knowledge was important, particularly so as to place my key findings in the national context and to reflect on the policy implications of my findings (see Chapter 8).

I decided not to focus the literature review on the large body of literature on the measurement of quality of care in primary health care (e.g. Donabedian, 1988; Kringos et al., 2010) because this thesis is primarily concerned with the broader question on mechanisms of governance in primary care quasi-markets. Thus, it was beyond the scope of this review to do a general search related to measurements of quality of care in primary care.

3.2.2 Identifying Relevant Studies

The databases used in this literature review were selected based on their scope and relevance in consultation with a qualified librarian at the University of Edinburgh. A structured literature search on topics reflecting the research question and the subordinate questions were conducted in the following databases and platforms: Global Health (CABI), MEDLINE, Scopus, Web of Science Core Collection, Cumulative Index of Nursing and Allied Health Literature (CINAHL), EBSCOhost (including the databases CINAHL Plus, Academic Search Complete, EconLit, Humanities International Complete, Library, Information Science & Technology Abstracts, Political Science Complete, Sociology Source Ultimate), and ProQuest (including the databases Social Science, Dissertations & Theses, Global and Social Science Premium Collection [Politics Collection, Social Science Database, Sociology Collection]).

A grey literature search was also conducted with Google’s advanced search function and in the WHO and OECD websites. The websites of various government entities in Sweden were also searched, including the Swedish Competition Authority (Swe.
Konkurrensverket, Stockholm Region, SALAR, and Swedish Agency for Health and Care Services Analysis (Swe. Vårdanalys).

The search was limited to literature in English and Swedish published after 1980 and up to 2021. The start date was chosen as most of the quasi-market reforms happened after this year. The search was first conducted in December 2019 and repeated in the databases in May 2021 to update the scoping review with key new studies.

The search strings were developed iteratively for each research question of focus in the literature review. For certain databases, that generated thousands of results with the basic search strings; the search string was then redefined to narrow down the results. A backward and forward search (snowballing method) was applied to include papers to ensure that relevant research was captured. Reference lists of key studies such as systematic reviews were also searched to ensure that they were included in the literature review. The references were exported to Endnote for duplicate removal and final review.

I, the author, was the only person to implement the search strategy. Three searches for each research question were conducted in each database. The basic search strings for each research question are summarised in Table 1.

Table 1. Basic Search Strings for Research Questions

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Basic search string</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i)</td>
<td>What is known from the existing literature about the governance of primary care quasi-markets? (governance OR stewardship OR regulation OR management) AND (primary<em>care OR ambulatory</em>care OR primary<em>health</em>care) AND (quasi<em>markets OR new</em>public<em>management OR patient</em>choice).</td>
</tr>
<tr>
<td>(ii)</td>
<td>What is known from existing research on the effect of ownership of primary health care facilities?</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>(ownership) AND (primary<em>care OR ambulatory</em>care OR primary<em>health</em>care).</td>
</tr>
</tbody>
</table>

Source: Author.

3.2.3 Study Selection

Articles were screened based on title and abstract using inclusion criteria as per below. Given the research questions of the literature review, I focused on studies in primary care, as it was otherwise too large. Thus, research on governance of quasi-markets for specialised care (e.g. dialysis) and hospital care that sometimes showed up in the search was not included except for a few cases where the article, after I read the abstract, had the potential to contribute to my understanding of the governance of primary care quasi-markets or was a key study (e.g. systematic review). Duplicates were also excluded both within and between categories.

Figure 1 provides an overview of the review process. I reviewed, separately, the literature retrieved from the academic databases mentioned above, for the research questions. A total of 48 and 65 articles were retrieved for research questions (i) and (ii), respectively, after deleting duplicates within categories. Once duplicates were deleted between categories, a total of 111 articles remained and were included in the review. For a detailed review of searches including specific search strings and the references retrieved for each category, see Annex B. In addition to these retrieved studies, I also reviewed grey literature as mentioned above.
3.2.4 Charting the Data

The research questions were first used to organise the data retained from the databases. Of the relevant studies, I read the abstracts. If the paper was particularly relevant for the objectives of the thesis, I read the entire paper and summarised it in a table including the author/s, year of publication, title, aim of the study, methodology, results, and any other relevant information for the purpose of the aim of this thesis. Given the large number of studies included in the scoping review, it was not possible to read all papers. I drew on meta-analyses or reviews of existing studies when possible (e.g. Eggleston et al., 2008; Propper, 2012).
3.2.5 Collating, Summarising, and Reporting the Results

The literature review spans many disciplines, including political science, public administration, economics, and management and organisation, and it includes qualitative, quantitative, and mixed-method studies. This made it quite challenging to figure out how to best report on the results, and it was clear that the results of the literature review could be presented in many ways. Since the main purpose of this chapter is to gain an overview of the existing literature on governance of primary care quasi-markets, identifying the gaps, and how this thesis can contribute to filling those gaps, my priority was to report the results to fulfil this objective.

In practice, this meant that my focus was on accounting for the results for the main research questions of the literature review. After reviewing the literature, and as mentioned above, I decided not to present a separate section on the subordinate research question (iii), as I wanted to keep the literature narrowly focused on the research questions in this thesis. Still, conducting a literature review on this topic served to enhance my general knowledge and policy debate about quasi-markets in Sweden, which informed my analysis of the data and the concluding discussions in Chapter 8.

When reviewing the retrieved studies I discovered a growing body of primarily quantitative research in the discipline of economics, focused on the relationship between quasi-markets/competition and various outcome measures, such as quality of care, equity, and productivity. This literature is not directly related to my research objectives but given its prominence in the literature on quasi-markets, and as it is important as a background to understand the type of issues that the governance system needs to manage to deliver on public health objectives, I decided to briefly summarise this literature and place it in Annex A.

This literature seeks to understand the impact of outcome variables on the introduction of competition, but it is largely silent on the prevailing governance system in the quasi-market under investigation and therefore it is less important to me. Another weakness of this literature is that the demand and supply side mechanisms in the market that create
the reported results are often just speculated about as these studies are quantitative in nature and in-depth investigation into these mechanisms requires other research approaches.

The results of the structured narrative literature review are presented in line with the two research questions of focus in this review.

The first part (Sections 3.3.1 and 3.3.2) focuses on the question “What is known from the existing literature about the governance of primary care quasi-markets?” Section 3.3.1 gives an account of the theoretical literature on the mechanisms of the quasi-market, including a short account of the literature on motivation of agents. The subsequent section turns to the empirical evidence on what is known about the governance of primary care quasi-markets. Section 3.3.1 builds on the theory of quasi-markets presented in Chapter 1 and is included as a background to situate the existing empirical literature in a theoretical framework. In accordance with the theoretical literature, Section 3.3.2 discusses the empirical evidence derived by research on the demand side, the supply side, and on the overall governance of quasi-markets.

The second part (Sections 3.3.3 and 3.3.4) addresses research question (ii) “What is known from existing research on the effect of ownership of primary health care facilities?” Like the first part, it first discusses the theoretical literature (Section 3.3.3) and then turns to the empirical literature (Section 3.3.4) on the same topic.

### 3.3 Results

**Part I: “What is known from the existing literature about the governance of primary care quasi-markets?”**

#### 3.3.1 Theories on the Governance Mechanisms of the Quasi-market

Quasi-markets are a hybrid between a market structure and a traditional form of hierarchical structure dictated by a bureaucracy (Lewis, 2017). Thus, quasi-markets are ‘markets’ because there is competition between the immediate providers of services, but
they are only ‘quasi’-markets because they differ from conventional markets in a number of important ways (Le Grand & Bartlett, 1993, p. 10). As explained by Le Grand (1991), in a quasi-market the government is primarily a funder of services, which purchases services from a variety of providers that are competing with one another. Financing is allocated either through a competitive bidding process where the state is the purchaser or, alternatively, the state allocates a budget for vouchers that are given to potential users of services, who then allocate the voucher to the provider by choosing one of the competing providers, that is, money follows the user (Le Grand, 1991). Thus, quasi-markets differ from conventional markets because services are publicly financed.

As mentioned in Chapter 1, in quasi-markets providers face hard budget constraints set by the government (assuming that providers cannot be loss-making for extended periods of time) (Lewis, 2017), as the prices of services are regulated (fixed-price regime). Thus, provider income is determined on, for example, a per patient basis (capitation) or per finished course of treatment basis (fee-for-service), and not set by the provider. In other words, providers do not compete in terms of the price of services but rather on the type and perceived quality of services provided, which in turn determine whether the provider attracts income-generating users. Thus, the income of service providers is very sensitive to patient choices.

The theoretical literature on quasi-markets is grounded in economic theory and predicts that health care organisations operating under a competitive fixed-price regime will provide higher-quality services than health care organisations that operate under a non-competitive fixed-price regime, if: (1) demand for services responds to variations in quality (individuals are rationale actors who exercise choice on the basis of informed knowledge to maximise self-interest [Gabe et al., 2015]); (2) providers are profit (or surplus) maximisers; (3) the cost to serve one additional patient (marginal cost) is constant; (4) the profit margin, i.e. the price minus marginal cost (margin), is positive; and (5) providers meet whatever demand is generated by their choice of quality (Brekke et al., 2014). This theoretical literature, based on economics, is rather simplistic and based on Brekke et al. (2014). Table 2 summarises key reasons why assumptions underpinning the theory of quasi-markets may not hold.
Table 2. Reasons Why Assumptions Underpinning the Theory of Quasi-markets May Not Hold

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Description of potential challenges to theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand side</td>
<td></td>
</tr>
<tr>
<td><strong>Information on quality of care</strong></td>
<td>The underlying assumption for the beneficial influence of the competition/choice is that consumers, armed with good information, will make informed choices about which providers can offer the highest quality in accordance with their needs or preferences (Greener, 2007). Thus, if information on quality of care is not available and demand does not respond to variations in quality, higher levels of quality of services may not be achieved in a quasi-market.</td>
</tr>
<tr>
<td><strong>Demand sluggishness</strong></td>
<td>Quality of care is often difficult to observe, and because of habits or trust, users may not respond to changes (e.g. deterioration) in the quality of care by a provider immediately. Thus, demand may be sluggish. Theory predicts that more demand sluggishness reduces the pro-quality effects of provider competition.</td>
</tr>
<tr>
<td>Supply side</td>
<td></td>
</tr>
<tr>
<td><strong>Providers’ objectives, preferences, and actions</strong></td>
<td>If and how providers respond to competition and user choice depends on the preferences of those who are taking the decisions that affect the quality of care provided and who controls the profit of the organisation. A public clinic that does not benefit financially if it increases quality of care and attracts more patients (if for instance, salaries are fixed) may not be incentivised to do so. The incentives to respond to competition by raising quality may in this case be diluted. Decisions about quality of care may be taken at different levels by</td>
</tr>
</tbody>
</table>


actors with diverging preferences. For example, patient-facing staff may respond less to financial incentives if they are motivated by altruistic concerns for patients’ health, compared to an owner of the clinic.

<table>
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<tr>
<th>Cream-skimming</th>
<th>If the provider can vary the level of quality depending on the user, then they may have an incentive to increase the quality for users with a positive profit margin (cream-skim) and reduce the quality for users with a negative profit margin (skimp on quality).</th>
</tr>
</thead>
</table>

### Market regulation

<table>
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<tr>
<th>Profit margin</th>
<th>If the fixed price in the payment scheme is not set so that providers can make profit from treating an additional user, then quality of care will not increase. This may be the case if a prospective payment scheme does not consider investment costs/capital costs or is based on the average cost of services and the profit margin for certain services/users is negative.</th>
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<tr>
<th>Profit distributional constraints</th>
<th>In many health markets, public and private non-profit providers cannot distribute profits to those who make decisions about provider quality. Brekke et al. (2012) showed that a distributional constraint could severely alter provider incentives with respect to quality.</th>
</tr>
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</table>

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<tr>
<th>Soft budgets</th>
<th>Providers, particularly those that are publicly owned, often face a 'soft budget constraint’, where the government partially covers deficits or confiscates profits. If the cost-reducing effort is constant, profit confiscation decreases the providers’ pro-quality incentives.</th>
</tr>
</thead>
</table>

Source: Author, based on Brekke et al. (2014).
This overview of key assumptions underpinning the functioning of the quasi-market does not just give a sense of the many conditions that need to be in place for the market to operate as predicted, it also points to the many challenges that a governance regime needs to address in order for the quasi-market to “work” as intended. This includes to ensure that service users have information about the quality of care offered by different providers, that it is feasible for users to make choices about from whom to receive care based on this information, and that service providers cannot only select the most profitable patients (cream-skimming) and prevent providers from skimping on quality of care.

Brekke et al. (2014) also point to the importance of understanding the actors in the market (e.g. primary care providers) and their objectives, preferences, and actions, as this determines how they respond to the incentives in the governance regime. Related to this, I wish to focus below on the issue of agent motivation, as this is a topic that has been discussed extensively in the literature, and is of critical importance to various aspects of my study, including the focus on how governance arrangements (re)shape incentives and the importance of the ownership of primary care units.

Le Grand (2003) stressed the importance of structuring incentives in quasi-markets in such a way that they generate relatively good performance from both “the knight and the knave” (p. 164), where the knight signifies the archetypal altruistic and intrinsically motivated public servant whereas the knave signifies the actor motivated by self-interest.

Related to this, there is a large body of literature on what determines professional conduct. It is beyond the scope of this literature review to cover this comprehensively, but, in short, there are three strands of theoretical literature of relevance for understanding health care worker behaviours (Andersen, 2009).

First, the economics literature, including the general theory of incentives (see, for example, Gibbon [1997] and Prendergast [1999] for overviews), tends to position professionals in general as self-interested actors who are optimising for material reward — notably, wealth and leisure. Behavioural economists have challenged this model and stressed that non-financial incentives, such as social preferences, reciprocity, and ethical values, are also key for how economic agents make their decision (see, for example,
Camerer et al., 2004). Behavioural economists have studied the interaction between extrinsic and intrinsic motivation and found that sometimes they interact as complements (e.g. material incentives can add to agents’ intrinsic motivation) and sometimes as substitutes (e.g. material incentives reduce agents’ intrinsic motivation) (see, for example, Bowles & Polanía-Reyes, 2012).

To what extent the general theory of incentives holds in public organisations has been questioned by economists. Dixit (2002) theorised that incentives may be weaker in public organisations that are characterised by, for example, multiple principals that seek to influence the organisations, multiple tasks between which the trade-offs are not always clear, conflicting interests about ends and means, lack of competition, and the difficulties of understanding the actions of intrinsically motivated agents (Dixit, 2002). In general, the health sector is perceived as attracting workers who are more intrinsically motivated by saving lives and improving the health of users than extrinsic motivators, such as power, prestige, and personal material reward (Besley & Ghatak, 2005).

While Dixit’s (2002) work does not focus on the health sector per se, it includes some analytical elements that are highly relevant for this thesis, including: (1) the lack of separation between ends and means in the public sector, which implies that some agents whose behaviour policymakers seek to influence are themselves principals in political games and are able to set the rules and regulations for implementation (sometimes those being governed are also involved in governing); (2) government agencies have several principals who engage to influence their action, while private firms’ actions influence many people but the owners’ interest is the most critical — the bottom line; and (3) exposing public agencies to competition or privatising a certain task may have adverse impacts as a task may have multiple dimensions, some observable and some unobservable, and with the pressure of consumer choice, the focus may shift to observable dimensions from the eye of the consumer, while other dimensions suffer.

Second, in line with Dixit’s observations in the field of economics, there is much literature on public service motivation (see Ritz et al., 2016 for an overview) that originated from the field of public administration. It focuses on the motivation of public employees and argues that financial rewards are of less importance as public employees are primarily
driven by public service motivation, that is, altruistic motivation to serve the people, a country, or humanity (Crewson, 1997; Perry & Wise, 1990; Rainey, 1982).

Third, the sociology of professions (Freidson, 2001; Mosher, 1968; Roberts & Dietrich, 1999) puts emphasis on belonging to a professional group as a major driver of behaviour and where professional norms influence actions regardless of incentive structures (Andersen, 2009). In the health sector, the research in this area is limited. Some papers study optimal incentive structures when doctors are intrinsically motivated (e.g. Kolstad, 2013; Makris & Siciliani, 2013).

Le Grand (2003) theorises that different motivations (financial, non-financial, and professional norms) coexist. Empirical investigations (e.g. Andersen, 2009; Goodrick & Salancik, 1996; Vengberg, 2021, referred to below), which will be discussed in Section 3.3.3, confirm that this is also true for health care providers.

Overall, the simple view of human behaviour used by early economists (and which has had a powerful impact on public service reform around the world) is now largely rejected in favour of a richer understanding based on the combination of intrinsic and extrinsic motivation as indicated above. Thus, an important goal of governance in the context of quasi-markets is to deploy mechanisms that harness extrinsic motivation without undermining intrinsic motivation.

My conclusion from reading the theoretical literature on quasi-markets is that although the move from a more hierarchical governance mode to a quasi-market appears straightforward in the theoretical economics literature, it rests on several assumptions that may apply in theory but may be challenging to achieve in practice. These assumptions, both on the demand side (e.g. there is good information on quality of care to users and no demand sluggishness) and the supply side (e.g. there is no cream-skimming, no skimping on quality, providers respond to incentives to increase quality of care), depend on how the quasi-market is governed and how individuals respond to the governance systems they operate in. Ultimately, markets are made of individuals and, as this section has shown, the motivation behind their actions remains uncertain. Thus, empirical investigation of the governance system of the market and the incentive structure it gives
rise to is warranted to understand and determine the functioning of quasi-markets, and this is what we turn to next.

3.3.2 What is Known from the Existing Empirical Literature about the Governance of Primary Care Quasi-markets?

Building on the theoretical literature referenced above on quasi-markets (Section 3.3.1) that shows the importance of understanding the governance system of the market, the incentives it gives rise to, and how this impacts both users’ and providers’ behaviours, this section critically discusses the empirical literature on these topics. First, patient/user behaviour (demand side) is discussed. I then turn to the provider behaviour (supply side), and, finally, this section discusses what we know from existing empirical literature on primary care quasi-market governance.

3.3.2.1 Demand side

As mentioned in Section 3.3.1, it is essential for the functioning of quasi-markets that users of services (demand) respond to quality of care and choose a provider accordingly, as patient choice drives quality of care as well as provider revenue (Le Grand, 2009).

When considering the empirical evidence of demand being responsive to quality of care, Glenngård et al. (2011) found in their study of three regions in Sweden, based on data from 1,449 completed individual questionnaires, that about 60% of the population made a choice of a provider when the PCCR was initiated; however, thereafter, individuals were quite passive in seeking information about providers and opted for providers nearby. This finding has been confirmed by Wahlstedt and Ekman (2016), who, in their rigorous study based on data from a regional population health survey in the southern part of Sweden using a logistic regression model, concluded that few citizens use Internet-based information sources, made available by authorities to facilitate choice, as a source of health care information.
However, evidence from the United Kingdom (UK) shows contrary results. Santos et al. (2017) showed that clinical quality is indeed an important factor when individuals choose their family doctor as per the theoretical predications, and Bornstein et al. (2000) found that those factors patients perceive as the most important to their choice of primary care doctor (e.g. the doctor’s professional certification and management practices) are also those that have the greatest impact on the quality of health care that they will receive.

Only a few papers have studied the mechanisms behind choice for the individual, namely factors that influence individuals’ willingness to seek information to inform their choice of provider. Some studies point to personal characteristics such as age, education, health status, income, gender, and ethnicity (e.g. Galizzi et al., 2012; Hoerger & Howard, 1995; Rademakers et al., 2014; Victoor et al., 2014), while other factors such as the individual's willingness to switch providers, earlier experience of care, and contextual factors (e.g. distance to provider) are highlighted by others (Harris, 2003; Hoerger & Howard, 1995; Ketelaar et al., 2014; Rademakers et al., 2014; Victoor et al., 2014, 2016).

Another rigorous study in Sweden (Hoffstedt et al., 2018) at the national level, of 1,039 individuals, based on logistic regression analysis, focused on identifying under what circumstances individuals seek out information when choosing a primary care provider. It showed the importance of taking situational context as well as personal motivation into account when studying whether individuals seek out information before making their choice. The study found that “not even individuals who are likely to search for information since they switched or considered switching primary care provider, do so to any greater extent” (Hoffstedt et al., 2018, p. 1). However, individuals who had switched provider due to “a new provider opened”, “another provider seemed better”, and “dissatisfaction with provider” (Hoffstedt et al., 2018, p. 8) were more inclined to seek information before selecting a primary care provider. The study concluded that since individuals are not making informed choices of providers, it is critical for market regulators to not just rely on patient choice as a driver of quality of care, but to also monitor quality of care.
Supply side

On the supply side, there are few studies that focus on provider behaviour in the primary care quasi-market (Vengberg et al., 2019), although this is a topic that has attracted researchers in Sweden in recent years. The existing studies use qualitative methods, as the most suitable method for the in-depth study of provider behaviour and motivation.

One of the most interesting studies is by Vengberg et al. (2019) who explored if and how choice and competition enhance quality of care in Swedish primary care. The study focuses on examining the mechanisms of how choice and competition impact quality of care, based on interviews with 24 managers and physicians in Sweden’s two largest cities — Stockholm and Gothenburg. Thus, the study is conducted in two cities with different governance systems based on a relatively small sample.

They conclude that it is questionable whether choice and competition stimulate improved clinical quality of care as they did not find evidence of providers competing on either process or outcome quality indicators.

Their study found that providers have limited access to information on patients’ choices and are not focused on competing for patients, as they perceive a never-ending demand for primary care amongst the population. Vengberg et al. (2019) find that the only aspect of quality that providers mentioned as key for attracting patients was patient accessibility. This finding is supported by a rigorous econometric study (using identification strategy) on the relationship between competition (introduction of quasi-market) and quality of care in Swedish primary care. The authors find small improvements of patients’ overall satisfaction with care, but not consistently significant effects on avoidable hospitalisation rates or satisfaction with access to care as a result of the introduction of the quasi-market (Dietrichson et al., 2020).

Vengberg et al. (2019) also found that providers’ objectives were not necessarily to maximise profit, but instead they behaved as “income satisfiers” (Vengberg et al., 2019, p. 222), where focus was on a manageable and economically sound primary health care practice, rather than aspiring to expand and increase market share and profit. The authors speculated that provider behaviour could have been different had not most of the respondents been salaried employees in Sweden. Contrary to Dixit’s (2002) theories that
incentives may be weaker in public organisations with intrinsically motivated agents, the study found no systematic differences between managers and physicians of private and public clinics and called for more research in this area (Vengberg et al., 2019). This may be because health care workers are primarily intrinsically motivated whether or not they work in the public or the private sector (Besley & Ghatak, 2005).

Vengberg et al. (2019) stress that although more research is required to establish the effect of quasi-markets on primary care, their results question if choice and competition function as quality enhancing drivers, at least in the Swedish primary care context. Thus, this study shows that despite the theoretical literature’s predictions that competition would lead to improvement in quality of care in a quasi-market with patient choice, empirically, providers have limited focus on enhancing quality of care to improve their competitiveness in order to attract patients and thereby revenue.

As part of the same research project, another rigorous study by Vengberg et al. (2021) uses the same method and data collection as the study referenced above but examines how physicians and primary care managers perceive the payments incentives affecting their work. This paper concludes that payments directed at the primary care unit send effective signals to the providers, which trickle down from the primary care unit level to the individual managers and GPs, even though they themselves are not directly benefiting financially. The study also found that in Stockholm, which had a higher share of fee-for-service payment as a share of total remuneration, respondents perceived these payments to induce shorter visits, up-coding of visits, and skimming of healthier patients. The findings are interesting and show that financial incentives are effective tools to change health worker behaviour. Yet, the study does not seem to indicate that health care workers are primarily extrinsically motivated, as the health care workers do not necessarily benefit from these incentives themselves. The authors call for more research that describes the incentive structure in depth, including GPs’ employment status and whether the studied incentives are directed to individual, group, or unit level.

Kjellström et al. (2017) in their study of primary health care professionals in five health centres in one region (Jönköping) in Sweden, based on interviews with 43 people in total, found that work motivation improved for health care professionals when there was
alignment between their individual goals, organisational goals, and the design of the health care reform (in this case the Choice reform and accompanying regulatory and quality improvement reforms) that was being implemented. In this process, the authors stressed the importance of local leaders’ understanding of professional motivation, as they facilitate the travel of a reform from the macro to the micro level, where a culture of non-hierarchy, collaboration, teamwork, and kindness are important success factors.

Kjellström et al. (2017) and Vengberg et al. (2019) illustrate, similarly to Brekke et al. (2014), that the assumption that providers operate as self-interested actors that are optimising for wealth and leisure, as predicted in the theoretical theory of the quasi-market model, appears a simplification as many factors (professional norms, intrinsic motivation, etc.) influence provider behaviour in the quasi-market.

The studies also show that it is critical to understand how the individual provider perceives their operating environment, as this, at the aggregate level, will determine how the market operates. Similarly, Saltman and Duran (2016) recognised that governance is formed at the macro-level but what is important is how regulation and incentives play out in the daily work of the providers. Similarly, Korlén et al. (2017) showed that health care professionals are an important source of information in the study of quasi-markets.

3.3.2.3 Governance of quasi-markets

Swedish literature

There is emerging empirical literature focusing on the governance of primary care quasi-markets, with quite a few studies originating from Sweden.

An early study (Anell et al., 2012b), which came a few years after the passing of the national law on choice in primary care, mapped out how the 21 regions in Sweden had designed their governance system in terms of: (1) the formulation of the assignment to providers; (2) the provider payment system; and (3) the financial risk borne by the providers. This study showed that there are large differences in the definition of which activities are included in primary care in different regions as well as how the governance systems are designed and implemented, making it difficult to gain a comprehensive picture of how primary care quasi-markets are governed in Sweden.
There were also studies (Hartman et al., 2017; Lindgren, 2014) focused on the influence exerted by different remuneration models in health care and social services. Hartman et al. (2017) focused on reimbursement models in two regions, including Stockholm, in primary care and home-based care, and found that the reimbursement models contribute to the micro-management of providers, which collided with professional norms, motivation, and engagement.

However, a methodological challenge with Hartman et al. (2017) and Lindgren (2014) was that they only focused on one part of the governance system — the remuneration model. An important contribution in the study of governance of primary care quasi-markets is Glenngård’s (2019) study, which takes a more holistic perspective on governance and focuses on understanding the overall management control package in primary care quasi-markets, based on survey and interview data from the 21 regions in Sweden. This study, which is at the national level and is based on survey data, interviews, and document review, is the most comprehensive study to date on the mechanisms of governance of the quasi-market in Swedish primary care.

Glenngård (2019) states in her study that despite over a decade of implementation of the Choice model in primary care, “there is limited knowledge about what may be regarded as an appropriate governance model from the perspective of different actors” (Glenngård, 2019, p. 3). She set out to explore this issue from the perspective of the public purchaser.

She found that regional representatives describe their governance model in primary care as a continuous process including several management tools, including contracts, reimbursement system, dialogue, and performance measurement, where no tool was more important than another. Berg and Ingre (2013) had previously shown that most regions used performance measurement systems and have comprehensive dialogue with the providers.

When providers were prompted to identify the most important tool, dialogue and the tender document were seen as more important than other tools, where dialogue was seen as the most suitable type of control as it builds trust, relationships, and shared knowledge between the purchaser and the provider (Glenngård, 2019). This confirmed Norén and Ranerup’s (2015) findings from two regions in Sweden, showing that the tender document
(Accreditation Document/Rulebook) is important as an instrument for governance and particularly to promote competition amongst health care centres.

Glenngård concluded that from the perspective of the government, an appropriate governance model should include “a high level of formalization of both coercive and enabling types of control but with greater emphasis on enabling types” (Glenngård, 2019, p. 11). In the discussion, she highlighted that her study only focused on the purchaser's perspective and that “perceptions about the role of governance among providers and its relation to innovation and trust is another interesting area for further research” (Glenngård, 2019, p. 12).

There are also two less rigorous qualitative case studies (Karlsson & Lilja, 2013; Malmkvist & Redic, 2012) that took a similar holistic perspective to study market regulation in the quasi-market in primary care. These were master's theses with very small samples (e.g. Karlsson and Lilja [2013] only interviewed eight people), and therefore their validity can be questioned. Yet, I mention them because they had some interesting findings with regard to governance of private providers. Malmkvist and Redic (2012) explored how the regions exercise governance and control of private health care providers and why they manage the way they do in one region (Värmland), and Andersson et al. (2017) focused on the governance system for public facilities in another region (Skåne). They conducted in-depth interviews with regional staff as well as managers of primary care providers. Both studies draw from theories on management of organisations (see Merchant & van der Stede, 2007).

Malmkvist and Redic (2012) showed that the region exercises tight control of private providers, with limited provider autonomy, using the tender document that details the requirements for entering and operating in the market. They concluded that the new quasi-market creates uncertainty in the environment and because of lack of confidence in private providers on behalf of the purchaser, the governance approach to this market resembles that of traditional hierarchical bureaucratic control.

With regard to governing for competition neutrality, and as pointed out earlier, Brekke et al. 2014 (Table 2) point out that soft budget constraints for, for example, public providers can challenge the functioning of the theory of quasi-markets. On this topic there
are some indications in Sweden (e.g. Malmkvist & Redic, 2012; Swedish Competition Authority, 2014) that competitive neutrality is not always realised. The Swedish National Audit Office (2014), in their national representative study, showed that public providers who existed prior to the introduction of the quasi-markets have on average more patients listed because they were automatically allocated a number of patients by the regions and thereby have a competitive advantage compared to new providers. This study also found that soft budgets for public facilities is a recurring issue, which is also confirmed in other studies that show that public facilities in rural areas were allowed to run at a loss to prevent them from closing down (e.g. Kullberg et al., 2018). However, the Swedish Competition Authority (2014) also shows that there are private facilities that run losses, indicating that the reimbursement levels may be too low.

In elderly care, an important contribution to our understanding of governance of quasi-markets and particularly in relation to private providers, and therefore relevant for this thesis, is Blomqvist and Winblad’s (2020) examination of how local government in Sweden holds private providers accountable in nursing home care. This study was based on 43 face-to-face interviews with elected political representatives, municipal civil servants, medically responsible nurses, and nursing home managers in four municipalities.

This study contributes to a larger field of study by political science and public administration scholars, who have examined the changes in governance of the welfare state, over the past decades, as it has moved from a classic bureaucratic hierarchical governance model to a network structure, with blurring of boundaries between state, market, and civil society modes of governance (Mattei, 2009). A key concern raised in the literature on governance in the changing welfare state is how the state can monitor the performance of private contractors, involved in providing welfare services, and hold them accountable (Blomqvist & Winblad, 2020; Ditillo et al., 2015).

This question is also what Blomqvist and Winblad (2020) examined in the quasi-market for nursing home care in Sweden. Building on Smith et al.’s (2012) definition of governance and leadership, the authors point to three accountability measures used by governments: (1) hierarchical (e.g. direct supervision, audit, and codes of civil servants);
(2) *market* (e.g. consumer sovereignty, competition, and contracts [Donahue, 2002; Savas, 2000]); and (3) *social* (e.g. collaboration, and trust between contracting partners [Amirkhanyan, 2009; Epstein, 2014; Van Slyke, 2007]).

Blomqvist and Winblad (2020) found that various mechanisms were used to hold private providers accountable in elderly care in Sweden, but social accountability was perceived as the most effective mechanism. This is in line with Glenngård’s (2019) finding that enabling control mechanisms (focused on dialogue, partnership, and building trust) is key for creating effective governance systems in quasi-markets. Interestingly, Blomqvist and Winblad (2020) also found that market accountability mechanisms, such as contract termination and financial sanctions, could not be applied in this market as local governments could not enforce them.

These findings regarding the accountability mechanisms in nursing care are in line with recent research showing that public administrators combine accountability measures into hybrid accountability regimes (Benish & Mattei, 2019; Blomqvist & Winblad, 2020). There are few empirical studies of hybrid forms of accountability, but researchers (e.g. Benish & Mattei, 2019) call for more studies to understand the conditions under which hybrid forms of accountability measures emerge and whether they are effective.

Apart from the studies cited above, there are also more policy-oriented reports, such as ‘Healthcare deserves better governance’ (*Swe. Vården är värd en bättre styrning*) (Anell, 2020), that explore how the governance and financing of Swedish health care should be developed and changed in the future. There are also attempts, in the literature, to shed light on the relationship between elements of the governance system and outcomes of primary care, but it has been challenging to see patterns and draw firm conclusions (Swedish Agency for Health and Care Services Analysis, 2017).

*International literature*

Outside of Sweden, there is some research on the governance of quasi-markets (beyond primary care) that uses empirical evidence to formulate theoretical conceptualisations. Thus, these studies sit between empirical research and theory, and I cite them as they have influenced this thesis’ research design and methods.
Saltman and Duran (2016), discussed the changing role of the state as it moves from provider to steerer and presented two case studies from Swedish primary care and Spanish hospital care. They developed a useful conceptual map of relations — where the key relations amongst steering actors are represented as taking place on and across three distinct system levels: *macro, meso, and micro*.

The macro level is the national-level policymaking functions, the meso level is the institutional-level decision-making functions\(^2\), while the micro level consists of the operational issues at the clinic or organisational level. They argue that the different levels are rather blurred, particularly management and policy decisions.

Similarly, Jakab et al. (2002) presented an interesting conceptualisation, in their study of the hospital market in Eastern Europe, where they found that the behaviours of hospitals depend on the interaction between external incentives and organisational structure. In their conceptual framework, the *external environment* has four sources of performance pressure on the provider: collective purchasing (relationship with purchaser); market-driven purchasing (relationship with consumer); stewardship (relationship with government); and governance (relationship with owner).

Focusing on the role of the state in making competition in health care markets work, Bevan and van de Ven (2010) conducted a similar analysis to Brekke et al. (2014). In their comparative study of the implementation of internal markets for choice of providers (for elective services and hospital care) in England and choice of insurers in the Netherlands, they concluded that several political and technical preconditions need to be achieved in the governance system to reap the benefits of competition in the health sector.

These include: (1) *risk equalisation* (to deter cream-skimming, i.e. insurers/providers only seeking low-cost/young and healthy users); (2) *effective competition policy* to ensure market competition (prevent cartels, anti-competitive mergers, and abuse of dominant

\(^2\) Duran et al. (2011) defined the meso level as a set of processes and tools related to decision-making in steering the totality of institutional activity, influencing most major aspects of organisational behaviour and recognising the complex relationships between multiple stakeholders. Its scope ranges from normative values (equity, ethics) to access, quality, patient responsiveness, and patient safety dimensions. It also incorporates political, financial, and managerial as well as daily operational issues.
position) and safeguard consumer interests, by, for example, actively managing the market; (3) a system of product classification, medical pricing to understand the cost of services; (4) transparent consumer information that ensures consumers are aware of their right to choose as well as understandable information on the quality and services provided; and (5) market regulation to protect patients from substandard quality of care and to ensure that providers/insurers fulfil their financial obligations. Similarly to Bevan and van de Ven (2010), Glied and Altman (2017) stressed the importance of government antitrust enforcement in the US, where the authors stated that market concentration is increasing throughout the hospitals, physicians, and insurer markets.

Having explored the first research question of this scoping review, the subsequent section turns to the second research question.

**Part II: “What is known from existing research on the effect of ownership of primary health care facilities?”**

### 3.3.3 Theories on Ownership

The issue of ownership in the health sector has been discussed as early as 1963, when Arrow (1963) recognised that because of the asymmetric information between the provider and consumer of health care, not-for-profit providers were seen as more trustable because they, as opposed to for-profit providers, would not induce consumers to purchase unnecessary health care.

Grossman and Hart’s (1986) work on ownership, as mentioned in Chapter 1, is relevant to this thesis because the idea of ownership as a purchase of residual rights has been used to determine whether government should own services provision or outsource it to the private sector. Hart et al. (1997) developed a theoretical model for exploring this question, through which they theorise around what incentives arise for different ownership characteristics (public and private).

They state that if a complete contract can be signed between the government and service providers, then the same outcome could be achieved whether the service is privately or
publicly provided. However, they argue, contract incompleteness occurs as the quality of services that the government wants often cannot be specified in its entirety.

Related to this, Donahue (1989), in his seminal book ‘The Privatization Decision: Public Ends, Private Means’, pointed to factors that make privatisation of public services worthwhile. These are: (1) the ability to identify and measure the output of the private provider (the clearer the product, the easier to write a contract specification that allows to monitor performance); and (2) the degree of competitiveness amongst potential providers, as this drives efficiency in service provision. Similar to Donahue’s (1989) predication with regard to the importance of competition, Petersen et al. (2018) also concluded that it is not ownership but rather the competitive environment that determines the outcome of contracting out public services, and they stress that it is therefore important to measure competition in these markets.

It is worth mentioning, in this context, the theoretical literature on economics of contracting as it shows a range of contractual difficulties when contracting for complex services (Williamson, 1985) such as health care, which means that transaction costs of contracting health care are likely high (Allen, 2009). Allen (2009) summarises the literature that explores the impact of transaction cost economics in health care (see, for example, Allen 2002; Ashton, 1997; Roberts, 1993) and mentions a few challenges in contracting health care, namely: (1) in specifying what is needed; and (2) in monitoring output due to information asymmetries, the complexity of services, and the risk of opportunism (Allen, 2009). She concludes that the efficiency gains from using a diverse set of providers (public and private) may be off-set by the transaction costs involved.

Returning to Hart et al.’s (1997) model, they show that, in general, private ownership leads to excessively strong incentives to engage in cost reduction and moderate incentives to engage in quality improvement of services. Public ownership, contrary to this, removes the excessive tendency to engage in both cost reduction and quality improvement. Hart et al. argue that whether public or private ownership is better depends on which distortions are less damaging. For instance, if the deterioration of quality from cost reduction is very small or if opportunities for cutting costs (and quality) are small and government employers have weak incentives, then private ownership is superior. But if
there are large adverse effects of cost reduction on quality or if government employees have incentives to improve quality of services, then public ownership is superior.

The paper concludes that:

the case for in-house [public] provision is generally stronger when non-contractible cost reductions have larger deleterious effects on quality, when quality innovations are unimportant, and when corruption in government procurement is a severe problem. In contrast, the case for privatization is stronger when quality reducing cost reductions can be controlled through contract or competition, when quality innovations are important, and when patronage and powerful unions are a severe problem inside government. (Hart et al., 1997, p. 1159)

The authors apply their theories to several government activities using the available evidence. They conclude that the case for public ownership is high for, for example, foreign policy, armed forces, and police, and that the case for privatisation is strong for, for example, garbage collection and weapons production. In their analysis of the health care sector, they mention some critical factors: (1) that the gains from innovation are large in health care; (2) as is the damage to quality from reducing costs; (3) the importance of distributional aspects of quality, that is, that cream-skimming is a risk if the government pays less than it costs to treat expensive-to-treat patients; and (4) limited ability of consumers to assess the quality of services they receive. They conclude that “the combination of private ownership and competition would not be nearly so effective in healthcare [as in education], making the case for some government ownership stronger” (Hart et al., 1997, p. 1157).

Hart et al. (1997) make an important point of not lumping “together the issue of public or private ownership with the issue of competition” (p. 1129), and they state that private ownership is separate from competition as it is possible to have publicly owned firms (or management teams) competing with each other (to run a government company) as well as to have private ownership without competition (in a monopoly market).

3.3.4 What is Known from Existing Empirical Literature on the Effect of Ownership of Primary Health Care Facilities?

For primary care, there are few empirical studies on the effect of ownership. In a review of governance and organisation in the health care sector in Sweden, Hallin and Siverbo
(2002) found that most attention in research has been placed on the relationship between the purchaser (e.g. government or insurance agency) and the providers, with less attention being given to the role of the owner of the health care provider and ownership governance, that is, the owners’ influence on their providers. Below, I first turn to the literature in Sweden and then explore the literature outside Sweden.

Swedish literature

The studies on performance differences across ownership forms are few in the Swedish primary care context (Anell, 2011), and in Sweden there is an absence of studies comparing for-profit and not-for-profit private health care providers, because there are few private not-for-profit providers in the health sector (SOU, 2016).

Ellegård (2020) found in her rigorous national study, using provider-level outcome panel data from the Swedish Prescription Register, on the effect of pay-for-performance on compliance with hypertension drug guidelines amongst private and public primary health care providers that pay-for-performance increased compliance with treatment guidelines, particularly amongst private providers. She stated that her findings are consistent with the idea that financial incentives are of higher value for profit-maximising providers than those that are not and concluded that policymakers should take ownership into account when designing incentives for health care providers. This study is interesting since it shows that public and private providers respond differently to the incentive environment that the governance system gives rise to.

One comprehensive study, based on data from the annual National Patient Survey in three regions (Skåne, Västra Götaland, and Halland) found that private primary care units score significantly better than public ones on variables such as accessibility, continuity, and overall impression of clinic. However, when controlled for socio-economic status and health needs amongst the listed patients, this ownership difference disappeared almost entirely (the overall impression of the clinic was still higher for private clinics) (Glenngård & Anell, 2012). This indicates that public and private clinics serve different patients, but that the quality of care they provide does not differ systematically by ownership characteristics.
Another similar study of two regions (Skåne & Västra Götaland) found that private ownership was positively associated with patient views about responsiveness of the primary care provider (Glenngård & Anell, 2017). Maun et al. (2015), in their study on whether there is any difference in patient-perceived quality of care in the Västra Götaland region, could not answer the question whether quality of care is influenced by the ownership of primary care clinics. However, they found that there were tendencies of an (unintended) unequal distribution of the population between the two groups of providers (Maun et al., 2015 p. 1).

In the Stockholm Region, one study that evaluated the Choice Reform after 2 years of implementation based on register data found that there are no significant differences in productivity measures between public and private units (Rehnberg et al., 2010).

A less rigorous master’s thesis by Karlsson and Lilja (2013) focused on ownership differentials with regard to quality of care measures and financial performance measures in primary health care clinics in Sweden, but their study does not control for patient characteristics, thus its validity is questioned. However, the authors found that private-equity–owned facilities outperform public facilities on quality of care measures, though the best performing clinics were units privately owned by Praktikertjänst (an ownership model where the owner of the clinic is actively engaged in clinical care). Clinics owned by Praktikertjänst outperformed private-equity–owned facilities. On most financial performance measures (except revenue growth), Praktikertjänst also outperformed private-equity–owned units. While this study has methodological challenges, it is interesting as it reveals performance differences within the group of private primary care units.

There are several important contributions (e.g. Stolt et al., 2011; Winblad et al., 2017) that examine quality differences between public and private elderly care homes in Sweden. They found that private care providers seem to focus on services aspects (e.g. offering different food alternatives or having residents involved in the formulation of their care plan) rather than structural prerequisites for good care (e.g. number of employees.

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3 Measured by studying the use of antibiotics and benzodiazepine derivatives, as well as follow-up on certain routines related to chronic diseases.
per resident). However, Winblad et al. (2017) found that while ownership seems to matter, the evidence is inconclusive. For instance, privately owned homes had higher processual quality. The same study found no differences between various types of private owners (e.g. for profit, non-profit, and private-equity companies).

There are also some more policy-oriented reports, such as a contentious Swedish government report (SOU, 2016) that discusses ownership in the welfare sectors at length, with the objective to propose a new regulation for publicly financed and privately provided/owned welfare services. This report points to the risks involved with profit-maximising owners, including that they may: (1) only deliver the quality of care that is possible to measure; (2) cherry-pick “low-cost” users, which creates segregation in welfare services; and (3) be encouraged by strong financial incentives for for-profit entities to expand their market share, and thereby there is a risk to reduce competition and limit patient choice.

This report gave support to the view that governance matters, as they stated that how governance systems in the welfare sector are designed is of outmost importance, not just to ensure provision of high-quality services, but also for trust in the government and ultimately for willingness to pay taxes and for the society.

*International literature*

Outside of Sweden, there is empirical literature that focuses on the ongoing trends of retail clinics offering primary care services (e.g. Kaissi & Charland, 2013; Laws & Scott, 2008) and the integration of primary care independent practices in hospitals in the US. The latter literature is not comparing publicly and privately owned clinics but rather different types of private ownership structures. It focuses on the difference between hospital-owned and physician-owned clinics on various performance measures, such as: overall cost of care (McWilliams, 2016; McWilliams et al., 2013; Robinson & Miller, 2014), rates of preventable hospital admissions (Casalino et al., 2014), and hospital choice (Baker et al., 2016), etc.

In general, this literature has found that there are differences between the two ownership structures examined, but with inconclusive results regarding what ownership structure
performs best. For instance, Robinson and Miller (2014) found that local hospital-owned physician organisations incurred higher expenditure per patient than physician-owned organisations did, Bishop et al. (2016) found that hospital-owned clinics provided better chronic disease management and quality of care than physician-owned, and Cuellar et al. (2018) found more favourable rating of the work environment in hospital-owned practices compared to independent practices. Lindner et al. (2019), in their study of 989 small and medium primary care practices in the US, found that primary care practice ownership was associated with differences in quality improvement process measures, with Federally Qualified Health Centres reporting the highest use of quality improvement strategies. While the literature from the US does not give clear evidence regarding how ownership should be structured for improved performance, it does indicate that ownership matters.

There is also literature from New Zealand (Crampton et al., 2005; Crampton et al., 2004; Crampton et al., 2001; Crampton & Starfield, 2004), summarised in Crampton (2005), on studies of different ownership structures (community-governed non-profits and for-profits) of primary care clinics, and the various studies by Crampton and co-authors also find systematic differences that the authors ascribe to ownership. For instance, community-governed non-profits charged lower patient fees per visit and employed more Maori and Pacific Island staff compared to for-profit clinics, and they thereby reduced the financial and cultural barriers to access services (Crampton et al., 2005). This literature studies the ‘ownership structure’, which includes both the ownership of the primary health care unit and who participates in governance of the primary health care unit. Crampton (2005) concluded that an ownership framework must be used more widely in health policymaking.

There are more recent studies (e.g. Wei et al., 2015; Wei et al., 2017) that compare government-managed, hospital-managed, and privately managed community health centres in China. These papers find that ownership and management of community health centres impact the services they provide, where the private community centres were the smallest and in the most disadvantaged position to deliver high-quality care. Wei et al. (2017) confirmed this, finding that private primary care ownership may be associated with lower-quality and less equitable care distribution, and concluded that it
may be beneficial to promote public-owned and non-profit-owned providers in the future. However, Meng’s (2000) study of village health clinics in China found no evidence that care provided by private clinics was inferior to that of public clinics.

Similar to this, a study (Gauri et al., 2004) of the impact on contracting out provision to health care cooperatives in Costa Rica found that these cooperatives had superior performance to public clinics, with the authors concluding that cooperatives, if appropriately regulated, can combine advantages of public and private approaches to health care service provision. Chlabicz and Marcinowicz (2005) found in their study in Poland that from the patient perspective, the quality of family physician care in non-public practice is better than in public institutions, especially regarding communication and work time management.

Beyond primary care, there is a large body of literature comparing public and private health care service providers that focuses primarily on hospital care. The studies from the US compare not-for-profit and for-profit private caregivers. A review by Schlesinger and Gray (2006) of this literature, including 162 sophisticated studies (using multivariate models or matched samples), focused on ownership differences for hospitals and nursing homes with regard to measures of economic performance, quality of care, and accessibility for unprofitable patients. The review revealed that: (1) for-profit nursing homes have lower costs and greater efficiency, while it is difficult to distinguish any ownership differences with regard to costs and efficiency results for hospitals; and (2) for quality of care measures (adverse events and inpatient mortality), ownership-related differences are more pronounced in nursing homes than hospitals. The review also found that for-profits more aggressively marked up prices, while not-for-profits appeared more trustworthy and innovative in delivering services but slower to react to change in market conditions compared to for-profit providers. The authors painted a rather complex picture of whether ownership matters, and concluded that “the effects of ownership manifest in different ways for different services” (Schlesinger & Gray, 2006, p. 291) and stressed the importance of understanding how the context impacts ownership-related differences.

Similarly, Eggleston et al. (2008) reviewed the literature of hospital ownership and quality of services. The authors found that the observed differences in mortality rates and
adverse events between hospitals of different ownership appear to be contingent on data sources, time period covered, and region studied. The study concluded that “the ‘true’ effect of ownership appears to depend on institutional context, including differences across regions, markets, and over time” (Eggleston et al., 2008, p. 1345). Ruseski (2009) came to a similar conclusion in her study on the expansion of private sector delivery of surgical services in Canada.

Andersen and Jacobsen (2010), in their study of the difference between public and private providers of hip surgery in Denmark, found that professionalism of the staff off-set some of the ownership differences (e.g. that private clinics employ stronger individual incentives) and pointed to the importance of professional norms for avoiding that strong financial incentives lead to opportunistic behaviour with adverse impact on quality of care. The authors recommended that policymakers “reject simplistic and axiomatic perspectives of the private and public sectors and take both incentives and professional norms into consideration when deciding where (in public or private sector) services should be produced” (Andersen & Jacobsen, 2010, p. 972).

While there seem to be systematic differences between the ownership characteristics, it is difficult to ascertain the influence of ‘ownership’ in isolation from other variables. As pointed out by Eggleston et al. (2008) and Shlesinger and Gray (2006), the context in which facilities operate also seems to matter.

There is literature beyond the health sector that studies the economic and quality effects of contracting out public services that is worth mentioning. However, it is important to notice that this literature does not necessarily include quasi-markets’ governance arrangements, but rather focuses on cost savings that can be made by, for example, contracting out a public service, such as garbage collection, to a private provider.

The most recent systematic review of this literature for the period 2000–2014 (Petersen et al., 2018) concluded, similarly to Hart et al.’s (1997) theoretical predictions, that there is empirical evidence of cost savings from contracting out in technical areas, but not in social services (such as health, elderly care, etc.). However, the evidence with regard to social services is thin and few studies examine service quality as well as the empirical estimates of the transaction costs of contracting out. Romzek and Johnston (2005)
offered a clue as to why it may be different to contract-out social services compared to other services. They found in their study on social services (foster care, adoption services, Medicaid), and in line with theory, that it is particularly challenging to achieve contract accountability as these services are complex and hard to evaluate for the state.

3.4 Concluding Discussion

In this section I first summarise the results of the literature review and then discuss the gaps in existing literature and explain how this thesis contributes to the existing body of knowledge.

3.4.1 Summary of the Literature Review

3.4.1.1 What is known from the existing literature about the governance of primary care quasi-markets?

As described in the theoretical literature on quasi-markets, economic theory predicts that this way of organising primary care will produce superior results, in terms of efficiency and quality of care, than a “planned” model, if a number of assumptions on the demand, supply, and governance sides are realised.

These assumptions include the following:

- that the demand for services responds to variations in quality (i.e. that individuals who choose a provider do so on the basis of informed choices);
- that providers are profit (or surplus) maximisers;
- that the cost for serving an additional patient is less than the price obtained for doing so; and
- that providers aim to meet whatever demand is generated by patients’ choices, rather than act to stimulate demand for the services they supply, or aim to supply.

As presented in the theoretical review, there are several reasons why, in reality, the assumptions underlying this model might not hold. How well a real-world quasi-market delivers on the objectives set for it is dependent on several factors related to the demand
side and supply side of primary health care services, which is in turn influenced by the incentive structures that the governance system creates and how individuals respond to these. On the supply side, theory predicts that agents may not be profit maximisers — particularly in public organisations (Dixit, 2002) but also in private organisations and that intrinsic motivation is likely to be a larger factor in the health sector than in other sectors (Besley & Ghatak, 2005). Moreover, belonging to a professional group — and the sense of belonging and responsibility that this affords — could also be a major check on responses to purely extrinsic incentives (Freidson, 2001; Mosher, 1968; Roberts & Dietrich, 1999).

My review of the empirical literature on the demand side shows that this literature focuses on whether individuals actively chose their providers and if they use information in their decision-making process. The results vary by country, but for Sweden's primary care market, studies find that only about 60% of the population made a choice of provider when the reform was introduced (Glennård et al., 2011), and that their choice is not always informed by data (Glennård et al., 2011; Wahlstedt & Ekman, 2016). Thus, there appears to be some demand sluggishness in the Swedish primary care market. This contrasts evidence from the UK, which shows that clinical quality is indeed an important factor when individuals choose their family doctor (Santos et al., 2017).

Whether an individual uses information also appears to depend on the motivation for changing provider. One study concluded that since individuals are not making informed choices of providers, it is critical for market regulators to not just rely on patient choice as a driver of quality of care but to also monitor quality of care (Hoffstedt et al., 2018). This is an important conclusion of the literature review and motivated my focus on examining in detail how regulators hold providers accountable for delivering high-quality care (Chapter 7).

Overall, the empirical evidence from Sweden indicates that the assumption of the quasi-market theorists that demand responds to variations in quality of care does not hold (even in regions where authorities have made information about quality of care easily available online [Wahlstedt & Ekman, 2016]), a key assumption in the quasi-market theoretical model. This is problematic since uninformed users who are not taking data on quality into
account before making a provider selection may give providers less incentive to compete on quality (Le Grand, 2007).

On the supply side, I find only two papers — Vengberg et al. (2021) and Vengberg et al. (2019) — that examine provider behaviour in the quasi-market in Swedish primary care. Vengberg et al. (2019) show that providers’ actions are not aligned with the quasi-market theoretical predications. They did not find evidence of providers competing on either process or outcome quality, as providers perceive a never-ending demand for primary care amongst the population and since patients were mostly attracted by patient accessibility, which is just one dimension of quality of care. Furthermore, the study found the providers do not necessarily act as profit (or surplus) maximisers, which may indicate that health care providers are intrinsically motivated, as predicted by theory.

A key conclusion from my review of the studies on the supply side is that it is critical to understand provider behaviour in quasi-markets, the incentive structure (Vengberg et al., 2021), and how the individual provider perceives their incentive and operating environment, which the governance system gives rise to, as this, at aggregate level, will determine the performance of the quasi-market. This motivated my inclusion of health care managers who work in health care units in my study, as what matters is how they behave as a result of the incentive structures that the governance system produces, not just the rules of the game developed by public authorities.

With regard to what we know about how primary care quasi-markets are governed by public authorities, this is an issue that was long ignored in the literature. Perhaps this is because the theory of quasi-markets originates from ideas in neoclassical economics that are not focusing on market organisation (Ahrne et al., 2015), or possibly because of the limited experience with implementing quasi-market reforms. However, in recent years, there is increased interest in this subject and there is an emerging body of literature, with several studies that originate from Sweden.

The existing literature on the primary care market in Sweden shows that governance arrangements vary across regions, which makes it challenging to paint a national picture. This finding motivated my choice to study the largest region in Sweden, namely Stockholm, rather than doing a national study, particularly as I wanted to conduct a deep
analysis, capturing different stakeholders’ perspectives, which would be time-consuming to do nationwide.

Many of the early studies on governance of the primary care quasi-market focused on the impact of one part of the governance system, for example, the reimbursement model (e.g. Lindgren, 2014), while researchers acknowledge the importance of a holistic perspective and studying various governance controls. Only a few more recent studies focus on the overall management control package used to govern primary care quasi-markets. A key study is Glenngård (2019) that is based on a survey and interviews with market regulators in 21 regions. This is also the most rigorous study to date on the topic of governance of primary care quasi-markets. She found that regional representatives describe their governance model in primary care as a continuous process including several management tools, including contracts, reimbursement system, dialogue, and performance measurement, where dialogue and the tender document were seen as more important than other tools. Glenngård (2019) pointed out that “there is limited knowledge about what may be regarded as an appropriate governance model from the perspective of different actors” (p. 3).

With regard to governing for competition neutrality, there is empirical evidence (Malmkvist & Redic, 2012; Swedish Competition Authority, 2014) that a level playing field is not always obtained, with, for example, soft budget constraints for public facilities being a recurring issue.

I also give account of a broader strand of literature on how the state monitors the performance of private contractors involved in providing welfare services (Blomqvist & Winblad, 2020; Ditillo et al., 2015). In the case of elderly care in Sweden, Blomqvist and Winblad (2020) show that social accountability (e.g. collaboration and trust between contracting partners) is key to hold private providers accountable, while it has been challenging to enforce market accountability mechanisms, such as contract termination and financial sanctions in this market.
3.4.1.2 What is known from existing research on the effect of ownership of primary health care facilities?

Regarding the theoretical literature on ownership, it predicts that ownership of government services does not matter if you have complete contracts and competition. For health care services, the characteristics of these services (e.g. limited ability of consumers to assess quality of care, the damage to quality from reducing costs is large, risk of cream-skimming, etc. [Hart et al. 1997]) are such that it is reasonable to believe that complete contracts are difficult to obtain as it is challenging to specify what is needed, to monitor the output, and given the risk of opportunism (Allen, 2009).

Turning to the empirical literature, my review finds that the impact of ownership in primary care facilities is quite varied. In some contexts, ownership seems to matter for outcome variables (e.g. New Zealand primary care, US primary care [but within the private ownership category], China), but the literature is not conclusive in saying that one type of owner is better than the other. However, in Sweden’s primary care, there appear to be small ownership differentials between public and private clinics with regard to patients’ views on various variables (e.g. accessibility, continuity, impression of clinic) once socio-economic status and health needs amongst patients are controlled for (Glenngård & Anell, 2012). Research from Stockholm shows that there is no difference in productivity measures between public and private providers (Rehnberg et al., 2010). Yet, a recent study (Ellegård, 2020) found that private providers are more responsive to financial incentives to comply with certain quality requirements than public providers, and the author concluded that it is important to take ownership into account when designing incentives for health care providers.

More importantly, the studies in this area are few and have several methodological challenges as it is difficult to ascertain the influence of ownership in isolation from other variables. While there are no reviews of the literature in primary care, other reviews of the impact of ownership in the hospital sector stress that the impact of ownership is contingent on the institutional context, including differences across regions and markets and over time (Eggleston et al., 2008). Thus, whether ownership matters for service provision outcomes depends on how the incentives that the owners put in place impact the
providers as well as whether these are curbed by other incentive structures, for example, put in place by public authorities.

3.4.2 Gaps in Existing Literature and how this Thesis Contributes to the Existing Body of Knowledge

There are several research gaps that emerge from the literature review.

First, and related to research question (i), I find that the body of knowledge on the governance of quasi-markets is growing, with many recent contributions from Sweden (e.g. Blomberg & Winblad, 2020; Glennård, 2019), but the literature on this topic is still scarce (Glennård, 2019), particularly in primary care. For instance, to my knowledge, there is no study that focuses exclusively on the governance mechanisms used in the Stockholm Region even though this is the largest region in Sweden. More research is also needed on hybrid forms of accountability measures (Benish & Mattei, 2019) and on the practical mechanisms used for governance/regulation in the quasi-markets (Carey et al., 2020), particularly from a holistic perspective that uses a qualitative research approach that allows for better understanding of the interactions between different elements (purchasing, quality regulation, etc.) (Hartman, 2017) and levels (micro, meso, and macro) of the governance system (Saltman & Duran, 2016). I have sought to fill these gaps with my research by conducting a qualitative study on the governance of the primary care quasi-market in the Stockholm Region.

Second, the empirical literature I gave an account of above on provider behaviour (supply side) and user/patient behaviour (demand side) in the quasi-market indicates that neither providers nor users appear to act according to economic theory. This gives an indication that the governance of quasi-markets is more complex than predicted in economic theory and therefore interesting to study. Moreover, several studies (Kjellström et al., 2017; Vengberg et al., 2019) show that providers are an important source of information about the governance of quasi-markets. Yet, there is a dearth of studies on supplier behaviour and on providers’ perceptions of the governance system and the incentive structure it gives rise to, although existing studies (Vengberg et al., 2021; Vengberg et al., 2019)
indicate that this is an important area to study to understand the functioning of the quasi-market in practice. Glenngård (2019) highlighted that her study on the primary care governance system only focused on the purchaser’s perspective and that “the perceptions about the role of governance among providers and its relation to innovation and trust” (p. 12) would be an interesting area for future research. I sought to fill this gap by going beyond examining the governance system as implemented by the public authorities but seeking to understand what incentives it gives rise to for the providers and how they perceive that it impacts their actions. Because of this quest, my research is designed to capture the perspectives from those who govern as well as from those who are governed.

Third, while there is recent research (Ellegård, 2020) indicating that providers of different ownership status may respond to the incentive environment differently, there is limited research that includes providers of different ownership characteristics, although theory predicts that ownership status matters (Hart et al., 1997). Vengberg et al. (2019) called for more research that studies the differences between different types of providers, in terms of their perceptions of market regulation that in turn influence behaviour. I sought to address this gap by including providers with different ownership status (public and private, small and large owners) in my research.

In summary, to fill existing research gaps, the aim of the thesis is to explore the governance system of the primary care quasi-market in the Stockholm Region and examine how this system is perceived by different stakeholders. This thesis adds to Glenngård (2019) and Vengberg et al. (2019) by capturing both the perspective of public authorities and providers in the same region. Vengberg et al. (2019) focused on the provider perspective while Glenngård (2019) focused on the public authorities’ perspectives. This thesis also contributes to the call by Vengberg et al. (2019) to capture the views on the governance system of providers with different ownership status. Building on Hart et al.’s (1997) work pointing to the importance of the state being able to write complete contracts to ensure similar outputs by public and private providers and Donahue’s (1989) work that stresses the importance of the state being able to identify and measure the output of the providers and to measure competitiveness amongst
potential providers when inviting private providers to deliver public services, my research focuses on how public authorities govern to achieve competition and quality of care.
4 Research Design and Methods

4.1 Introduction

Previous chapters introduced the aim and objectives of this thesis, reviewed existing literature, and outlined how this research contributes to the existing body of knowledge. The purpose of this chapter is to present the research design pursued to realise the research aim and answer the research questions.

To achieve this objective, this chapter first explains the underpinning philosophy of science of this research and various sources of theoretical inspiration for this thesis. Thereafter, I present the research design and method, including the data generation approach, data collection method, approach to analysis, ethical considerations, and conclusions.

4.2 Research Philosophy and Theoretical Inspiration

4.2.1 Research Philosophy

The underpinning philosophy of science for this study is critical realism. This philosophy of social science is a critique of both the positivistic hyper-naturalism and the hermeneutical anti-naturalism (Bhaskar, 2016). It situates itself as a via media between these duals.

The holy trinity of critical realism is ontological realism (reality has an objective existence), epistemological relativism (knowledge is fallible, but not equally fallible, and open to adjustment), and judgemental rationalism (it is possible to assess the validity of knowledge) (Bhaskar, 2016, p. 6). It seeks to produce ‘serious’ philosophy, where serious derives from the German philosopher Hegel's idea of the unity between theory and practice (Bhaskar, 2016). In Bhaskar’s words, critical realism seeks to “produce a serious philosophy that we can act on, and one moreover that is relevant to the pressing challenges we face and that ideally can illuminate a way forward (telling us something new)” (Baskar, 2016, p. 2). This research philosophy fits well with this research project.
that explores the intersection between the theoretical predictions of the quasi-markets and the practice of governance of a quasi-market in primary care in the Stockholm Region.

According to critical realism, reality is oriented towards three ontological domains: the *empirical domain*, which consists of observable events that we experience (directly or indirectly); the *actual domain*, which, in addition to our experience, includes unobservable events that happen whether we experience them or not; and the *real domain* that consists of both unobservable and observable events as well as the mechanisms that trigger them, which are contingent on the context.

This epistemological perspective appears suitable for the purpose of this study since I aim to explore a phenomenon, i.e. the governance mechanisms of a primary care quasi-market, with an analytical focus that goes beyond the observable events (e.g. rules codified in the Rulebook or the Compensation model designed by the public authorities) beneath the empirical surface to include deeper causes behind the observable ideas and beliefs of the stakeholders that operate in the governance mechanisms, and the incentive environment it gives rise to, which form the governance system of a primary care quasi-market. Critical realism offers possibilities to provide answers to questions concerning how and why something works (or not) while also considering the different contexts (Blom & Moren, 2011) and perspectives of a phenomenon.

The critical realist epistemology allows for various research methods or approaches. However, Danermark et al. (2019) pointed out that not all methods are suitable and what is most important is that the researcher understands how to use certain methods and what conclusions can be drawn.

For the purpose of this thesis, I examine the governance of the quasi-market and an intensive design (Sayer, 2000) method was deemed suitable, which contains substantial elements of data collection and analyses of a qualitative kind. I used strategic sampling,  

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4 During the project, I considered using a mixed-method approach and a realist evaluation design (Pawson, 2013) to evaluate the PCCR. However, after further exploration, this idea was abandoned chiefly because there are already several studies, as reported in the literature review, that evaluate the reform by studying its effect on various outcome variables and, secondly, because I was more interested to understand the governance system rather than evaluating the PCCR since this is where the largest gap appeared for policymakers as well as in existing literature.
which selects varied cases to collect information about various conditions for producing the phenomenon, governance of a primary care quasi-market, under investigation (Danermark et al. 2019, p. 181).

Moreover, this research is situated in an interpretivist frame, which puts emphasis on studying people’s understanding/perceptions in their individual context (Ritchie et al. 2014, p. 22). In practice, this meant that from the onset of the research project, existing literature and theories informed the design of the project. However, during data collection and in the first interpretation of the data, I focused on understanding the interviewees’ points of view and on letting the data speak for itself. Towards the end of the project, I returned to existing research and theories and started a process of twinning individual data and interpretations together with theory and previous research, while placing importance on ensuring that higher-level interpretations were well grounded in the data collected in this research project.

4.2.2 Theoretical Sources of Inspiration for the Research

My project is concerned with understanding what the public authorities concretely do to govern the primary care quasi-market. Given this, the research is inspired by other policy studies that see public administration or governance as a practice or work rather than a step-by-step process (e.g. Colebatch, 2006; Freeman et al., 2011; Howard, 2005; Wagenaar, 2004). As pointed out by Wagenaar (2004), “we know surprisingly little about what the work of public administrators entails” (p. 643). I share this perspective and am interested in exploring the ‘practice’ and ‘lived experience’ of policymakers in governing a primary care quasi-market. Wagenaar’s (2004) description of a context where the work takes place “as a dynamically integrated systems of relations” (p. 648) where the actor “negotiates” the environment, rather than a fixed container (organisational, cultural, political, historical) is particularly relevant for this study as I explore how health care managers, often patient-facing staff, perceive the governance system and the incentives it gives rise to.
Building on Duran et al. (2011) and Saltman and Duran’s (2016) conceptualisation of key relations amongst steering actors taking place on and across three distinct system levels — macro, meso, and micro — this research project recognises that the governance of the quasi-market involves many decision-makers at different levels. Therefore, data collection captures the perspectives of the public authorities as well as the managers of the primary health care units and the owners of the primary health care units.

Another source of inspiration for this thesis is Alford (1975), who in his study on the failure to implement measures to improve health care in New York City categorised interest holders in western health care systems and the political relationship between them.

He identified three major categories: (1) professional monopolists (e.g. doctors in clinical practice) who are primarily concerned with individual patients; (2) corporate rationalisers (e.g. civil servants in government who carry out political directions) who seek to use resources efficiently for a defined population of patients and control the professionals and the clinical work; and (3) the community (e.g. users and patient advocates) that seeks accessible, equitable, free, and high-quality universal health coverage. Building on Alford (1975), I seek, in this thesis, to understand who are the stakeholders that influence the mechanisms of governance in the quasi-market for primary care in the Stockholm Region and their perception of the governance system, and I structure my results chapters according to the perspectives of the different stakeholders.

To structure my analysis of the mechanisms of governance in the primary care quasi-market in the Stockholm Region (Chapter 5), I find Ahrne et al.’s (2015) conceptualisation of the mechanisms of governance in the market — in their words, the market organisation — useful.

Ahrne et al.’s (2015) framework builds on ideas that have been used to analyse organisations. Their view on markets stands in contrast to the view in neoclassical economics, in which markets are conceptualised as spontaneously occurring at the price where the demand and supply for goods or services meet (Heyek, 1973; Smith, 1981) and where, led by the invisible hand of the market, people acting in their own self-interest will eventually act in the best interests of the greater public good (Smith, 1776). Rather, Ahrne et al. (2015) see markets as often organised based on a decided social order
produced through decisions about, for example, rules, sanctions, or memberships (Ahrne et al., 2016). This view is congruent with the work of Walsh (1995), who argued that markets and organisations exist on a continuum:

The distinction between organisations and markets has become less valid as markets come to be structured in a way that makes them resemble organisations and organisations come to be structured in a way that makes them resemble markets. Just as within organisations we can now conceive of various forms of quasi-markets operating, for example through the use of internal trading processes, so the market can be understood as quasi-organisation. Market and organisation are then seen as being the ends of a continuum rather than binary opposites. (cit. Walsh, 1995, p. 45–46)

This conceptualisation resembles Smith et al.’s (2012) definition of governance (see Chapter 1) as social coordination with three modes — hierarchy, network, and work — in the sense that both conceptualisations reflect a continuum where the level of organisation, and with that the role of the state, changes along the continuum.

Ahrne et al. (2015) elaborate on the nature of social interaction and highlight five fundamental elements needed for a social interaction (such as in an organisation) to be continued and repeated, namely:

1. those who interact must be aware who is involved in the interaction;
2. they require a shared idea about what they are doing and how to do it;
3. they must observe each to know how to continue;
4. they must be able to take measures for others to do what they expect them to do and;
5. they must understand who has the power and initiative. (Ahrne et al., 2015, p. 11)

According to the authors, these fundamental elements can be formed through, for example, culture norms or tradition or by decision. Formal organisations are created when these elements are formed by decisions, i.e. through statements to others about what they are expected to do. In the case of formal organisations, decisions are made on five elements, according to the authors:

1. Membership, i.e. who is a member and who is not?;
2. Rules for the actions of its members;
3. How to monitor their members;
4. Positive and negative sanctions of its members; and
5. **Hierarchy**: pronouncements on whether decisions are binding for members or prospective members. (Ahrne et al., 2015, p. 11)

These five elements are important because even if markets are not “formal organisations” with all five elements at play at the same time, markets can be characterised as partial organisations (Ahrne & Brunsson, 2011) where some of the five elements listed above are used.

Andersson et al. (2017), in their analysis of three important market authorities, namely government bodies that have as their main task to influence markets, very similar to the SRHCO in the primary care market, use Ahrne et al.’s (2015) conceptualisation to understand how public authorities govern the market. Forsell and Norén (2018) used the same conceptualisation to study the primary health care market in Sweden.

In addition to the five elements mentioned above, Andersson et al. (2017) found in their mapping of measures taken by public authorities to influence the market that two other elements are used, namely:

6. **Information**, which is described as a soft method of influencing the market. It is different from a rule, that is often short and precise, because it seeks to make someone aware of something rather than instruct a certain action.

7. **Depiction** (Swe. Avbildning) this is another soft influencing method, that primarily is about creating depictions of how the relation between different units and/or individuals are connected (for example, who belongs to what unit in an organisation) and it can also describe the future of the organisation through predictions, risk analysis etc. These are important activities to influence ideas, activities, their boundaries and connections. (Anderson et al., 2017, p. 86–87)

I use Ahrne et al.’s (2015) framework and the extension of it by Andersson et al. (2017) to categorise my empirical data in my first Results chapter (Chapter 5). It is, however, important to mention that this does not mean that I view the primary health care market as an organisation. I primarily used this framework to sort my empirical data in a meaningful way as it provides a more detailed and easily applicable conceptualisation of market governance than, for example, Smith et al.’s (2012) definition of governance.

I also use theories about quasi-markets and ownership in this thesis. These were already described in the literature review in Chapter 3.
4.2.3 Other Sources of Inspiration and Planning

Through my professional experiences working as a senior health economist with the World Bank, I have been involved in the development and teaching of a course titled Managing Markets for Health (MM4H) over the past seven years. This course aims to provide policymakers in low- and middle-income countries with case studies and tools for how to engage the private sector in achieving public health care objectives such as universal health coverage. As part of the curriculum of MM4H, I developed a teaching case study of the introduction of quasi-markets in primary health care across the 21 regions in Sweden for teaching purposes and conducted interviews with key informants in March 2014.

The case study was formative for this research project because I familiarised myself with existing theories and research about the quasi-markets and with the practical aspects of the reforms through key informant interviews. While conducting the case study I noticed a gap in detailed knowledge about the reform process and the design of the governance systems. I was motivated to fill this gap. I was also inspired to broaden my perspective as an economist to understand the governance mechanism behind the choice reform and expand my knowledge of other academic disciplines relevant to advising policymakers on how to engage private providers to deliver on public interest objectives.

Thus, the research design and research questions of this thesis were informed by the interviews conducted in 2014 and informal scoping meetings with stakeholders whom I had met while conducting the case study. These meetings served to inform my thinking around the project and to develop a relevant research aim and objectives that would contribute to the existing body of knowledge. As these meetings were not part of this research project, they were not recorded, nor were informed consent forms signed, but they were still important for informing the project.

As mentioned previously, another source of inspiration for the focus of this thesis was questions that came up in my professional work with policymakers from low- and middle-income countries. They often struggled to know how to best create primary care governance system inclusive of private providers, that delivered on public interest objectives. In many cases, they asked for information from OECD countries that had
carried out similar reforms. Thus, the research questions originated from practice and my search for knowledge about how to best advise these policymakers and future ones I hope to work with.

During the pre-planning phase, I discovered how the primary care quasi-market reforms in Sweden were quite unique from an international perspective, given that the primary care providers were predominately public prior to the reform. In many OECD countries, primary care providers are primarily privately owned (OECD, 2016). Thus, the reform experience in Stockholm also provides an interesting example for low- and middle-income countries that are interested in privatising their public health care systems.

4.3 Choosing and Using a Qualitative Embedded Case Study Approach

4.3.1 Selection of Qualitative Embedded Case Study Approach

Given the ontological outlook of this project, its interpretivist viewpoint, and its aim and research questions, as mentioned above, a qualitative research method is most suitable. This was motivated by the fact that the project aims to explore ‘how’ a primary care quasi-market is governed by portraying mechanisms, processes, and other instruments that exist independently of those who observe/work/shape the governance system. But it also aims to go deeper and understand the complex interaction between the individuals shaping the governance system and those who operate within it. These aspects are best captured through a qualitative research method.

I considered using a mixed-method approach where qualitative data collection would be complemented with a survey of a more quantitative nature, however, given the nature of the research questions, this idea was discarded as such survey would have added limited insight and would have potentially risked the feasibility of the project as the scope would have increased substantially.

Yin (2018) explained that a case study approach is appropriate when ‘how’ or ‘why’ questions are posed, when the investigator cannot manipulate the behaviour of those involved in the study, contextual conditions are relevant to the phenomenon of study, and
the boundaries between the phenomenon and the context are not clear. All these characteristics fit with the research aim and background for this study, therefore a single case study approach was selected focused on the Stockholm Region.

The case study approach gives in-depth insight into the governance arrangements and the different providers’ perceptions of the same, while interviewing them in their different contexts. This type of research approach is suitable for exploring multiple perspectives, rooted in different contexts, that can be brought together to build an in-depth understanding that is holistic, comprehensive, and context specific (Ritchie et al., 2014).

I sought to capture the perspectives of different types of providers (with various ownership characteristics), as well as actors at various levels (macro, meso, micro) of the governance system, and engage directly with policy practitioners to form an understanding of the governance mechanisms of the primary care quasi-market, while viewing governance as an ongoing ‘practice’. In addition to capturing multiple perspectives through accounts from different people, several views were also explored through various data collection methods, including in-depth semi-structured interviews and documentary analysis, as explained in detail below.

An alternative research design would have been a multiple case study approach, including several regions in Sweden. However, given that each region in Sweden has its own governance system (Anell, 2012; Swedish Agency for Health and Care Services Analysis, 2017) and that an important aspect of the study was to explore the perceptions of the governance arrangement by different types of providers, with various ownership status, I decided to focus on one region as there was a risk that analytical clarity would be lost if various regional governance systems would be mixed with different ownership characteristics and I wanted to isolate the ownership effect. This decision was taken building on the logic that “the more similar the settings being compared, the simpler it should be to trace an association between dependent and explanatory variables” (van der Heijden, 2014, p. 38).

The choice of a single case study approach was also motivated by the fact that in-depth data (Yin, 2018) across various levels of the governance system and from providers with different ownership characteristics was collected. And, as mentioned previously, given
existing time and resource constraints (one lone researcher for the time period of a PhD), expanding the study to several regions would have made the study challenging to complete in time.

In the design of the study, it was important to include views from various levels of the governance system by capturing the perspectives of the regional authorities and owners as well as the different types of providers. It was also important to build a comparison between primary health care units that had different ownership characteristics in the research design to not just understand the governance arrangements in this quasi-market but also to understand if the perception of the governance system varied amongst the clinics with different owners. This also allowed me to understand if the providers perceived that the governance system and the incentive structure it gave rise to had different impact, for example, on provider action in varying settings.

The embedded case study design that incorporates these different sub-units into the analysis is an ideal study design for these purposes as it allows for incorporation of different sub-units and the development of a more complex design to better understand the single case study (Yin, 2018). It also allowed me to isolate potential ownership differences. Thus, I used a case study (of one region) with embedded units (primary health care units with different ownership characteristics). See Figure 2 for a representation of the embedded single case study design. The benefit of such a rich analysis is that “data can be analysed within the subunits separately (within case analysis), between the different subunits (between case analysis), and across all of the subunits (cross-case analysis)” (Baxter & Jack, 2008, p. 550).

In the trade-off between breadth of coverage and feasibility, I strived to have enough interviewees (not just one) in each sub-unit (for example private-equity-owned unit) to reflect the diversity within each group (Ritchie et al., 2014) while limiting the number of interviews to make the project feasible. Most importantly, the learnings from the different sub-units would feed into the overall understanding of the governance system in the primary care quasi-market in the Stockholm Region.
Before embarking on the sample design, it was important to bound the case with respect to time. In the case of the Stockholm Region, and as mentioned in Chapter 2, there were several forerunners to the PCCR that was introduced in 2008.

Given that the focus of this study was to understand the governance arrangements of the quasi-market, I decided to bind the case study from the introduction of PCCR reforms in 2008 and focus of the interviews as well as the sample selection to capture people with knowledge of the governance arrangement from 2008 to 2018/2019 when interviews were conducted. However, in some interviews, the interviewees mentioned the history of the reforms beyond 2008, as they thought it was important for the governance system of the primary care quasi-market.
Even if the period of investigation is long, I found it difficult to shorten the time period as the new governance arrangements in the quasi-market were introduced in 2008 and the data was collected 10 years later. Thus, this seemed to be the most adequate period to study.

It is important to mention that even if the case study is bounded, the time period of study is still long (more than 10 years) and the governance arrangements have been modified during this time. This means that not all changes to the governance system can be captured during the entire time period, only the most important shifts in the system.

4.3.2 Designing Sample Frame and Selecting Sample

Since the aim of the project was to understand the governance mechanisms of the quasi-market in one region, the region is the unit of analysis for this study.

Stake (1995) stated that the primary consideration when selecting a case should be “to maximize what we can learn” (p. 4). Thus, purposeful sampling was used as the general sampling strategy with the intention to select the primary sampling unit as well as participants to provide information-rich cases that maximise learning on the governance of the quasi-market and that generate the greatest depth of understanding (Patton, 1990).

According to Patton (2002), various purposeful sampling strategies can be used for such purposes. Informed by Ritchie et al. (2014), the sample frames were designed to ensure that they contained the details required to inform selection, that they were inclusive and contained relevant groups, that they were sufficiently large to provide an adequate number of respondents (even if some drop out), and that they produced a sample that is practically feasible to include given the constraints of the study. The selection of the sampling frames is explained below.

4.3.2.1 Sampling frame for selecting the case study region

As discussed in Chapter 2, Sweden’s political system has three democratically elected levels (national, regional, and municipal). Citizens elect politicians to the regional
assembly every four years. The state decides on the laws and regulations that govern the work of the 21 regions and 290 municipalities (SALAR, 2020), the regional assembly is the smallest unit of state administration and is responsible for certain functions in the region, particularly health care, public transportation, and regional development. Municipalities oversee childcare, elderly care, water, sewage, and education.

The original sampling frame for the single case study was the 21 regions in Sweden as each one of them oversees and creates the governance system for primary health care. As one of the key objectives of the study was to understand the extent to which the primary care governance system, as well as the perceptions of the governance system amongst health care providers, varies by ownership of primary care unit, it was critical to sample a region that had primary care units that are public, as well as private units that are owned by private-equity holders and regular private owners.

To my knowledge, and according to my discussions with regional officials in Stockholm and the National Competition Authority, there is no national administrative database indicating the ownership status of all primary care units currently operating in Sweden. Thus, this information needed to be obtained from each region. This made it challenging to know in which regions I would have enough representation of the three categories of providers.

To ensure that at least a few units of each ownership status were represented in the case study region, I first studied the share of private providers to total providers in the 21 regions and arbitrarily picked 50% of private providers/total providers as the cut-off point for ‘high share’ of private provision because it seemed possible to ensure representation of the three providers if at least half of the providers were private. Studying the latest available data on the share of privately owned primary care units from the National Competition Authority, there were only two regions with over 50% of private clinics: Västmanland, and Stockholm (National Competition Authority, 2014).

When examining these regions in more detail, based on data from each region’s website, I found that there were 29 primary care units in Västmanland and out of these none were private-equity owned in January 2018, when the sampling frame was created. Two units were owned by Capio, and used to be private-equity owned, but since Capio was, at the
time of the selection of the sample, already a publicly listed company (since 2015), these were no longer private-equity owned. The Stockholm Region had, as of January 2, 2018, a total of 209 registered primary care units, of which 9 were private-equity owned (by Aleris). Given that there were no private-equity owned facilities in Västmanland, it was not a suitable region to conduct the study in and naturally Stockholm was selected as the case study and the unit of analysis.

There were additional reasons why the Stockholm Region represented an appropriate case for the study, including the following:

1. It is the most populous region (2,299,593 inhabitants who represent 23% of Sweden’s population) (Stockholm Region, 2018) and thereby the most significant region in Sweden, with high potential to influence other regions. Therefore, it is strategically more interesting to study for both a domestic and an international audience.

2. Stockholm is the region in the country that purchases the most health care both in terms of share of all costs (25.7%) and in terms of the amount of financing going to private providers (Swedish Competition Authority, 2018). It is also the region that has the most quasi-markets/choice systems (37 in 2018), for different types of health care services. Given the high share of private providers, it is likely that the policy environment related to public–private interaction is more evolved in Stockholm compared to other regions, which maximised what could be learned.

3. The national importance (both in terms of size and influence) of the Stockholm Region means that more research is conducted in the region and, also, important government institutions as well as national relevant events/lectures take place in the region, which was helpful for improving understanding of the topic.

4. Because of my existing contacts in the region (I was born in Stockholm and interviewed people in Stockholm for the purpose of the initial teaching case study as described above), it was likely that the most information-rich interviews could be obtained there.

For all these reasons, the Stockholm Region was selected as the primary sampling unit and the subject of the case study.
4.3.2.2 Sampling frame for sub-unit selection: primary health care units

To advance my understanding of the quasi-market governance system, and to explore how primary health care managers perceive the government arrangements, different types of primary health care units were selected as embedded sub-units. Due to resource constraints (one lone researcher for the time period of a PhD), it was not possible to randomly select enough primary care units to generalise across the region, and thus a selection had to be made. To select primary care units within the Stockholm Region, a maximum variation (heterogeneity) sampling method was used, where ownership characteristics were the main criteria used to construct the sample.

I used an existing source, a list of all accredited primary health care units in Stockholm Region (latest updated January 2, 2018), made available by the SRHCO. The list indicated 209 units in total at this time, of which 32% were publicly owned by the SLSO, 4% were private-equity owned by Aleris, and 64% were privately owned but not by private-equity holders. Please see Table 3.

**Table 3. Ownership Characteristics of Primary Health Care Units in Stockholm**

<table>
<thead>
<tr>
<th>Ownership status (main categories)</th>
<th>Number (share of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>67 (32%)</td>
</tr>
<tr>
<td>Private-equity Owned (Aleris)</td>
<td>9 (4%)</td>
</tr>
<tr>
<td>Privately Owned (not by private-equity holders), including:</td>
<td>133 (64%)</td>
</tr>
<tr>
<td>Praktikertjänst</td>
<td>23</td>
</tr>
<tr>
<td>Capio</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>209 (100%)</strong></td>
</tr>
</tbody>
</table>


When reviewing the list of accredited units by ownership status, I noticed, because of my familiarity with the Stockholm Region, that many of the public units were located in the relatively poorer areas, with low socio-economic status, while the private units were in areas of higher socio-economic status. To avoid a situation where the sample only
contained public clinics exclusively located in poorer areas and private clinics in wealthier areas, I decided to stratify the sample by socio-economic status of the municipality in which the unit was located, building on the logic that the more similar the settings being compared, the easier it would be to examine the governance system through the eyes of the different stakeholders, including the primary care units with different owners. Thus, I strived to get a balanced sample with units operating in similar environments within each ownership category.

I used average income per capita using 2017 data from Statistics Sweden (https://www.scb.se) to rank the municipalities according to socio-economic status and, thereafter, placed between 6 and 12 units into each group (public, private owned by private-equity owners, private owned by regular owners) from the relatively rich and relatively poor municipalities within the region.

The socio-economic ranking was an important tool to ensure there was a balanced selection of units. For certain categories (e.g. public units), there were so few units located in the relatively wealthy areas, that all those were selected.

One weakness with the way the sample was constructed was that I classified all municipalities by socio-economic status, and then selected units from the bottom and the top of the ranking. Thus, it is possible that the sample is less representative of clinics that are located in areas that represent the average socio-economic status. However, the advantage of the approach I used is that the sample contains similar clinics (both those located in high and low socio-economic areas) in all the different categories of providers with different ownership characteristics.

In the category of private-equity–owned units, all companies were owned by Aleris as this was the only private-equity owner in primary care in the Stockholm Region at the time the sample was constructed. Thus, this category only represents one company and not several different companies that are private-equity owned. Given this, one weakness of the study is that it is difficult to distinguish if the results from the interviews with managers working at clinics operated by Aleris are representative for a private-equity–owned firm or rather for Aleris as a company.
4.4 Recruitment of Interviewees

To consider who to interview for the study, I did an initial actor mapping (Annex C) based on previous knowledge of the governance system of primary care in Stockholm, drawing from literature and previously conducted interviews for the teaching case study mentioned above. This included a wide range of actors that could potentially be interviewed, from the Stockholm Region, other national government agencies (e.g. National Board of Health and Welfare), providers (owners, managers of units, and patient-facing staff), and other interest organisations (labour unions, patient organisations, etc.).

This actor mapping was helpful at an initial stage as it casted the net wide; however, as interviews started, it quickly became evident that it was important to prioritise interviews with those involved in the actual implementation of the reform as well as the everyday governance of the primary care market, at the regional level, and providers of the three categories of ownership as described above. This finding is consistent with previous research on choice markets in Sweden that have found that health care professionals are an important source of information when evaluating these types of policy reforms, as their accounts often go beyond their immediate organisation to cover a broader system perspective (Korlén et al., 2017).

4.4.1 Interviews with Regional Public Authorities

Since the SRHCO and the politicians in the Regional Assembly and its Health Committee are the core governing bodies, these were the first approached. However, there are over 400 staff working at the SRHCO, and to determine who to interview and get access to the most relevant people within the SRHCO, I conducted several informal interviews with key informants who I knew had previously worked at the SRHCO but had not been directly involved in the reform effort. These individuals helped to identify a few individuals at the SRHCO who worked in the department for primary care. I started by contacting these people and then used the snowball technique to identify other relevant interviewees (Miles et al., 2014), who were either involved in 2008 when the new governance arrangements were designed or were currently involved in managing the primary care quasi-market.
The previous group is important as it helped to shed light on what new functions and policies were created to govern the new quasi-market when the PCCR started.

This strategy yielded many knowledgeable interviewees with rich insights about the governance system. My interviews were complemented by searches online to understand the organisational structure at the SRHCO, to make sure that key relevant stakeholders involved with the governance of the primary health care quasi-market were included in the sample. After several interviews where snowballing was used to identify new interviewees, I approached a 'saturation point' when the same people kept being recommended and I had already spoken with them, which indicated that there were a relatively restricted number of people involved in the governance of primary care quasi-markets in the Stockholm Region.

I emailed all interviewees before the interview. To generate awareness of the study, the recruitment email explained clearly what the research was about and contained more details about the study in an attachment (Ritchie et al., 2014). When I obtained a name via another interviewee, I referenced that person in the introductory email. Once the interviewee accepted to be part of the study, I sent a follow-up email with the Informed Consent Form (Annex D) and Interview Guide with interview questions (Annex E) in preparation for the interview.

4.4.2 Interviews with Owners and Providers

Drawing on previous literature focused on the governance system in primary care (e.g. Andersson et al., 2016; Malmkvist & Redic, 2012), the head of the clinic was selected as the main person to interview on the provider side. I used the list of all accredited providers, available from the SRHCO, with the name of the unit head, to identify interviewees and looked up their email addresses online.

I then emailed each one of the managers of the units that I had selected as described in Section 4.3.2.2. I sent a follow-up email or phoned if I didn’t get a response to my first email. I emailed a third time if necessary, and if no response was provided the third time, I marked it as no response.
In addition to using the list of accredited providers, I also always asked at the end of each interview if there were any other relevant people that the interviewee thought I should interview for the purpose of realising the aim of my thesis. Sometimes this question generated suggestions for providers who would be good to interview. These were then also contacted by email. Some of these recommendations were particularly valuable as they helped me identify unit managers who were also engaged in discussions with the SRHCO about the governance mechanisms and had a wealth of knowledge about the governance system.

In terms of sequencing, the interviews with the providers happened after I had conducted several interviews with public authorities. This was intentional as it was important for me to learn about the governance system before asking the providers how they perceived it.

Initially, I intended to complement the interviews with heads of unit with interviews with patient-facing staff in the same clinic. However, during my first clinic visits, interviews with patient-facing staff did not turn out to be very fruitful, as these interviewees tended to be stressed and those staff who were available for interviews were often more junior staff with limited experience working in the unit, who were mostly focused on the clinical practice and had limited reflections on questions relevant for the thesis.

When I realised that the head of the units were often also involved in clinical work, or had been, and worked so closely with the clinical staff that they had extensive knowledge about the implications of the governance system on the practice of primary care, I decided to focus on interviewing the managers of the selected units. Still, there are some patient-facing staff included in the sample. These were primarily staff who were knowledgeable about the system (had worked for various owners and over a long time) and were recommended by other interviewees through snowballing as well as a few patient-facing staff I interviewed before I decided to focus primarily on managers of units.

Through the interviews with public authorities and providers it became clear that important actors in the governance system and highly relevant for the study were the owners of the clinics. But for the larger owners, such as the SLSO and Aleris, these were not always represented at the clinic level. Therefore, I decided to also include interviews with people who represented the owners’ views by conducting interviews with SLSO headquarters.
and Investor (which owned Aleris at the time of the interview). With regard to owner representatives, I also searched online, and drew on information and introductions, provided by someone I know who is in the senior management team for a company in the welfare sector and who knew many people in the same sector and was willing to make introductions.

Some of the interviewees who were particularly helpful to interview were individuals who had a long experience working in primary care in the Stockholm Region and had experienced various governance systems. These individuals were often retired and willing to speak freely about their experience of the PCCR and their perceptions about the governance mechanisms and their effects on the primary care quasi-market.

4.5 Rationale for Data Collection Methods

Given the ontological outlook of this project, its interpretivist approach, chosen qualitative method (single embedded case study design), and its aim and objectives, as described previously, it was important to use a data collection method that allowed me to understand both the formal instruments for governing the quasi-market as well as the subtle perceptions and interpretations of those who govern and those who are being governed. Semi-structured in-depth interviews seemed most suitable for these purposes and was selected as the main data generation method.

In-depth interviews allow for understanding of complex and sensitive issues and are used to generate in-depth personal accounts, to understand personal context and explore issues, such as the governance arrangements in primary care in Stockholm, in depth and in detail (Ritchie et al., 2014, p. 59). This method also allowed me to directly interact with various actors at different levels of the governance system and collect rich data about the governance arrangements, including how they worked in practice as well as perceptions about them.

Group interviews were considered but given that the PCCR is a highly political topic in Sweden I thought it would be better to do individual interviews as the interviewees would be freer to speak with me than in a group. Practically, group interviews would also be
challenging to implement, particularly at the provider level, as heads of units often are spread out in the region and have very tight schedules.

In-depth interviews were complemented with documentary analysis and observations, although observations were not part of the formal data collection but rather an extra source of information received when conducting the in-depth interviews.

Documentary analysis was important as this source of data helped to unpack historical policy decisions about the primary care quasi-market governance system that had been codified in documents. As argued by Codd (1988) and more recently by Clarke (2012), I see policymaking and policy decisions as a process of acting on normative choice of political nature, rather than a technical and politically neutral process. Given this, it was critical to study and analyse political, strategic, and technical documents in the documentary analysis, to interpret how the authors of the documents have constructed the meanings of the policy-relevant situation as well as patterns of action and frames.

4.6 Data Collection

In this section, I describe how each of the data collection methods were carried out.

4.6.1 In-depth Interviews

4.6.1.1 Access and response rate

A total of 39 semi-structured in-depth interviews were conducted. The response rate and interviews per type of interviewee are indicated in Table 4.
### Table 4. Response Rate by Interviewee

<table>
<thead>
<tr>
<th>Type of organisation</th>
<th>Organisation/type interviewee</th>
<th>Interviewed</th>
<th>Declined</th>
<th>No response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional level</td>
<td>Stockholm Region</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Politicians</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Former or current market shapers/ regulators (SRHCO)</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Provider level</td>
<td>Private, owned by private-equity holders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heads of units and Owner representatives</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Owner representatives</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Heads of units</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Private, owned by regular owners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Owner representatives</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Heads of units</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Patient-facing staff</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td><strong>39</strong></td>
<td><strong>13</strong></td>
<td><strong>9</strong></td>
<td><strong>61</strong></td>
</tr>
</tbody>
</table>

Source: Author.

At the regional level, it was easy to get access to interviewees at the SRHCO and the response rate was very high; however, it was more challenging to access politicians, particularly as the interviews took place at the same time as the election campaign for regional elections. Most participants expressed that they found the research topic relevant and seemed interested in participating. The snowball method and citing the person who had provided the reference was helpful in approaching the interviewees and creating an open dialogue. The combination of coming from a well-respected foreign university, University of Edinburgh, while being interested in and familiar with Sweden, and speaking Swedish, could be one reason for positive reception.
At the provider level, the response rate was lower as many heads of units stated that they did not have time or simply did not want to participate. When I probed for the reason for not participating, some did not respond. My impression was that most heads of units were under tight schedules, particularly the privately owned units, and some even answered “I don’t have 45 min right now.” However, since the number of declines seemed quite equally distributed across the groups and I kept contacting more private unit heads to ensure that I had a balanced sample and that I got the information needed for the field work, I do not believe that the lower response rate at the provider level created any bias in the data.

4.6.1.2 Interview sequencing
The interviews took place from February 12, 2018, to November 21, 2018, with most interviews happening in the spring of 2018. As mentioned, the interviews with the regional authorities were scheduled to take place before the interviews with the providers, to ensure that I had a basic understanding of the governance mechanisms before discussing them with the providers. In a few cases, the interviews with regional authorities and providers happened in parallel due to availability of interviewees, and this was also helpful as perspectives from the providers could then be probed on when discussing with the public authorities.

I requested 45 minutes of the interviewees’ time in the recruitment email and tried to stick to this time. However, when the interviewee had more time and was willing to talk, I stayed and in a few cases the interviewee took more than 90 minutes.

Interviews with the regional authorities took place in an office or conference room. However, in a few cases they were held by phone. For the provider interviews, I visited the primary care unit as it was important to understand the operating environment, and the interview took place in an office or conference room in the unit. In a few cases, and upon request from the interviewee, interviews took place over the phone (three) and in a restaurant (two). In one case, I did a group interview with three patient-facing staff in a private unit during their staff meeting as the head of the unit invited me to their staff meeting.
4.6.1.3 Topic guide and format of interviews

I developed a topics guide that I used as an aide-memoire during the interview to ensure I mentioned topics that I wanted to explore and some degree of consistency in data collection while maintaining flexibility (Ritchie et al., 2014, p. 149). The Interview Guide (Annex E) consisted of four parts: (1) questions related to the characteristics and background of the interviewee; (2) a section related to the current quasi-market governance system, with particular focus on strategies used to achieve quality of care and competition; (3) a historical section, focused on changes that were introduced with the PCCR and how the governance system changed over time; and (4) a final section asking for personal reflections and recommendations for anyone else to interview.

The topic guide was shared with my supervisors and some minor modifications were made based on these discussions. The topic guide was also pilot-tested in two interviews with interviewees I knew personally, who had worked in primary care, and could give me some honest feedback on whether the questions and structure of the interview made sense. While they had minor feedback, this was an important step for me to gain confidence in the interview process.

More substantive adjustments to the topics guide were made when I moved from interviewing representatives of regional authorities to interviewing providers. With more experience, I learned to tailor the questions for the individual interviewee while interviewing, depending on their experience. For instance, for interviewees who had recently started to work in primary care, I dropped Section 3 that collected more historical perspectives. I also learned throughout the interview process that it was sometimes helpful to provide some examples for the interviewee to understand the question at hand. For instance, when I asked, “What tools and processes are used to govern the primary care health units?”, it was useful, in certain instances, to mention examples such as the provider payments, regulations, etc. to get the interviewee to start speaking. This was done while carefully balancing the risk of directing the interviewee to speak about certain topics.

With regard to the structure of the interview, it started with greetings and then the review and signing of the Informed Consent Form by the interviewee including an explanation
about confidentiality and anonymity. Thereafter, I gave a short introduction to the research project.

It became clear very early on in my project that the introduction of quasi-markets and the growth in number of private providers is a highly politicised and topical issue in Sweden. Because of this, I decided to mention in the introduction that I was not interested in a discussion about whether the PCCR (or public or private providers) were good or bad, but rather that I was interested in the governance mechanisms of the primary care quasi-market. At the end of the introduction I also checked whether the interviewee had any questions and were fine to proceed to the interview. Thereafter, questions started according to the topics guide described above.

Each interview ended with concluding remarks where I first asked the interviewee if they had anything to add, then I thanked them, reassured them that the interview would be anonymous, and offered to share the transcript if they so wanted.

My intention was to present myself as a curious, competent, professional, and politically neutral PhD student when meeting the interviewees, both in terms of self-presentation and behaviour. Because of this, I refrained from mentioning my professional background as a senior economist with the World Bank as I was aware that this may have led the interviewee to “box” me into something other than a PhD student, for example, an advocate for privatisation. I was also aware that it could have created power imbalances, as I might have been perceived as someone scrutinising their work.

At the end of the interview, however, and when suitable, I sometimes mentioned that I had long professional experience working in low- and middle-income countries on similar issues and asked for lessons learned for other countries that wanted to implement similar reforms.

Overall, I had a very positive experience of the field work. Most interviewees were very helpful, open, and happy to share their experiences. I got the impression that they appreciated that someone listened to their thoughts about their everyday work and that they enjoyed reflecting on their work and the governance of the primary care quasi-market.
4.6.2 Documentary Sources

To complement the in-depth interviews, I studied and analysed nine strategic and policy documents related to primary care, which are listed in Table 5. Most of these documents were selected as they were mentioned during the interviews or shared with me during the interviews. In addition, a few were identified when searching the website of the Stockholm Region for policy documents about primary care and through the literature search. One of the most critical documents on this list is the Rulebook, or tender/accreditation document, for providers in primary care. I studied this document in detail as it was frequently mentioned in the interviews and also since previous research (e.g. Glenngård, 2019; Norén & Ranerup, 2015) shows that this document is influential in the primary care quasi-markets, particularly with regard to creating competition between providers. The strategic documentary sources were helpful to understand the stated reasons for implementing the PCCR and expectations around it. The policy/audit documents were critical in understanding the governance system codified in writing. They helped validate the data generated from the in-depth interviews and thereby improve precision in the analysis.

Table 5. Documentary Sources

<table>
<thead>
<tr>
<th>Name (original name in Swedish)</th>
<th>Author</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic documents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Goals and strategic focus for primary care 2019-2025 (Swe. Mål och strategisk inriktning för primärvården 2019-2025)</td>
<td>SRHCO</td>
<td>2019</td>
</tr>
</tbody>
</table>

5 I used the 2018 edition of the Rulebook, shared with me during the interviews. This edition is not available online but available upon request. The 2022 edition is available here: https://vardgivarguiden.se/globalassets/avtal/vardavtal/vardval-stockholm/huslakarverksamhet-med-basal-hemsjukvarden/ffu-hlm-2022.pdf
<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Author/Institution</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Availability and security Growth and faith in the future Budget 2008 with plans for year 2009-10 (Swe. Tillgänglighet och säkerhet Tillväxt och framtidstro Budget 2008 med planer för år 2009-10)</td>
<td>The Alliance (parties in the centre-right political coalition) (Swe. Alliansen)</td>
<td>2008</td>
</tr>
<tr>
<td>3</td>
<td>The Health Care Law (Swe. Hälso- och sjukvårdslag (2017:30))</td>
<td>Sveriges Riksdag</td>
<td>2017</td>
</tr>
<tr>
<td></td>
<td><strong>Policy/Audit documents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Rulebook for providers of primary care (Swe. Förfrågningsunderlag enligt LOV vårdval: Husläkarverksamhet med basal hemsjukvård)</td>
<td>Region Stockholm</td>
<td>Version 2018-01-01</td>
</tr>
<tr>
<td>6</td>
<td>Quality audits, public provider (Swe. Kvalitetsbokslut, SLSO)</td>
<td>Region Stockholm</td>
<td>2017, 2018, 2019</td>
</tr>
<tr>
<td>7</td>
<td>Quality works in the GP practice in Stockholm 2018 (Swe. Kvalitetsarbeten inom husläkarverksamhet i Stockholm 2018)</td>
<td>SRHCO</td>
<td>2019</td>
</tr>
<tr>
<td>8</td>
<td>Annual Report 2016: contract follow-up, GP practice (Swe. Avtalsuppföljning 2016, Husläkarverksamheten med basal hemsjukvård)</td>
<td>SRHCO (provided by interviewee)</td>
<td>2016</td>
</tr>
</tbody>
</table>
4.6.3 Observations

Observations were not considered a formal part of my data collection, however, visiting 12 primary care health care units across the Stockholm Region as well as the offices of the SRHCO and owner organisations constituted an import input for the analysis. The observations made during these visits, and particularly when visiting the health care units in divergent socio-economic areas, were critical in understanding the context in which the providers operate as well as how the primary health care units are managed.

Before and after the interviews, particularly with the providers, I would often sit in the waiting room/office environment and observe people, and specifically the interactions between patients/users and health professionals in the health care unit. I was also actively observing what Schein (1992) called artefacts, especially in the physical space but also language (ways of speaking, slogans, and expressions), that were a visible part of the culture of the organisations I visited.

I was surprised by the vastly different contexts in which the primary health care units in the Stockholm Region operate, particularly with regard to the socio-economic status and background of their users/patients. I also noticed how the working environment for the public regional authorities was also very different from that of the service providers.

While I didn’t do a specific analysis of artefacts or analyse my observations separately, the fact that I visited facilities was critical for creating a broader and deeper understanding of my data and analysis of it. It provided me with information about the interviewees and their local context, which helped me to understand, interpret, and analyse my empirical data.
4.7 Approach to Analysis

To analyse my empirical data, I used thematic analysis as it fitted well with my philosophy of science as well as theoretical inspirations for this project. This approach is not associated with any discipline or theories and is suitable when a researcher wants to focus on what the empirical data says — i.e. capturing the meaning of the data rather than focusing on the language or structure of what was being said (Ritchie et al., 2013).

All interviews were audio recorded and transcribed using word processing software. All qualitative data, including interview transcripts, email correspondence, documents, diary of the researcher, and notes is stored in an online drive and can be made available for independent inspection. The drive is password protected to ensure that no intruders get access to/modify the database.

Once the empirical data had been collected and transcribed, I used NVivo 12.0 Pro to analyse the data. After the data was transcribed and inputted into NVivo, it was important to take a step back and see the data, which I had collected myself, with new eyes. I did this through the data management process described below drawing on Ritchie et al. (2013).

First, I read the material in its entirety and took notes of subjects of interest and topics that appeared in the data. Based on these, I then sorted them into themes and subthemes and thereby constructed a thematic framework (Annex F). This was constructed based on the order of questions in the Interview Guide, which was guided by the research questions, and mixed with the themes and subthemes that appeared when I read the data in its entirety.

Using a cross-sectional method, I then labelled the data based on the themes and subthemes in the framework and sorted the entire data set according to the framework. This first high-level categorisation of the data according to the thematic framework was helpful as it allowed for an intense review of the content and to see patterns in the data as well as notice the perspectives of different data sources on various themes of interest.

Moving into the work of abstraction and interpretation of my data, I read the transcribed data that was sorted in the thematic framework once again and categorised it, in a finer
way, based on new patterns that appeared. Seeing and analysing the data in the thematic framework, I saw new cross-cutting themes. To exemplify, one such theme that appeared was how the heads of primary care units perceived their actions to be influenced by a range of mechanisms employed by a variety of principals — public authorities, organisational owners, and the professional ethics associated with their medical profession. This was not something that I asked a question about in the interviews, but I observed this finding when reading the accounts of the providers repeatedly.

Since I did not use content analysis as an approach to analyse my data, I did not systematically consider the frequency of appearance of certain themes, as sometimes I realised that something being said by a very influential person in the primary care quasi-market could be very important even if it was only mentioned once in my empirical data. In one instance in my documentary analysis, I did, however, use word count to count frequency of using a word, but this was just to illustrate a point, rather than a result of analysing the frequency of appearance of certain phenomena throughout my entire data set.

At this point in my analysis, I started to create data summaries and captured main findings based on the classification of data. Based on these, I wrote first drafts of chapters on themes that appeared in all sources of empirical data, including, for instance, citations from the interview data as well as key findings in the documentary analysis.

Critical throughout the process of working with my data, including indexing, sorting, developing, reviewing key findings and data summaries, and, eventually, drafting chapters, was to remain grounded in my empirical data. Although I had a general knowledge about theory and previous literature on governance of primary care quasi-markets, based on my initial work with the literature review, I refrained from intentionally drawing on others’ work before I wrote the first draft of my chapters because I wanted to develop concepts, ideas, and themes directly from my data rather than make use of ideas in the literature to understand my data. This approach also allowed me to create an independent voice in relation to previous research and not get too influenced by what other researchers had found in the past.
Having said this, the analysis as well as the pattern that I saw in my data were of course informed by previous theories that existed in my head, particularly in the field of economics, as this is my educational background. For instance, when initially studying my data, I structured my thinking about the relationship between the SRHCO and the providers according to the principal and agent theory (Arrow, 1986; Jensen & Meckling, 1976), which is standard in economic tradition. How I interpreted the data was also informed by my practical professional knowledge of working in health policy.

After producing the draft chapters, I went back to the original data to classify the sorted data based on certain categories — for example, providers with small and large owners, and providers with public owners, private-equity holders, and regular private owners — to search for any systematic pattern of differences/similarities between the categories of interviewees. This helped me to make linkages between certain phenomena or experiences described in the data (for instance of being discriminated against by the governance system) and a certain subgroup (private providers with small owners). I then updated the chapters based on the new patterns that emerged.

Once I had draft chapters and higher-order concepts and wanted to explain certain patterns I saw in the data, I also reflected on theories that have inspired this research project as well as the theory of quasi-markets and previous research captured in my literature review. I then rewrote the chapters to twin together my empirical data with theory and previous research, while ensuring that higher-level findings were well grounded in the data collected in this research project. This is, for instance, when I decided to present my data in Chapter 5 according to Ahrne et al.’s (2015) framework.

As my literature review was updated over time, and particularly after the second search in databases in May 2021, I had a chance while completing the literature review to locate my findings within the wider context of thinking and theory in this field of research. This is when the sections titled “Concluding Discussions” in my results chapters were finalised as well as the final chapter.

Guided by the method literature (e.g. Ahrne & Svensson, 2011; Ritchie et al., 2013), my goal, throughout my data analysis, was to present themes that most clearly illustrated the phenomenon being examined, namely the governance mechanisms of a primary care
quasi-market, and to provide answers to my research questions by using my data, in the most meaningful way.

4.8 Ethical Considerations

4.8.1 Ethical Approval

The research project was granted ethical approval by the School of Social and Political Science at the University of Edinburgh in January 2018 (Annex G). Given that patients were not included in the study, it was considered low risk and it was not necessary to apply for other ethical approval in Sweden.

4.8.2 Interview Ethics

In the recruitment email, I included information about the aim and objectives of my research and my affiliation with the University of Edinburgh. Once the interviewee had accepted to do the interview, I also shared the Informed Consent Form (Annex D), so each participant had time to review it prior to the interview. During each interview, I went through the Informed Consent Form with the interviewee and offered to answer any questions they might have about the research project or their participation. Thereafter, the interviewee signed the form.

The Informed Consent Form as well as the Information Sheet about the study were modelled on best practice and included information about the purpose of the study, me, the researcher, and my affiliation, that participation was voluntary and there was the option to withdraw at any time, and that the interview would be recorded and transcribed and anonymous. It also said that I might use the data for citations in the research, but that no personal information would be revealed that would make it possible to identify the interviewee. The funding of the study was not presented in the Information Sheet, given that there was no external funder (apart from myself and the University of Edinburgh) that contributed to the study.
I understood through my interviews that maintaining strict confidentiality and anonymity was important for the interviewees to feel comfortable to express themselves freely. One participant even explained to me that there were few individuals working in primary care in the Stockholm Region and that it would be easy to identify who said what if too much information was exposed.

Although the Informed Consent Form allowed for the use of professional titles in the study, I have chosen to select confidentiality over preciseness if there was ever a trade-off between the two, to not risk the trust that the participants put in me when they decided to sign the Informed Consent Form and participate in the study. I was also careful to not reveal any personal information that would risk the confidentiality of the interviewees when I sometimes referred to something that had been said in another interview while still conducting interviews.

4.9 Concluding Discussion

The purpose of this chapter was to present the research design and methodological approach pursued for this research project. I presented the main ideas behind critical realism and the underlying philosophy of science, which have guided me in the research.

Subsequently, various theoretical sources of inspiration for the thesis were discussed, including the view of governance as a practice rather than a step-by-step process that is being ‘practiced’ by interest holders at different levels, including macro, meso, and micro. Moreover, I discussed Ahrne et al.’s (2015) conceptualisation of market organisation that I used to structure my empirical data on the mechanisms of governance in the subsequent chapter. I also discussed prior research and practical experiences of and questions posed by policymakers in low- and middle-income countries, which informed the formulation of the research questions.

Thereafter, I discussed the research design and methodological approach used. I provide the rationale for selecting the qualitative embedded case study approach. I also account for the sample frame and approach to sample selection. I presented the process for collecting the data from the main data generation source, namely 39 in-depth interviews,
complemented with documentary analysis of 9 strategic and policy documents. Finally, I described the approach to analysing the data and reflected on the ethical aspects of conducting this qualitative study.

Building on this presentation of the method and critical decisions I have taken with regard to research design and execution, the following chapters turn to the results of data collection and analysis.
Preface to the Results Chapters

The subsequent three chapters are the results of my empirical analysis. In this preface to the results chapters, I explain how Chapters 5, 6, and 7 are outlined and how they relate to the aim of the thesis and the research questions.

As discussed in Chapter 1, the aim of this thesis is to explore the governance system of the primary care quasi-market in the Stockholm Region, Sweden, and examine how this system is perceived by different stakeholders.

To achieve the above, I developed the following research questions:

1. What mechanisms are used to govern the quasi-market and how do these influence the incentive environment in which primary care providers operate?
2. How do stakeholders perceive the impact of the governance system on the achievement of competition across providers in a context of diverse ownership characteristics?
3. How do stakeholders perceive the impact of the governance system on quality of primary care services?

The research questions as well as the structure of the results chapters were tweaked as the research progressed, as can be expected in a qualitative research project (Ritchie et al., 2013). This process was informed by the findings of the literature review, preliminary data analysis, and my own reflections, as well as discussions with different stakeholders. The outline of the results chapters in relation to the research questions is presented below.

The first of the results chapters, Chapter 5, examines, in general terms, how the primary care quasi-market is governed and explores what mechanisms public authorities use to govern the market. Thus, it focuses on research question 1. It analyses how the mechanisms are perceived by those who govern as well as those who are governed, i.e. the primary care providers, and what incentive environment they give rise to.

Building on Chapter 5, Chapter 6 drills down on one outcome that the governance system wants to achieve, namely competition. It examines how this primary care quasi-market is governed to create a competitive environment particularly in the context of diverse
ownership characteristics. Thus, it focuses on research question 2. Competition is essential in a quasi-market to drive efficiency in service provision as well as quality of care as stipulated in previous chapters. Chapter 6 puts emphasis on competition neutrality and whether the incentive structure that the governance system gives rise to creates a level playing field, from the perspective of market regulators and providers of different ownership status.

The subsequent Chapter 7 focuses on whether the incentive structure that the governance system gives rise to ensures quality of care. Thus, it focuses on research question 3. It drills down on accountability arrangements for achieving quality of care, by examining what mechanisms regional authorities use to identify and measure the output of the providers, with regard to quality of care. It also focuses on how managers of primary care units perceive the existing governance system with respect to how it assures achievement of quality of care and explores challenges and opportunities for improvements. Since the literature review shows that empirical evidence (for instance, Hoffstedt et al., 2018) indicates that individuals are not necessarily making informed choices of providers, it is critical to study the market’s regulators’ ability to monitor quality of care, as patient choice appears to be a limited driver of quality of care. This motivates the focus of Chapter 7.

Following the three results chapters, Chapter 8 discusses the thesis as a whole. It synthesises and integrates its main findings, puts them in relation to theoretical frameworks I have used and discusses emerging themes, such as who are the interest holders in the governance of primary care quasi-markets in Stockholm and whether choice systems can ultimately limit patient choice, and presents my contributions to scholarship. Lastly, it considers implications for future research and policy practice.
5  The Mechanisms Used to Govern the Primary Care Quasi-market

5.1  Introduction

The purpose of this chapter is to analyse the mechanisms that are used by public authorities to govern the primary care quasi-market in Stockholm. It examines these mechanisms and the incentives they give rise to from the perspective of the purchaser and the providers. It provides the foundational pieces for understanding the governance system and responds to research question 1. Chapters 6 and 7 dig deeper into how these mechanisms of governance are used to achieve competition and quality of care, respectively.

As mentioned in Chapter 1, I use “mechanisms”, “elements”, and “controls” synonymously throughout this chapter.

To organise my empirical data on the mechanisms of governance used by public authorities in the primary health care market, I draw on Ahrne et al.’s (2015) and Andersson et al. (2017) framework for market organisation, presented in Chapter 4.

While there are other frameworks available (e.g. Hellowell, O’Hanlon et al., 2020; Malmi & Brown, 2008; Smith et al., 2012), I selected this framework as it gave a comprehensive view of various controls used to manage the markets that seemed appropriate for the purpose of this thesis. But, I could have used another framework with similar results. I do not see this as the only way to present the data, but rather one of many.

Since I used this framework, it is also important to point out that I do not argue that the primary health care market in Stockholm is an organisation. Yet, I do agree with Ahrne et al.’s view that decisions about rules, sanctions, and memberships shape the structure of the market (Ahrne et al., 2016).

The chapter is structured as follows. The subsequent section provides a brief overview of the seven elements, based on Ahrne et al. (2015) and Andersson et al. (2017), that I use to structure my data with examples from my empirical data on the primary care quasi-market in Stockholm. In the following section, I present my data from interviewees with
the SRHCO as well documentary analysis of the Rulebook, organised by the seven elements. The third section analyses how the market works in practice and is perceived through the eyes of managers of primary care units. In the final section, I discuss the main findings of my chapter.

5.2 Organising the Data on Governance of Primary Care Quasi-markets

I use the seven elements discussed in Chapter 4 to categorise my data, namely Membership, Rules, Monitoring, Sanctions, Hierarchy, Information, and Depiction (Ahrne et al., 2015; Anderson et al., 2017). Table 6 describes the seven elements in more detail with examples from the primary care quasi-market in the Stockholm Region drawing on my empirical data.

Table 6. Description of the Seven Elements for Market Organisation with Examples from the Primary Care Market

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Example from Primary Care Quasi-market in Stockholm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Membership</td>
<td>Membership in markets is used to decide who may act as a seller or a buyer in the market. Access to market is limited not only because of decisions on limited membership but also because not everyone has the resources to buy, manufacture, or sell.</td>
<td>Requirements for market entry of providers. For example, a certain number of staff must be available in the health care unit all the time to operate in the market.</td>
</tr>
<tr>
<td>2. Rules</td>
<td>Rules pertain to all aspects of the market, for instance rules about how sellers or buyers should behave, prices that should apply, how the market exchange should be made. Rules can be binding (combined with sanction) and non-binding.</td>
<td>Rules around what care that should be provided.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3. Monitoring</td>
<td>Like rules, monitoring pertains to all aspects of the market. Monitoring of compliance can take place by many organisations (e.g. voluntary associations) that issue certification or accreditation.</td>
<td>Annual report requested by government to supervise the providers; government authorities certify health professionals.</td>
</tr>
<tr>
<td>4. Sanctions</td>
<td>These are rewards and penalties. Sometimes sanctions are combined with organised monitoring.</td>
<td>Reimbursement model. In a quasi-market with choice, the user’s choice is a sanction (positive sanction) as it generates money.</td>
</tr>
<tr>
<td>5. Hierarchy</td>
<td>The right to take decision on behalf of others, setting the agenda, and calling meetings. Individuals or organisations delegate power to an entity that can act on their behalf. Power and influence can also come through oligopolistic positions.</td>
<td>The regional authorities decide on the rules for the primary health care market. Private providers, with smaller units, set up an association for all private providers who negotiate with those who govern the market.</td>
</tr>
</tbody>
</table>
6. Information

Dissemination of information to influence the market, e.g., information to buyers to support them to act in a certain way.

Publicly sharing information about the health care provider’s performance to influence consumers in their choice of providers.

7. Depiction

Creating depictions of the relation between different units and/or individuals (e.g., who belongs to what unit in an organisation) or analysis of the future of the market.

Consulting firm produces a report stating that the future of primary care is for digital primary care providers.

Source: Author, adapted from Ahrne et al. (2015), Anderson et al. (2017), and Forsell and Norén (2018), and with personally collected data to provide examples from the primary care quasi-market in Stockholm.

5.3 The Mechanisms Used to Govern the Primary Care Quasi-market — The Perspective of Public Authorities

5.3.1 Introduction

Interviews with staff from the SRHCO show that they primarily see their role as defining the services that the provider must provide in the market, purchase those services, pay the provider and monitor that services defined in the agreement are being provided (SRHCO staff). Thus, they do not consider that they have any operative responsibility for service provision. The SRHCO also recognises that they have a role to play in research and development, but they outsource these tasks to academic institutions. Quotes from the interviews below illustrate the role that the public authorities define for themselves in the market:

We as purchaser should not focus on how to do things but on what to do. But it’s not always easy either. (SRHCO staff)

We ourselves are not so much out in the health care system and give hands on support. With a few exceptions, I must say. But we have an agreement with the
Academic Primary Care Centre, which is tasked to conduct research and development work in primary care. We as purchasers should focus on our assignment, as well as give assignments, pay and follow up. It’s like our loop. To be hands on, it is a bit outside, the operational responsibility is not here. On the other hand, we must promote development when we purchase care. (Staff, SRHCO)

According to the SRHCO, various mechanisms are used to manage the primary care market, where the Rulebook (Swe. Förfrågningsunderlaget) is described as the main framework for governing (Staff, SRHCO). While there is a specific contract between the provider and the purchaser, the Rulebook can also be viewed as a form of detailed contract between the two as it contains all the rules for operating in the market.

The Rulebook has seven main sections and its focus is on the conditions for entering the market, the assignments that the providers are expected to carry out once in the market, what is required by providers in order for the SRHCO to be able to monitor performance, the Compensation model, and information management. There is also a more standardised, general section that rarely changes and includes references to rules and regulations, and other critical areas such as regulating provider behaviour in extraordinary situations such as state of emergency. Annex H summarises the main content of the Rulebook in the Stockholm Region.

The subsequent sections in this chapter describe the mechanisms used to govern the primary care quasi-market, organised according to the seven elements for market organisation (Ahrne et al., 2015; Anderson et al., 2017) drawing on the Rulebook and interviews with public authorities.

5.3.2 Membership

To become a member and enter the market of primary care services in Stockholm, all requirements and other conditions that are mentioned in the Rulebook need to be fulfilled by the provider (Rulebook, 2018, p. 4). Once the provider’s application has been submitted it becomes a public document and a decision about market entry will be taken
within four months. The decision is taken at the political level by the sub-committees of the Health Committee (Swe. Sjukvårdsutskott).

The purchaser takes the following into account when deciding about market entry: who owns the organisation; the applicant’s financial status (including credit information) to ensure that the organisation has a solid economic foundation; and criminal records. Foreign companies need to prove that they are registered in their country of origin. With regard to ownership, information about the form of association, for example, limited liability company, for-profit company, or not-for-profit organisation, is not asked for.

The application needs to contain information about how the applicant will run their activities and the staffing of the unit, including detailed information on the head of the unit and the individual who is medically responsible. Furthermore, information about the premises, including a checklist on physical accessibility and health care hygiene, needs to be complied with. Finally, the applicant must certify that they: (1) can carry out the entire commitment under the agreement under the Primary Care Choice System; (2) have the required staff with required competences; and (3) accept that the purchaser makes a visit to the premises of the provider two weeks prior to the starting date of the contract to check that the provider fulfils all requirements for running a primary health care unit (Rulebook, 2018, p. 10).

The purchaser can deny the applicant the right to market entry if the application is not complete, certifications are incomplete or absent, or requested information is not submitted. The purchaser can also refuse market entry if it assesses that services provided by the provider will not meet quality requirements stipulated in the agreement, or if the business will not be conducted according to the agreement, taking into account the history of the provider (e.g. if the applicant has been convicted of a crime that may impact the credibility of the provider), has shown serious shortcomings in similar assignments in the past five years, or has history of bankruptcies (Rulebook, 2018, pp. 12–13).

Interviewees agreed that the reform sought to create a market that was both “easy to enter but also easy to exit” (Staff, SRHCO).
With regard to exiting the market, the Rulebook stipulates that the purchaser can terminate all or parts of the agreement immediately if the “provider substantially breaches its obligation under the agreement and does not take correct action after being reminded to do so” (Rulebook, 2018, p. 18). Various examples of breaching obligations are provided in the Rulebook, including: serious professional misconduct; serious risk for patient safety; and if it is obvious that the provider does not meet current medical requirements for care. Other circumstances include if the providers have not paid taxes in multiple instances, reported incorrect information as a basis for remuneration, entered into bankruptcy, or acted in a matter that risks the trust in the provider or the health care system. Force majeur or if regional authorities do not approve an ownership transition are other reasons mentioned to justify exiting a provider from the market (Rulebook, 2018, p. 19).

The provider can also end the agreement with the purchaser at the time the conditions of the agreement between purchaser and providers changes, or if the purchaser substantially infringes its obligations under the agreement and it is not due to the circumstances of the provider.

In sum, the rules around market entry and exit are detailed and clear in the Rulebook. However, interviews with staff at the SRHCO show market exit in practice has been challenging from the time the PCCR was introduced. Interviewees described:

> It should be easy to get in [to the market] but it should be easy to get out as well. And the latter has turned out that it may not be so easy to get out [short laughter] once you are inside [short laugh]. Some (providers) have actually exited [the market] during these years ... but there have not been very many, so to speak. And it is a difficult for the purchaser ... to follow up on that and capture shortcomings (of the provider). ... It can be quality of care shortcoming, it can be other fraudulent actions, which there has been sometimes, that some have cheated with accounting, for example, and booked more revenue than they should have and it can be a challenge for the purchaser in this kind of performance-based system, so to speak, [to discern] if these performances really were really performed or not. (Staff, SLSO)

> We had health centres that had obviously abused the system and I know that some of them had a fairly long legal process before they were excluded. I myself have not been involved in exiting health centres, but I have understood that when you have done that, it has been a difficult process. (Staff, SRHCO)
We were probably not clear enough on how to get rid of such health centres that did have good operations. It was probably a lesson we learned that it was a little too easy to get in and a little too difficult to go out. (Staff, SRHCO)

5.3.3 Rules

5.3.3.1 The assignment

The Rulebook contains rules for various aspects of the provision of primary health care as detailed in the section describing the assignment, that is, the services that the provider is expected to bring to the market, including detailed description of a broad package of services\(^6\) that the provider is expected to offer. In addition to the detailed description of the services that must be provided, the Rulebook also gives some indications of minimum requirements for the provider with regard to staffing and opening hours.

There are also clear regulations and requirements with regard to environment certification, participation in research projects, and residencies for medical students. The Rulebook also points to regulation regarding rational, cost-effective, and safe use of pharmaceuticals and instructions to ensure that only accredited medical services, for example labs, are used.

The Rulebook, in line with the Health and Medical Service Act, discusses the target group for the assignment and prioritisation amongst patient groups:

Elderly people with large and complex care needs, people with extensive disabilities and chronically ill people should be given priority for permanent and continuous care contacts as well as coordination of care and drug treatment. For these groups, support for close relatives must also be given priority. Likewise, the Caregiver shall prioritize that this target group have a permanent doctor contact through listing of individual doctors. (Rulebook, 2018, p. 24).

In a quasi-market, where competition between providers is key for the functioning of the market, it is noteworthy that the Rulebook stipulates that providers are not only competitors but that they are expected to collaborate in certain areas such as death attestation, unscheduled home visits, vaccinations, and infection control work in the

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\(^6\) The package contains general primary care, basic homecare (care planning and coordination for home visits), including at elderly homes that do not require specialist palliative care. Furthermore, the assignment also includes the provision of care for mild to moderate mental illness and patients, primary care emergency services, and infection control work as well as care coordination.
geographical area where they are located. It also emphasises that the provider “must actively contribute to collaboration, in support of patients who need care and attention from other care providers and principals” (Rulebook, 2018, p. 31).

5.3.3.2 Listing patients

Another critical part of the market regulation pertains to the rules around listing patients, as illustrated in the case study in Chapter 1. Since a listed patient triggers a capitation payment, this represents a rule that is tied to a positive sanction. The listing rules are not only critical for the reimbursement of the provider but also fundamental for determining the functioning and performance of the quasi-market. They may, for instance, determine if providers can engage in cream-skimming and only list healthy users.

The rules for listing stipulate that a provider does not have the right to deny listing of a person with a physician at the clinic. This can only be done in special circumstances, such as a threatening situation or conflict of interest, and in such instances, the person shall be offered to be listed with another physician at the clinic or directly at the clinic.

If a provider reaches full capacity, it must immediately alert the SRHCO and in such circumstance place a patient who wants to register with the clinic on a waiting list. Thus, even at full capacity, listing can still not be denied. When the provider has more capacity, it needs to first list patients with the shortest waiting time, and, thus, they cannot cherry pick patients but must follow the list. If possible, these transactions should happen at ListOn, a platform available from the Stockholm Region, but this is not compulsory. With regard to the procedures for listing, a person gets listed once a form has been filled out and handed to the provider or if the patient lists themselves online. The provider must also check the identity of the patient before listing. Complete delisting (i.e. if a user does want to be listed with any provider, in which case they do not generate any payments) must also be communicated in writing to the SRHCO.
5.3.3.3 Changing the rules

In terms of balance of power, the Rulebook gives the purchaser the flexibility to change the rules of the market at any time: “purchaser has the right at any given time to amend the terms of Agreement” (Rulebook, 2018, p. 21). The provider in turn, can let the purchaser know, within 60 days from the time that the purchaser announced the change in rules, if it does not accept the new rules and the rules of the original agreement then run for 12 months after which the contract ceases to exist (Rulebook, 2018, p. 21). According to interviewees, the provider changes the terms of the agreement by revising the Rulebook for the primary care market about once a year, but sometimes more often.

SRHCO staff described that changes to the Rulebook are determined in an interplay between the SRHCO and politicians. The politicians decide where they want changes and the SRHCO, decides ‘how’ the changes will be implemented. One interviewee described:

the politicians put their foot down on the “what”. … But “the how”, how we should do it, it is more up to us at the civil servant level to shape it. So, then we have, as it were, an ongoing dialogue with the political leadership so that we can also be one step ahead and understand as well, what is important to them and what direction they want to take and so on. (Staff, SRHCO)

5.3.4 Monitoring

The performance monitoring of the primary care market is critical for the enforcement of the rules mentioned above and also a key dimension of governance (Smith et al., 2012). The section on general terms and conditions in the Rulebook describes the overall right of the purchaser to supervise the provider:

The purchaser has the right to follow up the provider on the Assignment. The purchaser is responsible for the design of supervision activities, including its forms, content, and times when it takes place. Follow-up can be planned or by random sampling. (Rulebook, 2018, p. 71)

The Rulebook indicates that the purchaser monitors the providers for several reasons, including for: (1) follow-up and analysis; (2) oversight (to ensure that the provider delivers according to agreement); (3) dialogue and development; and (4) as part of the
governance system (as a basis for payment as the purchaser, for example, pays upon certain results being achieved by the provider).

The Rulebook stipulates that the provider needs to collaborate with the purchaser in the supervision work and may be subject to in-depth monitoring at any time, for which the provider will be financially responsible for any costs of in-depth monitoring. Furthermore, all information provided can be made public and can be used for ranking the providers.

The Rulebook provides a detailed instruction around the annual follow-up of the agreement, based on an annual report with registry data and information that is reported manually by the providers. The data is extracted from existing registers, from a web-based reporting system for data (Swe. Webbaserad Inrapporteringsmall, WIM) that is outside national registers. This data is analysed by the purchaser and then discussed with the providers either during a meeting with staff from the SRHCO or by email (Rulebook, 2018, p. 41). More details around the annual follow-up and report are provided in Chapter 7.

The provider is responsible for quality control of all data that is submitted to the provider and in keeping patient journals according to the instructions by the purchaser. The provider is advised to report to different quality registers (dementia register, palliative care register, road register) but is only obliged to report to the National Diabetes Register (Rulebook, 2018, p. 31).

Staff from the SRHCO reported on other non-formal tools, which are crucial for the supervision of the providers who are used in combination with the formal annual follow-up:

We have different forms of follow-up. We have this ongoing follow-up. You hear things ... we check, is there a provider that suddenly starts to have very long waiting times ... or if prescribing patterns or visiting patterns start to deviate, then we will check it out. Then we also do ... annual follow-up when you go through each activity a little more in detail and look at different key data. Then we sometimes do in-depth follow-ups and it is usually for a reason. That we have received a tip or that there is something in the regular follow-up that deviates. As we have identified that ... then we need to look more closely. (Staff, SRHCO)
Staff at the SRHCO mentioned that an important control mechanism in the market happens through the choice of the patient (consumer accountability mechanism), but stated, as also observed in the literature review (Hoffstedt et al., 2018), that complementary data to supervise the providers is also needed:

... if you are to see primary care as a market ... then the individual makes their choice. But it does not have to be the case that the individual is right. ... We can see in many follow-up data that it can be a good average, but there is variation in all things that we measure ... there is a huge range. ... So, you need a combination, ... of result/outcome quality, structural quality and process quality, so to speak, [to see] how you [the provider] work. (Staff, SRHCO)

The interviews revealed that purchasers see many ways in which the supervision of the providers could be improved, including doing risk-based supervision and targeting providers who have shown problematic behaviour, digitalisation, and automatisation of all interactions with the providers (currently, some interaction is paper-based). The latter is important since it would allow the SRHCO to connect different data registries and triangulate data, and thereby be able to detect providers who do not comply with the contract (Staff, SRHCO).

5.3.5 Sanctions

The main sanctions in the governance system of the primary care market in Stockholm are captured in the Reimbursement model. It is composed of two parts: the Description system, which captures the relation between the user and the provider (e.g. user fees) and the compensation system, which regulates the purchaser’s compensation to the provider (Rulebook, 2018, p. 42). The Description system regulates user fees in the Stockholm Region and has a separate regulation document (Stockholm Region, 2020). The quasi-market in Stockholm has a fixed-price regime, where the user fees that the providers can charge are set by the Stockholm Region and are highly subsidised. Providers retain the patient fee in primary care, and it is deducted from the reimbursement. Given that the share of the providers’ revenue generated from patient fees is modest because of this regulation, I will not elaborate on the Description system
further. Thus, in this section, I will focus on the compensation system for the providers since this is critical for the governance of the market.

Turning to the compensation system, it has three components of payments: fee-for-service, capitation, and result-based financing.

The *fee-for-service* part is structured around a baseline reimbursement of 260 SEK per visit. An extra reimbursement is added to this baseline depending on the nature of the visit. For instance, a home visit adds 500 SEK to the baseline reimbursement and the provider is reimbursed 760 SEK per home visit. The provider gets extra reimbursement for patients between 80 and 84 years old and additional extra for patients above 85 years.

There are also extra reimbursements for visits for specific peripheral geographical areas and for specific Classification of Care Measures/Codes (*Swe. Klassifikation av vårdåtgärd [KVÅ]*) called KVÅ codes (Rulebook, 2018).

The *capitation* part (or per capita payment) of the reimbursement per listed patient is 478 SEK for a child (0–5 years), 390 SEK for an adult (6–64 years), and 1,091 SEK for a senior (65 years and above) (Rulebook, 2018). According to the interviews, the capitation is regarded as a basic allowance for delivering on the assignment as well as supplementary remuneration for activities outside of the care production, for example, collaboration between providers as well as public health promotion activities.

The capitation payment has various adjustments. It is linked to the Care Need Index (CNI), which is a socio-economic index that is used to measure the risk of ill health in a population (Stockholm City, 2019). The CNI is calculated on a yearly basis by the National Statistics Office to determine the index for each individual provider and the capitation payment is adjusted accordingly. The capitation payment is also linked to the Adjusted Clinical Group (ACG) Index, an index developed by Johns Hopkins University that captures the user’s past health condition with the intention to predict the future need for care. In the Stockholm Region, the ACG is based on reported diagnostic codes (KVÅ codes) from an individual’s care contacts during the past 18 months and is calculated for each provider on an annual basis. Diagnosis codes in all occupational categories and in both outpatient and inpatient care are included in the calculation (Stockholm City, 2019).
The result-based financing part of the compensation system contains both quality-related remuneration (see Chapter 7) and fines for goals that were not attained and is calculated on an annual basis. For each quality area, the compensation is multiplied by the number of patients listed with the provider, thus the number of listed patients is an important determinant for the result-based financing compensation.

While the three components have been part of the compensation system from the outset of the PCCR, the share of the reimbursement coming from the fee-for-service part was about 60% when the PCCR was introduced in Stockholm, where capitation was the other main component (making up a little less than 40%) (Staff, SRHCO). The high share for fee-for-service in the compensation system was introduced to incentivise an increase in production of visits and was unusual from a national perspective as it was the highest share of fee-for-service part of the overall payment to providers in the country (Staff, SRHCO). However, in 2014/15, this shifted, so that the fee-for-service part made up 40% while the capitation came to be a more important part (about 60%) in the reimbursement. Another important change in the Reimbursement model over time was the introduction of socio-economic adjustments (CNI) and disease-burden–related adjustment (ACG) as described above. These adjustments were made to give increased incentives to providers to serve users of lower socio-economic groups and with higher health care needs (Staff, SRHCO).

In addition to the positive sanctions through the compensation system, the Rulebook also contains several areas where the provider can be penalised by the purchaser (negative sanctions); these include deficiencies in the reporting, lack of environment certification, and if the provider does not provide emergency hours. But the provider can also obtain extra remuneration (positive sanctions) for collaborating with the municipality, or another authority that is not financed by the region (800 SEK per hour), for providing emergency hours, as well as for special assignments, such as hosting medical students for their residency, which is awarded with 560,000 SEK per student yearly (Rulebook, 2018).

With regard to terms of payments, the provider is in charge of providing the needed evidence for the invoice and the provider is reimbursed ex ante. The payment is made 20 days after the date of the invoice (Rulebook, 2018, pp. 54–55). The Rulebook also clearly
stipulates that the provider is responsible for paying all the costs associated with delivering the agreement, with a few exceptions that are listed in the Rulebook.

There is constant tinkering of the Compensation model to try to fix issues that the purchaser detects in how primary care is delivered (Staff, SRHCO). Financial incentives are described by the public authorities as the fastest and most effective way to trigger change in provider behaviour (Staff, SRHCO), which is usually done by incentivising a certain treatment or action by reducing or increasing payments for certain treatment codes. Sometimes it is revised even more frequently than once a year.

When asked about the most important controls of the governance system, “the Compensation model” and “money” were prevailing answers by the public authorities (Staff, SRHCO). SRHCO staff also described that tinkering with economic incentives in the Compensation model is the main tool used to steering the system in a certain direction. The quote below illustrates the importance of the Compensation model for steering the market:

Since they [providers] are so dependent on the compensation, they always want to maximise their compensation. The smallest change you do in the compensation system, you notice that it has an impact, I mean, the care provision changes. We have had quite a lot of fee-for-service compensation, based on visits and on other measures, and you can see that if you gave an extra compensation for a drug review, for example because you thought it was important to work with, then the drug reviews increased sharply. So, you notice that it has an effect that way. We have also noticed that when you have this piecemeal compensation based on visits, the visits become many more and then we have received lots of signals from both patients and caregivers that you do not let patients take two things during a visit without saying “No, that’s another matter, then you can come back and book a new visit.” In order to receive two fee-for-service payments for the visit. We have noticed this quite clearly. I think the financial incentives is what they [the providers] adapt to the fastest. (Staff, SRHCO)

5.3.6  Hierarchy

There is hierarchy in the primary care market as the Stockholm Region decides on the rules that the primary care providers must observe (Forsell & Norén, 2018). As stated
above, the public authorities decide who gets to be a member in the market, the rule of the market, and the Reimbursement model as well as who must exit the market.

My empirical data shows that the SRHCO finds it challenging to balance between practicing coercive control and being supportive of the providers (enabling control). A staff member from the SRHCO described the provider purchasing relationship as follows:

   We are striving for a ... that these contacts between the purchaser and the providers ... that they are ... like .. open, friendly but that we ... we are an authority ... that we also have a professional relationship with the providers. (Staff, SRHCO)

The officials at the SRHCO try to balance the supportive role with the coercive role, while also striving to achieve public interest objectives.

5.3.7 Information

Information, or knowledge management, both to providers and users is an important tool for governing the primary care quasi-market.

Information in the form of publication of latest evidence to providers is frequently mentioned in the Rulebook, including a site entitled Vårdgivarguiden (the caregiver's guide). This is a website with information, services, and guidelines for caregivers operating in the Stockholm Region that has the objective to provide a one-stop-shop to support caregivers’ needs, both with regard to administration and matters related to patient care (Error! Hyperlink reference not valid.).

All providers must also follow the care programmes and guidelines provided in VISS, which started in 1996 and contain comprehensive medical and administrative information with focus on collaboration between different levels of care within primary care in the Stockholm Region (http://www.viss.nu). VISS serves as evidence-based decision support to providers in their handling of patients and it has about 100,000 visitors per month (ibid.). There is a similar site focused on supporting providers in psychiatric matters. These sources of information are produced by collaboratives of medical specialists and reviewed by representatives from the different medical councils in the Stockholm Region. Therefore, they represent a type of self-regulation by the profession.
Another such important knowledge management support system that was mentioned during the interviews is Janusinfo (https://janusinfo.se/), which is a non-commercial site that provides support regarding pharmaceuticals to health care professionals with the objective to provide evidence-based and cost-effective drug treatment. It is developed by clinical pharmacologists and other experts and is provided by the Drug Therapeutic Committee and the Health and Medical Care Administration of the Stockholm Region.

My empirical data indicates that these sources, although not legally binding rules, are described as critical for knowledge management, which the SRHCO describes as an important complementary tool to managing through financial incentives (Staff, SRHCO). As references to these information sources are included in the Rulebook, the lines between information and rules become quite blurry in this governance system.

In addition to these information sources, the SRHCO shares information with the providers by email and organises biannual dialogue meetings. The public authorities explain that the biannual ‘dialogue’ meetings with providers are more focused on providing information than engaging in dialogue:

Those are dialogue meetings but with a large component of information dissemination. It is like that when you have so many people in a meeting, it is more like a cinema show, someone talks in the front and then people have some comments. It is usually how it has been. (Staff, SRHCO)

5.3.8 Depiction

Depiction seems like a less frequently used tool by the SRHCO. However, the Rulebook does contain certain descriptions of the primary health care system that may nudge the provider to act in a certain way, for instance:

The main idea in the Future Plan within the Region is the establishment of network health care, a health and medical care where different care providers cooperate in a man-made care process together with the patient and where the patient attention and care needs are in focus. The patient must be able to experience health and healthcare efforts as a whole. (Rulebook, 2018, p. 23)
But there are other public authorities than those that are directly involved in governing the market (the SRHCO and political representatives), such as the Swedish Agency for Health and Care Services Analysis (Swe. Vårdanalys) and the Swedish Competition Authority that depict the primary care market. The former agency, for instance, has as its mission to strengthen the position of patients and users through analysing health care and social care services from the perspective of patients and citizens (Swedish Agency for Health and Care Services Analysis, 2014, 2015, 2017).

5.4 How the Primary Care Quasi-market is Governed — The Perspective of the Providers

5.4.1 Constant Tinkering with the Governance Model

The interviewers with the providers confirmed that there is a constant tinkering with the Compensation model. They described that they have the option to “run after” different “stimulation money”, but that it is not always worth doing so.

Regular tinkering with the governance system is described as challenging by the providers because they continually need to adapt their operations on very short notice and re-educate staff in new procedures. Managers of units described:

One year is very short time to do things and so it will change after a year. It’s like you can be thrown here and there sometimes, a ship that just ... you know it’s a great storm ... So it is a bit tricky sometimes, because you just have to start a good job and then you have to change working methods and routines. (Manager, public unit)

... you get the Rulebook, you get it too late, you cannot change the organisation ... one period they were crazy about these KVÅ codes ... and teaching the organisation thousands of KVÅ codes that was mission impossible ... [...] you get the [new or updated] Rulebook in December and you need to adapt such a big organisation. Now one has learned to not make such big changes too quickly. (Manager, public unit)

The expressed fatigue of running after different stimulation money may reflect an overuse of this instrument and may erode the effectiveness of this tool for changing the behaviour
of the provider over time. At the same time, the providers are dependent on the revenue generated by adapting their activities to changes in the Compensation model.

5.4.2 Provider–Purchaser Relationship: Coercive or Supportive?

As described above, the public authorities are balancing their role as a market regulator (authority) and practicing coercive control of the providers on the one hand, including setting and enforcing the rules of the market. On the other hand, they need to build a trusted relationship with providers to support them (enabling controls), and understand the provider and what is behind the data that they submit, to be more effective in the regulator role.

In my empirical data from the interviews with the providers, the providers expressed that they want the purchaser to take a more supportive role:

Control of quality is there as a factor, but it can never be the main purpose from the perspective of the purchaser, I think ... the main purpose is to stimulate the provider to do quality work and improve, so to speak. Also, from the perspective of the purchaser. (Manager, private unit).

This dual relationship creates friction in the relation between the purchaser and the provider, which is characterised by distrust, where providers use language that reflects a “we and them” relationship with the SRHCO. Providers also described that they avoid having honest conversations with the purchaser to avoid repercussions. A physician in one of the private units explained:

I wish in some way that we could have a more honest dialogue with the officials, with SRHCO. But we probably feel a little that we do not really dare to say exactly how it is to them. It is a bit that we must show that we are so good ... So this is a really difficult thing, we dare not be really honest, because we are afraid that that will be used against us. So, it is a little difficult to influence [the system] in a good way. (Physician, private unit)

Related to this issue of lack of trust between purchaser and the providers, as described by the providers, they also see a gap between those who design/formulate the governance system and the “wise people” who are working in the “reality” of providing health care. This disconnect between those who govern the market and those who are
being governed seems particularly large during the first years of the implementation of the PCCR.

There is also a sense, from the perspectives of the providers, that too much time is spent on constantly finding new models and doing studies, which may not have any significance for the reality of the providers, and that there is a discrepancy between what is being said and what is being done in reality by public authorities, particularly related to promising more resources to primary care. Heads of units described:

… what I see, it is a care that is deteriorating with less and less and less quality, while then for the county councils they can write more glorious and better stories about how care is improved, but they get further and further away from reality because they have taken over the responsibility over everything. (Manager, private unit)

… in relation to the primary care … it’s a little tragic to see that you say that you should strengthen and then you say that it has strengthened it in one way or the other, which really does not affect the reality out in the field at all, but you have put a few million into something that one disseminates like “now we have invested in primary care” though it has no practical significance. (Manager, public unit)

A similar gap also seems to exist between the public providers and their owner, that is the large public organisation SLSO that owns all public providers in Stockholm. Public providers described, in the interview data, how the SLSO contributes with great structure to their work, with regard to, for example, quality improvement, but explained that in order for this to impact the work in the unit, people in the unit, professionals who meet patients, need to work with the document themselves and feel that they own them and benefit from them.

5.4.3 Frustration in the Dialogue

Providers also express frustration with the dialogue with the purchaser, particularly the dialogue meetings. A manager of a private unit explained: “these meetings where the purchaser delivers a message, it is called dialogue meeting, but I have never been in a dialogue meeting where it became actual dialogue, but it is a monologue, where they deliver a message.”
Providers also described a sense of mistrust, as exemplified by this quote from a unit with small private owners: “they [the SRHCO] listen, or they pretend to listen and then they do what they want when formulating the contracts. That way we feel a bit powerless” (Manager, private unit).

Primary care unit managers described that the dialogue with the public authorities is characterised by the purchaser saying “this is how it is” rather than listening to the providers who know what is happening in the day-to-day operation of delivering health care. Providers also described that there is very little focus, by staff at SRHCO, on learning from the providers. However, some providers find the dialogue meetings with the SRHCO useful for understanding what changes in the governance system they can anticipate and to put issues on the table (Manager, private unit).

The smaller meetings between provider representatives and the SSHCO seem more appreciated by the providers. Some heads of units expressed that they can provide feedback to the SRHCO, for example, through their contact person, but they also said that the contact person is often perceived as sitting too low in the organisation to influence how the market is governed.

The lack of a forum for frankly discussing the challenges in the governance system between the providers and the public authorities was raised in several interviews on both the purchaser and provider sides.

At the same time, the public authorities described how they have tried to engage in working groups with providers on specific topics (e.g. supervision and measurement) and how such efforts failed because providers were mostly interested in the Compensation model, so the dialogue around other issues pertaining to supervision and measurement did not happen.

The providers also described how dialogue with the purchaser has, for instance, resulted in better outcome measures. One provider described how the purchaser has moved from initially focusing on measuring individual indicators of, for example, average values for a specific disease group, to understanding that there are many factors that influence such indicators. The provider described how a good dialogue with the purchaser has shifted to
focus towards smarter quality of care measurements. This shows the importance of dialogue for understanding how the governance system is received by the providers, making needed adjustments, and ultimately for effectively managing the market.

The below quote by a provider captures the importance of involving the providers in the design of the governance system:

> I would listen even more to people in the field and then I would try to influence the politicians based on what the people in the field think ... There is far too little dialogue, it was almost non-existent dialogue between Stockholm’s medical council and the politicians, they almost never came there for eight years, even though they were supposed to be advisors to the politicians and the purchaser. So, there are the different worlds, which is completely crazy. They should ... they should listen to the profession a lot more. (Manager, public unit)

Another challenge with the dialogue, in the perception of the providers, is that they spend lots of time submitting different monitoring documents and reports but that they rarely receive any feedback on their submissions. Providers described long lead times for feedback and that they question whether anyone even reads the information they submit. One manager of a private unit noted: “I have even made a protest like this at some point to see if they read, so I posted something completely absurd somewhere to see if anyone reacted, but no one reacted.”

This lack of feedback is likely to impact the motivation of the providers to submit data over time and may eventually lead to a deterioration in the quality of data submitted by the providers.

### 5.4.4 Different Layers of Governance

#### 5.4.4.1 The owner’s logic

The providers described that their owners influence the governance system that the patient-facing staff are operating within. For the small entities where the owners are actively working in the practice, the owner’s philosophy/culture does not appear to conflict with the head of the unit since those roles are often held by the same person. In larger provider organisations (e.g. SLSO, or larger private companies), however, the heads of
units as well as the owners themselves described that the owner influences the governance system for their units both explicitly and implicitly.

With regard to formal and explicit mechanisms that the owners use to influence their providers, the SLSO, the public owner, has a specific scorecard for its units that focus on five perspectives: R&D; sustainable development; patient perspective (accessibility and quality); employee perspective (work environment); and economy. One of the larger private owners, Aleris, a private-equity–owned company (at the time of completing the interviews), also uses a balanced scorecard to drive performance, where they track the number of listed patients, number of visits for physicians and nurses, staff costs, staff ratio, and earnings before interest, taxes, depreciation, and amortisation (EBITDA), etc. This scorecard is more focused on financial performance measures than the SLSO scorecard.

According to staff at Aleris, EBITDA should, ideally, be positive and if it is not, the heads of units need to explain why it is not. In contrast, in publicly owned facilities, interviewees mentioned that a prerequisite for the organisation to work was to break even, but there is no explicit focus on earnings. These are two examples of explicit and formal instruments used by the owners to influence the health facilities they own.

Informal instruments, such as culture or ideas, are also used by owners for governing the providers. One such example is the perception amongst providers about what it means to be an SLSO unit. One head of an SLSO unit described: “For me, SLSO, it is a brand that we should stand for, which stands for security for patients, both patient safety, good care, the best care, and accessibility.”

Providers owned by the SLSO describe that they have two principals to report to: the purchaser (SRHCO), and the management team of the owner (SLSO) and that these two principals are not always synchronised in terms of what they want from the heads of units. One provider explained:

> So they do not cooperate, and it becomes very confusing in the operations of the organisation. It is difficult to teach pedagogically, what our goals are, because you have two incoming lines with goals. One from SLSO and one from SRHCO. (Head, public unit)
As an example, it is mentioned that sometimes the SRHCO signals that extra money will be available if a unit does "xyz" (e.g. extend opening hours) but that this is not compulsory, but then the owner says that it is compulsory. This can create confusion for the individual primary care unit. Heads of small private entities also described that they are happy that they do not need to deal with specific requirements from a larger owner, since they are the owners themselves.

5.4.4.2 The professional logic

Unit managers also experienced their professional logic often pulls in a different direction than the logic of the public authorities in how they govern and the owners. When asked, clinic managers often described that the professional logic “wins” and is ultimately what guides their actions. They described that they resist the governance system or outsmart the governance mechanisms imposed from above from public authorities and owners, to follow their professional values. For instance, one unit manager described that when they are sitting with the patient they want to focus on the patient and the medical problem rather than how many cents they can earn extra if they do this and that, and that their focus on the patient is guided by their professional ethos as a physician rather than the signals from the governance system that would take them in a different direction. Unit managers described:

Again, what matters most is professionalism. It sounds a bit grand maybe or fuzzy but that’s what drives us. Then you have to say, what kind of governance system do they have. Yes, it is well payment per visit, that is perhaps what is most important [in the governance system]. (Head, private unit)

Certainly, we are affected by what is stated in the contract, of course. But our … our intent with managing our own clinic is to be able to do, as I said, to provide a unit and health care, a care that we ourselves can stand for and the primary care we believe in. And that is aligned with the ideas in this document [the contract with the purchaser], but not a hundred percent. And then we still have the advantage of being able to do a little as we want, even if economically it is not optimal in this [governance] system. (Head and owner of private unit)
5.4.4.3 Contradicting logics

Heads of units described how the different governance mechanisms from different principals, namely, the public authorities, the owner, and the professional’s inner compass, creates layers in the governance system. They also described how the directions from different principals are not necessarily aligned and that this creates internal stress for them. One manager described:

I have a very difficult situation, stuck between different principals. I have requirements from the owner about generating profits, I have a society that gives me certain conditions for operating [this unit], which are not easy, and then I have my own code, professional code, or whatever you want to call it, that I have to follow to be able to go to sleep at night, and right now, they do not work together. (Head, private unit)

In these situations where the providers experience contradicting logics, the heads of units described, as mentioned above, that they to a large extent follow their professional inner compass.

The providers also expressed that the economist’s way of steering through incentives is not so simple in the health care setting, where there are both moral and knowledge decisions involved. One head of unit, who works in a private clinic, described:

I have been lucky that the owners have been serious. Basically, what I as a general practitioner and my employees do, I think there is no difference in private and public units because basically it is professionalism and professional proud and the thoughts about what good primary care should look like, there are such things that determine what the outcome is … But with the privatisation, maybe we will get into that, during the journey you have seen some deviations that I, thank God, have not had to be involved in, but when you put money on certain activities, the focus is attracted there … Some health centres and some people end up in this that you have to chase the money instead of the quality … It has been difficult to make it work. You have to chase the money, but you feel that sometimes there are more important things to do. To govern only with the money, I think it is a challenging way to steer. But there has been a great deal of faith in it over the years, and not least amongst economists who believe that you can control this in the blunt way. But it is well known that many sectors that are complex and have many knowledge, moral, and other decisions, that it does not work to control so simply with crowns and pennies. This is not to say that you should not do it, but I say that it is complex and there are many pitfalls in it during the journey. (Head, private unit)
The interviews reveal that multiple logics exist in the primary health care quasi-market in Stockholm and that these influence the behaviour of the heads of clinics, which in turn is likely to trickle down to patient-facing staff. A manager at the SLSO described this clearly:

This is a very complex sector with several logics. There is never just one answer, but it depends on the logic you are talking to. If you talk about the political logic, or the professional logic, it depends on what you have for driving forces in the whole. (Head, public unit)

5.4.5 Top Performers are Not Always Encouraged

While some unit managers described this stress of contradicting logics, others seemed to thrive in this environment and described how they had turned poorly performing units into well-performing units even in the most challenging socio-economic areas of the Stockholm Region, with sicker patients and where it is traditionally more difficult to recruit staff. This highlights the importance of leadership. One manager who has worked in several units both in the public and the private sector described that the manager is important for the focus of the operation:

... has it been an IT-interested doctor [as a manager], then maybe the IT park has been completely fascinating, and all IT systems. If I have come to a health centre that has been run by a nursing-oriented district nurse, then home care has flourished. (Head, public unit)

Several managers both in the public and the private sector described that they performed “too well” and that this was not appreciated by the organisations where they worked because it showed that others could do better and made others uncomfortable. This finding was particularly surprising to find in the private sector, where one would think that a high-performing manager with good results would be rewarded rather than discouraged.

A unit manager who had worked in the private sector but moved to another unit described:

I enjoyed it very much there (working for private provider), but I was the person who was so driven, who could show results and show changes ... so it became a bit like that ... you see, you climb too much, and that does not create a fun atmosphere. ... one should not forget about people who do a good job and people who work. You put so much energy on people who do not work and forget about the others who want to work. (Head, public unit)
As pointed out by one of the staff from the SLSO, the manager of the unit may be a more important determinant of performance, maybe even more important than ownership and size. They explained: “It is very person-dependent, what kind of manager a unit has determines if the unit is functioning well or not, whether it is a small or big company” (cit. Head, public unit).

Overall, emphasis on leadership training and recruiting good leaders in primary care seems to be largely absent in both the formal requirements from the purchaser (Rulebook) as well as in the dialogue with the providers. It is left up to the provider to decide whether they want to have leadership training — some providers, such as the SLSO, have leadership training while others do not. The empirical evidence, however, indicates that leadership skills are critical for the performance of the units.

5.5 Concluding Discussion

The first section of this chapter investigates the mechanisms used to govern the primary health care quasi-market from the perspective of the purchaser, using Ahrne et al.’s (2015) framework.

Both purchasers and providers state that the Rulebook is the main framework for governing and exercising controls over the providers. First, I notice that the governance mechanisms used by staff from the SRHCO mainly target the providers, rather than, for example, trying to influence the users/patients to, for instance, make better choices. Second, judging from the rules or “words on paper” (Ostrom, 2009, p. 15), the Rulebook, Stockholm Region is an active regulator of the market, as the Rulebook contains detailed rules about exactly what services need to be provided, but also with regard to opening hours and how services should be provided, for example, patients should participate, health care must be provided with a holistic view, and those with greatest needs must be prioritised.

Even if the staff at the SRHCO said in the interviews that their role is not to get involved with the ‘how’ of providing services, the Rulebook clearly goes beyond the ‘what’ to also describe the ‘how’ of services provision. This raises the question whether the role of the
public authorities is to only focus on the ‘what’, particularly if they want, as per the Rulebook, to influence how services are provided. The providers stated that they perceived the purchaser to be micro-managing.

Using Osborne and Gaebler’s (1992) vocabulary, this indicates that while the public authorities intend to steer rather than row, it seems complicated as a market regulator to pull back from ‘rowing’. This may indicate that finding the balance between rowing and steering may be more complicated in practice than in theory and public authorities also express that the steering only can be challenging.

The finding that the Rulebook contains detailed regulation is congruent with previous research (e.g. Andersson et al., 2017) that shows that the government, in other sectors in Sweden, takes an active role in market regulation, and with research in the primary care market (e.g. Malmkvist & Redic, 2012) that has shown that the governance system is using market mechanisms but still resembles hierarchical bureaucratic control.

A range of mechanisms are used by public authorities, who actively govern the market, including written rules, market entry/exit criteria, performance monitoring, the use of knowledge management, and sanctions. According to stakeholders, the Compensation model is perceived as the most important mechanism driving the incentive structure.

I show that all seven elements of the framework developed by Ahrne et al. (2015) and elaborated by Andersson et al. (2017) are used to govern in this market, although Depiction is the least used mechanism deployed by the SRHCO. The public authorities also combine various controls, such as rules, sanctions, and information, to allow for enforcement of rules. This finding is in line with Glenngård (2019), who also found, in her study of the governance of primary care in the 21 regions in Sweden, that several management controls are used by the purchasers and that they operate as a package.

The most important governance mechanism according to stakeholders, the Compensation model, changes frequently, and this is a way for the purchaser to micro-manage the providers. The constant tinkering with the economic incentives is stressful for the providers and they expressed how they constantly need to adjust to the new conditions by retraining staff and adjusting business operations on short notice.
Even if the “rules on paper”, in the Rulebook, contain detailed rules regarding the “how” of providing services, a critical question relates to market accountability mechanisms and if regional authorities can enforce the rules and hold the providers accountable in practice.

Regarding market exits, my empirical data shows that it has been challenging with enforcing the rules to exit providers from the market in practice, particularly during the early years of the reform, because of long legal proceedings. The lack of enforcements of exits creates a risk to a well-functioning quasi-market, particularly if there is demand sluggishness, as indicated in my literature review (Chapter 3), and non-performing providers may not be excluded through consumer accountability mechanisms.

With regard to holding providers accountable for other stipulations in the Rulebook around providing certain quality of care, or around prioritisation of elderly people with large and complex care needs, it is unclear how accountability is enforced from the findings in this chapter. For instance, the SRHCO only requires the providers to report on quality outcome indicators regarding diabetes, which indicates that regional authorities may be at risk of not detecting providers who are skimping on quality. I continue to explore this issue in Chapter 7, which hones in on the governance mechanisms used by public authorities to ensure that quality services are provided.

This chapter shows that there are various levels or layers of governance that influence the behaviour of the providers. The providers described that they must respond to the different principals: their own professional logic, the owners, and the public authorities.

An important finding is that the owners, primarily larger ones such as the SLSO, that own several units influence through explicit governance mechanisms and tools (e.g. scorecards used by the SLSO and the large private provider [Aleris]) but also through implicit governance controls, such as culture. Within the public sector, some providers (SLSO) perceive that they have two incoming lines of command from the owner (SLSO) and from the regional public authorities (SRHCO) and that these directions are not always consistent.

This may explain findings in previous research (e.g. Ellegård, 2020) that shows that public and private providers respond differently to the governance system and provides
evidence to support calls for ownership frameworks being used more frequently in health policymaking (see Crampton, 2005).

Ostrom’s (2009) influential Institutional Analysis and Development (IAD) framework, which has been useful in understanding institutional arrangements in multiple contexts (Imperial & Yandle, 2005, pp. 501–503), helped me understand these various levels of governance as well as the importance of not leaving governance with the rules on paper, but creating structures to be able to enforce rules.

Ostrom’s framework distinguishes between three levels of rules: constitutional-choice rules are the meta rules of the game and they change at the slowest pace, they determine who can be part of policymakers and space for crafting policy; collective-choice rules are policies that impact operational activities and determine who is eligible to be a participant and the rules to be used in changing operational rules; and operational rules are patterns of interaction, day-to-day decisions made by participants at the operational level. They can change daily. At this operational level, participants interact in response to both the internal and external world (Ostrom, 2005, p. 58–60).

Applying this to the governance of primary care markets in Sweden, the constitutional-choice rules are stipulated in the legal framework in the sector, codified in the Health and Medical Service Act (Sveriges Riksdag, 1982). The collective-choice rules are set by the Stockholm Region, summarised in the Rulebook and enforced through the combination of various elements such as sanctions, rules, and information. The operational rules, those that influence day-to-day decisions made by the providers, are a mix of formal regulation created by the Stockholm Region and included in the Rulebook, nested in goals/rules set both by the owners and by health care workers and managers own professional codes of conduct. With regard to formal rules from the owners, this seems most prevalent for providers with larger owners (e.g. SLSO, large private companies that own several units).

Listening to the staff at the frontline, it is apparent that these layers of governance or voices of different principals are not always aligned. Thus, there is dissonance between the different layers of governance. For instance, providers stated that the primary care
that they want to provide, according to their professional ethos, is not 100% consistent with what is in the contract (i.e. Rulebook) they have with the SRHCO.

This finding is consistent with previous research, although they put less emphasis on the layer of governance introduced by the owner, as described by my interviewees. For example, Falkenström (2014) wrote, in her book about managers in the health care sector in Sweden:

> The system conflicts that managers tell about in my research interviews and at managerial seminars are mainly about conflicts between on the one hand management logic (how the business should be organized to achieve high patient turnover and cost efficiency) and on the other hand professional ethics (where the needs and interests of the patient and the needs of different patient groups are at the center) .... it seems to be the clash between management logic and professional ethics that is the most difficult for managers to handle. (Falkenström, 2010, pp. 58–60)

Also in my data, I detect that providers described that these system conflicts create inner stress, which has also been observed by other scholars (e.g. Bornemark, 2018; Kälvemark Sporrong, 2007) of the changes in the welfare sectors in Sweden.

There is also dissonance in the governance system, even within one layer (constitutional-choice rules). There are rules in the Rulebook that stand in conflict with the incentives provided in the Compensation model. As an example, the Rulebook says that providers must prioritise elderly people with large and complex care needs, people with extensive disabilities, and chronically ill people and even provide support to their relatives. However, the Reimbursement model does not give any extra reimbursements for supporting relatives to elderly people. And although there are extra reimbursements for a patient who is above 85 years old (200 SEK) added to the base fee of 260 SEK per visit in the compensation system, it is questionable if a provider who wants to maximise profit thinks it is worth taking an older patient who may take substantially more time, instead of using that time to have a few more healthy patients come in who generate 260 SEK per visit. This dissonance in the governance system means that it then becomes up to the individual patient-facing staff (or possibly the owner) to decide what is the right thing to do in each situation.
What is also interesting to notice is that providers described that when they experience these kinds of governance system conflicts, the professional logic is more important than the higher-level rules. Thus, in practice, the rules on paper may only have limited impact on provider behaviour, if these rules are inconsistent with their professional ethos.

This seems to be the case in both private and public units. Thus, even in private units, which one could imagine would be more driven by profit maximisation, the professional ethos seems to guide providers more than anything else and may therefore cushion against a profit maximisation at the expense of patient safety. This is consistent with Andersen and Jacobsen’s (2010) finding that professionalism of the staff off-sets some of the ownership differences.

Many providers described frustration in the dialogue with the purchaser, where they described the dialogue meetings as a monologue where the SRHCO informs the providers about changes in the Rulebook, rather than a co-creation of the Rulebook. Providers also expressed that there is too little dialogue.

Using the IAD framework again, Cole (2014) stated that feedback mechanisms, from, for example, the operational level, can impact higher-level rules. In the case of the governance system in primary care in Stockholm, it does not seem as if the providers feel that this feedback mechanism is working because those who have influence over the governance system are not in a listening mood and because those who listen to them, for example, their contact person, are too low down in the hierarchy to influence the governance system.

This sense of being fed new rules and directives from above and not participating in the shaping of the governance system that the providers work in seems to have created a feeling of “we and them” amongst the providers, when they refer to the regional authorities. The providers also described a gap between those who design the governance system and govern and those wise people who are working in the reality and are being governed. Thus, there appears to be a lack of understanding between the public authorities and the providers. Furthermore, statements such as “I wish in some way that we could have a more honest dialogue with the officials, with SRHCO”, as described by one private provider, indicate that there may be a lack of trust between the parties.
Drawing on previous research, Glenngård (2019) found in her study of governance models in primary care in the 21 regions in Sweden, that in general, when the purchasers were asked to identify the most important element of the governance system, the most prevalent response was dialogue and the tender document (or Rulebook) underlying contracts between the actors.

In my data, the most prevalent answer, with regard to most important governance mechanism used by the public authorities, was the Compensation model or “money”, and rarely was the dialogue mentioned as the important element of the governance system, neither in my interviews with SRHCO staff nor with the providers.

The fact that Stockholm differs from the national finding by Glenngård (2019) may be linked to the fact that Stockholm, in the first years of the PCCR, had the highest share of payments to providers coming from fee-for-services (60%) amongst all 21 regions (Staff, SRHCO), and may therefore have developed a more financially focused governance system compared to other regions.

Moreover, Glenngård (2019) found that the purchaser reported that the dialogue was the most important tool as it “builds trust, relationships and shared knowledge between the purchaser and providers” (Glenngård, 2019, p. 6). My findings raise questions about whether the fact that the dialogue between the purchaser and the provider in the Stockholm Region seems inadequate has led to a purchaser–provider relationship that is not characterised by trust, as described by the providers.

Interestingly, both providers and staff from the SRHCO seem to agree that the governance system would improve if there was more dialogue between the purchaser and the provider. It is not clear, however, from the interviews why more dialogue is not happening. Staff from the SRHCO described that their attempts to set up working groups on supervision and measurement failed because providers are mostly interested in changes in the Compensation model. Similarly, providers, particularly smaller private ones, described that time cannot be wasted on meetings as they have small margins, and each hour in meetings means an hour away from seeing patients and generating revenue.
This highlights that in a system where health care units operate more and more like any production unit, providers also become more and more aware of the opportunity cost of their time and may therefore refrain from activities that take them away from revenue generating activities. Thus, activities, such as contributing to shaping the governance system in a quasi-market, which are important to build trust, shared knowledge, and possibly also to create a better governance system, must be compensated for providers to engage in them. This may be particularly stark in a governance system such as in the Stockholm Region where financial incentives are a key mechanism for governing.

5.6 Conclusion

It was the intention of this chapter to analyse the mechanisms that are used by the public authorities to govern the primary care quasi-market in Stockholm as well as to analyse what incentives they give rise to from the perspective of the purchaser and to provide the foundational pieces for understanding the governance system and respond to research question 1.

This has been done by analysing the empirical data collected in my interviews as well as by carefully analysing the document that provides the framework for governing the market, according to my interviewees, namely the Rulebook.

What this chapter reveals is that the market is tightly governed by public authorities. A range of mechanisms are used, including detailed written rules, market entry/exit criteria, performance monitoring, the use of knowledge management, and sanctions. This shows that although this is a market, the governance system still resembles hierarchical bureaucratic control. Yet, despite tight control of providers through, for example, rules on paper, there are challenges for the public authorities to hold providers accountable for compliance of these rules in practice. One area where enforcement has been difficult is with regard to exiting providers from the market, which turned out to be more difficult than anticipated, at least during the first years of the PCCR.

According to all stakeholders, the Compensation model, which constantly changes, is perceived as the most important mechanism driving the incentive structure. Yet, the effect
of the incentives from this mechanism is moderated by other factors. Providers perceived their actions to be influenced by a range of mechanisms employed by a variety of principals at different levels — public authorities, organisational owners, and the professional ethics, associated with their medical profession. This creates layers of governance and pressures from different principals that are often in conflict and creates internal stress amongst the providers. When reflecting on this resulting complexity, providers emphasised their values and professional ethics as the primary influences on their behaviours. Thus, in practice, the rules on paper may only have limited impact on provider behaviour, if these rules are inconsistent with their professional ethos. Providers also expressed frustration with those who govern the market because of limited opportunities for dialogue and perceived a feeling of “we and them” when describing the provider–purchaser relationship and they said the governance system would improve with more dialogue.
6 Governing Quasi-markets to Achieve Competition

6.1 Introduction

As discussed in the previous chapters, according to the theory of quasi-markets, competition between providers is an important driver for quality of care. While market regulators therefore strive to increase competition, they also want to exclude providers who do not fulfil minimum standards from the market, which results in reduced competition.

In this chapter, I continue to explore the mechanisms that are being used to govern the primary care quasi-market in the Stockholm Region, but with a focus on controls in use to achieve competition. The chapter gives an account of the incentives the governance system gives rise to with regard to competition, from the perspectives of both public authorities and service providers. It focuses on the second research question of this thesis.

In the theory of quasi-markets it is important that all providers, regardless of ownership and size, compete on an equal footing; therefore, market regulators seek to practice competition neutrality. I therefore pay special attention to this issue and if a level playing field is achieved in the Stockholm Region primary care quasi-market.

In the first section, I provide an account of the competitive environment before the introduction of the PCCR to provide a background to the dynamics in the market that ensued. I then examine the topics mentioned above through my interviews with officials from the regional authorities, who govern the market. The following section focuses on how managers of primary care units perceive the existing governance system with respect to what incentives it gives rise to. I also discuss how and if competition is achieved, and specifically a level playing field. The final section includes conclusions.
6.2 The Mechanisms Used to Govern for Competition — The Perspective of Public Authorities

6.2.1 The Competitive Environment Before the Introduction of the Reform

As mentioned in Chapter 2, the privatisation of primary care units in the Stockholm Region, as well as competition between providers, started long before the introduction of the PCCR in 2008. In 1992, the Stockholm Region split up the purchaser and provider functions in what was called the Stockholm model. The purchaser oversaw the formulation of the goals of the providers, while the providers would manage the health care units according to these goals (Israelsson & Ulveland, 2007).

The Stockholm Region differed from other regions because it encourages privatisation (Hjertqvist, 2000). The conversion of primary care facilities from public to private ownership also started in the 1990s, when staff working in public units were encouraged to acquire the units they worked in and thereby convert the units from public to private ownership. As discussed in Chapter 2, at this time, in addition to managing contracts and procurement processes with the providers, the public authorities also offered significant support, such as training and start-up consultations, through the spin-off office (Swe. Avknoppningskansli), to teams of staff who wanted to place a bid on their unit (Hjertqvist, 2000). One interviewee explained:

It was a group [the spin-off office] that, with the help of consultants, tried to stimulate employees in the region to start their own companies and then be able to acquire an existing health care centre. You could get consultancy and training support to start your own. (Staff, SRHCO)

This support to convert public ownership to private ownership was provided by a group of centrally located consultants, while contracts and procurements were managed by the SRHCO’s regional officers (Former staff, SRHCO).

At this time when conversion started, there were very few large companies (except for the SLSO [public provider] and Praktikertjänst [networked small private owners]) in the primary care market in Stockholm (Staff, SRHCO).
Interviewees described that the entry into contracts with these providers, often privately owned by a few staff who worked in the unit, by public authorities long before the introduction of the PCCR, created knowledge about market regulation amongst both providers and the public authorities.

At this time, there were no standardised entry contracts, but each contract between the purchaser and the provider went through a public procurement process under the Swedish Public Procurement Act and was negotiated between the single provider and the SRHCO. This meant that there were large differences in, for example, reimbursement rates between different providers, which depended on the outcome of negotiations (Former staff, SRHCO). One interviewee explained:

> Before we introduced the Choice reforms (PCCR), the capitation payment could differ a lot between different health centres that could be located quite close to each other ... like Alby, which is out in Botkyrka, had 650 SEK [in capitation payment] while Fittja, which is next door, had 1400 SEK in compensation, so it was a very unfair system that we had before and now [with the PCCR] everyone got the same compensation. (Former staff, SRHCO)

### 6.2.2 The Creation of a Level Playing Field

When the PCCR was introduced in 2008, an important principle that guided the SRHCO's work was that all clinics had to have the same conditions, with regard to how they were monitored, the content of the care, and remuneration, to create a level playing field (Staff, SRHCO). Thus, the main mechanism used by public authorities to create competition was the standardised Rulebook and contract — market entry criteria, operational requirements, and remuneration were identical for all units as stipulated in the Rulebook.

There were some minor differences in the remuneration with regard to VAT between public and private units (see below), but these also sought to establish equal market conditions. Furthermore, another difference was that some primary care units that already had existing agreements with emergency units were not required to provide certain emergency services from the beginning.
The level playing field was not created at once, but it took some time to phase in. One of the people involved in implementation described this:

We had thought that it would be easy to legally force some [of the units] into the new Choice model. But we did not. When we introduced [the PCCR] in 2008, there were about 30 units left on the old contract, so we had two parallel contract systems for a while until they [the old contracts] expired ... It was those who had agreements with a longer term than 2007. And there were some who thought that if they were to go into the Choice model, they would receive a worse compensation, so then they chose to stay on their old contracts. There were about 30 contracts, but as they expired, they then had to apply to be approved in the Choice model. The last one expired at the end of 2009. Then all had the same contract. (Staff, SRHCO)

This shows that the implementation of the PCCR did not happen in a day but as the old contracts expired the new standardised contracts were put in place, step by step, and market requirements became standardised and equal between providers.

In the 2018 Rulebook, which is the edition I used in this thesis, there are only two very minor differences between public and private providers, which are both related to reimbursement. The first one is that private providers get a VAT compensation, equal to the government VAT compensation, as they pay VAT. The size of the compensation is determined by the purchaser. The second is that private providers are reimbursed from the SRHCO through a specific pricing list for care provided to patients who either live in another region or abroad. The public providers (SLSO), on the other hand, shall invoice the other regions directly or claim payments through the Swedish Social Insurance Agency (Swe. Försäkringskassan). Thus, apart from these minor differences all other conditions are, at least on paper, the same for public and private providers.

According to the SRHCO they also try to treat public and private providers in the same way in practice. A staff member from the SRHCO described that they do not see any difference in how they manage public and private providers:

We have always been very careful at SRHCO that they [public and private providers] have the same conditions, they have the same Rulebook, and we follow up with them in exactly the same way. We could get more follow-up indicators from SLSO [public provider] because they have the same information system [as us], we could work to get more data from them, but we do not. We only follow up what we can get from everyone. At the senior management level, I do not know, but it
can be that there is more dialogue with SLSO than the private ones [providers]. I dare not answer. But from the SRHCO technical officer’s perspective, we have been quite careful that it should be the same. Stockholm differs greatly from other regions in this aspect, I believe. (Staff, SRHCO).

Political will seems to have been an important factor in establishing a standardised contract for all providers. The political majority in Stockholm was very keen on having the same conditions for private and public providers when the PCCR was introduced because they wanted private providers, including smaller units not owned by large corporations, to be able to enter the market and compete with similar conditions (Staff, SRHCO).

With regard to the competitive environment, it should be reiterated that even if providers compete, the Rulebook also incentivises a certain degree of collaboration between providers. For instance, providers are, together with other neighbouring providers, responsible for drawing up a plan with division of responsibilities between the caregivers. The plan covers areas such as disease outbreaks and various activities (e.g. vaccination, death notification, home care, compulsory care) for non-listed patients in the municipality or district where the provider is located.

6.2.3 Managing Market Entry

In the previous governance system, that is, pre-PCCR, all citizens on the list generated a revenue stream for the health care unit. Citizens could either register with the unit that they preferred or if they did not register and lived in a certain geographical area (the catchment area) that belonged to the unit, they were automatically allocated to the unit by the SRHCO (Staff, SRHCO). Thus, in the previous system, all citizens were registered either by themselves or automatically to a nearby clinic. This system was abolished with the introduction of the PCCR.

With the PCCR system, it is up to every citizen to decide if they want to register and citizens are no longer automatically allocated to a unit if they choose to not register. The majority opt for enrolment and two thirds say that they have made an active choice (Swedish Competition Authority, 2014). The resources attached to those citizens who do
not enrol do not benefit any health unit. However, the non-enrolled population has an equal right, as those enrolled, to visit a unit and no unit can refuse a non-enrolled patient.

According to one of the people who conceptualised the reform, the main challenge for private clinics that entered the market was not the initial capital investment, since this is relatively modest in primary care, according to this interviewee around SEK 1 million, but rather to obtain a long list of registered patients who generated capitation payments. They described:

… many of the new entrants failed for they were unable to build up a list [of patients] large enough for them to break even in their operations … For it is crucial that you have the patients … It is much more difficult to get them [patients] there than to get the relatively little start capital needed. (Former staff, SRHCO)

When the choice reform was introduced, there were already a large number of private providers in the Stockholm Region. All existing units already had a list of patients (both private and public). This gave existing units an advantage compared to the new market entrants who had to compete for patients. The new entrants strategically sought to establish themselves in areas that lacked well-functioning units, where they could more easily convince citizens to switch to their unit. One of the policymakers involved in the reform explained:

… where primary care worked well, there was no point in trying to establish [a new unit] and find new patients. However, many settled in Stockholm’s inner city. Partly because there are many living in the suburbs who find it quite convenient to have the health centre near the job instead of near where they live. (Former staff, SRHCO)

As mentioned above, in the previous governance regime there was wide variation in the remuneration between clinics since this was determined in negotiations that produced individual contracts. Interviewees explained that in that regime it was tougher for small companies, which did not have a large marketing department, to produce well-written proposals to win a contract for providing services (Former staff, SRHCO). However, with the PCCR, anyone who fulfils the basic criteria in the entry contract can operate in the market as there is no bidding process that requires a fancy proposal. Thus, there is no competition for market entry in the Choice regime, as opposed to the previous regime,
but there is competition for patients who generate revenue once a provider has entered the market.

6.2.4 Ownership Characteristics and Market Structure

The Stockholm Region has one of the largest shares of private units/total units in Sweden, and the Swedish Competition Authority showed in a report from 2012 that the number of new private units in Stockholm increased from 91 before the PCCR to 129 in October 2011 (Swedish Competition Authority, 2012). During the early years of the reform (2008–2012), 58 units entered the market (exclusively private), and 12 units exited due to bankruptcy or political decisions (Dahlgren et al., 2013). In terms of market structure, the large change in the Stockholm Region was that the public units’ share of the overall revenue decreased from 50% to 41% between 2008 and 2012, while private units with large corporate owners increased their share of the overall revenue from 11% to 20% during the same period (Dahlgren et al., 2013).

No new public units started when the PCCR was implemented (National Competition Authority, 2014). This was not explicit policy, but rather implicitly understood that the SLSO could not start new units as they did not get any new mandates by the politicians at the time (Staff, SRHCO). The SLSO can be mandated by the regional authorities to start a new unit or complete a specific mandate, but they cannot independently start a new unit.

The budget document states that “a diversity of healthcare providers is necessary to be able to offer citizens good and accessible care without queues” (Stockholm Region, 2008, p. 35). It is clear from the document, which explains how regional authorities are supporting staff in public primary care facilities to convert them to privately owned facilities, that diversity of providers was a key objective for the politicians when the reform was introduced.

In the interviews with representatives from the SRHCO, who were involved in the design of the PCCR, they described that the intentions with the reform, when it was established, were to increase accessibility to primary care to the patients and to increase the number
of private units that entered the market. As interviewees explained that no new mandates were giving to SLSO when PCCR was introduced, and more providers overall would enter the market, the share of the private providers/total providers would naturally increase. However, one of the politicians interviewed gave a contradictory view, stating that the goal of the reform was not to increase the share of private providers in the market:

... the political opposition believed or wanted to see it as a privatisation reform, but it was not. ... we really had no particular wishes about who the caregivers would be. The county council has its own fantastically good and well-functioning company called SLSO, which runs the county council’s own activities in primary care, psychiatry, and geriatrics. Very talented! So it would not have been strange if they had continued to expand. (Regional politician)

According to the interview material, there seem to have been few discussions about desirable ownership characteristics, risks of market consolidation, and what rules that needed to be put in place to ensure market consolidation did not happen, when the PCCR was conceptualised. One staff member from the SRHCO explained:

I should not say that I heard some big discussions about it [type of owners desired in the market], but I am not surprised that it has become that way [towards market consolidation]. When staff form a company to acquire a health care centre ... a health care centre itself does not have much capital need. There is some equipment needed, but when you then get started and get a list of patients, i.e. a customer base, the company can rise from SEK 1 million in value to SEK 20 million in a very short time and it is clear that when you get up to SEK 20 million in value for a health care centre, it is the large companies that are able to participate and bid to buy such a health care centre. Of course, no individual employees can go in and acquire that large of a value. (Former staff, SRHCO)

The Rulebook is also mostly silent with regard to ownership. However, and as mentioned in Chapter 5, it does recognise that a change in ownership must be reviewed by the region and stipulates that “significant changes with regard to the provider’s ownership or the ownership of the parent company of the provider, shall be notified in writing to the purchaser without delay” (Rulebook, 2018, pp. 16-17).

The information about the new ownership status is assessed by the purchaser, which determines the provider’s future possibilities to fulfil the agreement. The purchaser can decide to terminate the agreement, should the new owner, for instance, not meet the requirement for approval to sign the entry contract (Rulebook, 2018). Thus, significant
changes in the ownership status is one of the legitimate reasons for the SRHCO to terminate the contract pre-term with the provider. There is no information in the Rulebook about what is included in the evaluation of the new owner. The interviews with the SRHCO confirmed that they sometimes have internal discussions with regard to whether a new owner is appropriate or not.

6.2.5 Size of Units

With regard to size of unit, the Rulebook is general and stipulates: “The provider must have staff to the extent required to carry out the assignment in accordance with the Agreement” (Rulebook, 2018, p. 32).

It also includes specifications on specific technical cadres (district nurse) that continuously need to be present in the unit. However, there are no other specifications with regard to size of the unit or size of the owners.

With the introduction of the PCCR there was a lot of focus, amongst politicians, on the units owned by smaller private units (Staff, SRHCO). However, given competition neutrality, politicians said that small owners were not to be prioritised, but rules were made to ensure they could enter the market (Staff, SRHCO).

While small units were encouraged to enter the market initially, changes to the Reimbursement model, which put more emphasis on capitation rather than fee-for-service payments, made it financially impossible to start a unit when this change came, unless you have an existing patient stock of thousands of patients or financial strength that can take the revenue loss related to the low initial patient stock (Managers, private units). Consequently, with this change, it became more difficult to start a small unit since you cannot rely on fee-for-service payments to build up capital (Forsberg & Sundström, 2020).

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7 This policy changed again in 2020 (after the interviews were conducted for this thesis) when the Stockholm Region adjusted the Reimbursement model to pay 50% more in compensation per visit for newly established providers during the first year if they have fewer than 4,000 listed patients.
Staff at the SRHCO said that the intention with this new policy and change to the Reimbursement model was not to make it difficult for small companies to enter the market, but that this was one of the expected effects that they were aware of when the policy was proposed. As one of the staff described:

Here [amongst technical staff] we have been careful that it should be easy for small businesses to start. So it was rather something that the administration [the professional bureaucracy at SRHCO] saw as a possible effect of that [the change in remuneration model] ... Yes, they [the politicians] made that decision [to put more emphasis on capitation payments] anyway. (Former staff, SRHCO)

Furthermore, interviews with SRHCO technical staff gave testimony to fact that they have concerns about the performance of small providers and are considering putting new requirements in place (e.g. minimum of two doctors per unit) that would incentivise larger networks of units and thereby larger owners. One SRHCO staff member explained:

Personally, I think we have too many small providers. They can’t handle ... so accessibility becomes a challenge. They cannot cope with staffing during the summer months, they cannot cope with minor stresses, such as if a staff is sick or on parental leave. They are extremely vulnerable when someone quits and retires. In terms of quality, I also do not think that they ... they are too few to have this collegial exchange and my impression is that ... or I have to ask myself whether they really can manage to follow the latest evidence. (Staff, SRHCO)

Moreover, staff from the SRHCO explained that the size of the unit is a politically sensitive question, since many politicians still have the old-fashioned idea that every family should have their private doctor, operating from a small clinic, who takes care of the family. However, according to the SRHCO, this ideal is contrary to research on efficient primary care units. Although it does not seem as if the desirable size of the unit has been a political topic for discussion, the SRHCO mentioned that it is time to oversee these foundations of the PCCR now when it has been running for more than a decade.

As described previously, the Rulebook does not give preference to either large or small units. According to interviewees, there does not seem to have been a discussion about the desired size of the units at the political level during the formulation of the initial PCCR contract nor afterwards, while there was an expressed intention from the politicians to convert existing public units to small private units. For this reason, it is curious that a staff
member from the SRHCO expressed concerns about the performance of the smaller units. It is also important to consider, in this context, that it may be easier for the SRHCO to manage larger providers as it means that they have fewer counterparts. These practical aspects, which may be important to technical staff at the SRHCO, may influence the SRHCO’s view with regard to smaller units that seems to stand in contrast to the political leadership at the SRHCO.

The SRHCO studies if there are any differences in outcomes of care between units owned privately and publicly and between small and large networks of providers. To date, according to the interviews with public authorities, they have not seen any systematic differences in annual reports or in-depth reviews, including with regard to quality of care, manipulation of financial data, registration errors, etc. (Staff, SRHCO).

6.3 The Mechanisms Used to Govern for Competition — The Perspective of the Providers

This section describes the providers’ views on the mechanisms used to govern for competition and particularly with regard to the incentives that they give rise to.

6.3.1 Using a Standardised Contract

When asked about if the governance mechanisms give rise to any differences between how providers (public, private, or small and large) are treated in the market, providers referenced that they all sign the same entry contract and thereby are treated the same. Yet, the philosophy of using a standardised contract to create a level playing field assumes that providers are the same prior to signing the contract, that they play the same roles in the market, and that they face the same market conditions. Consequently, if they sign the same contract the same market conditions are obtained.

Interestingly, there are several examples that show that providers do not necessarily have the same conditions to start with. Technical officials from the SRHCO, as well as staff
from the SLSO, explained in my interview data, that, in practice, the SLSO, the public provider, has a slightly different role as provider of last resort. One interviewee explained:

I always think that it is not really about being private or public, but that it is about having slightly different conditions. The publicly run care, SLSO in this case, they always have a last resort responsibility. They cannot say no, when, like the Stockholm Region, the owner tells them that you must carry out this assignment. So they sit on a tough seat, in the way that they sometimes get assignments that are a bit mission impossible. (Staff, SRHCO)

The different providers also face dissimilar conditions in markets that are linked to the primary care quasi-market. An owner of a public unit explained:

You have to think about rent, you have to think about opportunities for financial investments and have a broader perspective. Because there is a difference if you are a large company or if you are a small entity and right now our contracts look identical with both the public, large private companies and small individual companies. (Owner/Manager, public unit)

The providers explained that there are several external factors that determine the level of profitability of a unit. For instance, units that are in areas with low socio-economic status now receive extra compensation through the CNI, but these units also benefit from lower rental prices as rents are cheaper in these areas compared to the city centre; thus, these units do not have the same conditions as a unit located in a high socio-economic area in central Stockholm.

Small private providers also described how the short length of the contract impacts their ability to access capital. The entry contract stipulates that it can be terminated from the purchaser’s or the provider’s side with 12 and 6 months of anticipation, respectively. This short length of the contract creates uncertainty that makes it more difficult for smaller providers to access capital. This is particularly challenging in the beginning when a new unit does not have any revenue stream. One provider explained:

I get a contract from the (Stockholm) region for one year that I do not control, I must get some kind of rental contract that is usually for 5 years and I get no compensation until I have a list of about 2,000 patients per doctor and it will maybe take 6 years. No one is investing in it. There is no bank in the world that thinks it is a brilliant idea. (Manager, [small] private unit)
Thus, the short length of contract makes it more difficult for providers with need for a bank loan to enter the market. This is often the case for small providers who start from scratch. Units that transitioned from public to private (staff) ownership in the 1990s or early 2000s had the advantage that they could often acquire their own equipment and infrastructure for a favourable price, and were therefore in less need of starting capital.

Smaller providers also described that they are challenged by the payment terms in their contract, where the SRHCO pays providers on invoice on the first available banking day 20 calendar days after the invoice date. A small provider explained: “SRHCO is one month behind so we are always out with money” (Manager, [small] private unit).

They continued to explain that when they are short on cash, they either use a credit like a buffer or lower the wages for the owners to make sure that there is always cash in the company to pay the staff. The use of credit to cover for negative cash flow is likely to be costly for small providers. They explained how small private units are under tremendous pressure economically and ‘locked in’ without opportunities because of their challenging financial situation.

This shows that for a standardised contract to create a level playing field, the role of the providers in the market, their characteristics, and market conditions in connected markets (e.g. rental and credit) need to be equal prior to market entry and while operating in the market — which does not seem to be the case in the quasi-market in Stockholm, as pointed out by the interviewees. This highlights the complexities involved in creating a level playing field, the unfair incentive structures that the existing governance mechanism gives rise to, and the importance for the purchaser to understand what it takes to operate in the market for different types of providers.

6.3.2 Tough Attitude Towards Small Private Providers

As described in the first part of this Chapter, the concerns expressed by the SRHCO regarding smaller private units is also reflected in the interviews with the providers. One co-owner of a small unit described their disappointment with the SRHCO with regard to
their tough attitude towards the small private entities, and described how this erodes the trust in the dialogue:

My personal interpretation is that they wanted small units like us, but then I have become increasingly disappointed that they actually work against us by making it so difficult. And the statements made in the media also signal this “if they [the small units] go bankrupt then there will be new ones”. There are many such statements by politicians when journalists ask “How do you help these small private caregivers?”; “Well, it is their problem, they need to manage themselves in this free market. If they do not manage it, then a new unit will appear”. It is so cynical in health care. And this does not create any trust. There is no dialogue about “how is it to run this kind of unit? How can we have better cooperation?” It is never that dialogue … Then we become more focused on showing off how well we perform, and we do not dare to be vulnerable. (Staff and Owner, [small] private unit)

The interviews with the providers also showed that they think there might be different wills within the public authorities with regard to small private providers. This was described by one of the managers:

I believe that in a governance model with political influence and technical officials, there may be different wills at different levels ... And, although there may have been, above all, a political idea that it would be good [with small providers], then perhaps the technical officials think it is easier to manage large companies than individual small providers and so on. You can’t say it was the whole organisation’s will, I don’t think you can say that. And to a large extent, the technical professionals formulate the agreement itself, the actual Rulebook. (cit. Staff and Owner, [small] private unit)

The concerns regarding whether the smaller private units can deliver on the contract raised by the SRHCO, as described in the beginning of the chapter, are also expressed by providers: “… small health centres run by three enthusiastic doctors, this is the standard appearance of health centres that take shortcuts. They send out the doctors, cheat with the capitation payment and with the listing of patients and similar things” (Manager, [large] private unit).

I think most people who work in all these organisations have good intentions and want it to be as good as possible and stand for quality. Then there may well be some smaller entrepreneur that has raised eyebrows a little and the seriousness is questioned at times. (Manager, [small] private unit)
At the same time, interviewees, particularly managers of small private units, emphasised consistently that smaller units are more cost-efficient, have better continuity of care, and have higher patient and staff satisfaction scores. One interviewee explained that the current governance regime is giving priority to larger units although patient surveys and staff surveys show that smaller units are best functioning: “I have told them [the SRHCO] this, but they say, ‘no it is not the case’ and do not want to talk about it” (Manager, [small] private unit).

From the interview material it is difficult to say whether small or large owners perform better, and this is also beyond the scope of this study.

In interviews with the owners of these small units, they described that the good performance of small providers is associated with the autonomy in the decision-making process in a smaller unit. The sense is that decisions are being made close to where the services are provided, which stands in contrast to larger organisations where directives, such as chasing after revenue, may come from above.

As pointed out in Chapter 5, both managers of small and large units described this internal conflict in larger units between central directions and professional values amongst the staff, but in small private units this is less of an issue because there the staff themselves are decision-makers.

With regard to the legal form of the organisation, which is also related to the size of the provider, the Stockholm Region treats all forms of associations equally. It is interesting to notice, however, that providers described that the legal form of association matters for the work environment. For instance, one interviewee explained that when their unit converted from public to private (staff) ownership before the Choice reform in the 1990s, the staff worked very hard to find a legal form of association where all staff would have a voice. They described:

… our view was that everyone should have a voice and we went in all sorts of ways to see how we could get there. We wanted everyone to invest money for everyone to be a co-owner, but at the same time we realised that a lab assistant, secretary, or cleaner did not have as great opportunities to invest as a doctor. So then we
found this model [legal form of association] where everyone could invest different amounts of money. As I remember it, it was a limited company owned by an economic association … (Former staff, private unit, previously worked in public unit)

This interviewee also described how this legal form of association contributed to a more collaborative and participatory work environment. This is an exceptional example of a unit that selected a unique form of association when they transitioned from public to private ownership prior to PCCR. However, I decided to highlight it as it provides an interesting example that shows that how the unit is owned can impact the work environment and who gets to have a voice and influence decisions.

6.3.3 Policies with Direct and Indirect Impacts on Competition

While the change in remuneration model towards larger share of capitation (smaller share of fee-for-service), as discussed in Chapter 5, was generally appreciated by providers, the private providers confirmed that this change has indeed increased the barrier to entry, or in fact blocked the barrier to entry for small providers. One private provider described:

> Today in Stockholm, it is quite impossible for three competent good general practitioners to open a health centre … It wasn’t when we did it in 2012, then it was doable. You must in principle have a list of at least 1,000 to 2,000 patients per doctor from scratch. Previously, one could gain money from visits (fee-for-service) for the first few years until you had a larger list, because the revenue was still there. Now there is no revenue unless you have a list. (Manager, [small] private unit)

This shows the complexity involved when new policies are introduced in the quasi-market as policies have multiple impacts. In this case, the change to the compensation system, from fee-for-service towards capitation, was perhaps introduced to mitigate the risk that providers could become increasingly focused on providing short visits, and ask patients

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8 The Compensation model changed in 2018, when a larger share of the remuneration (about 60%) originated from capitation payments. It should be noted, however, that after these interviews were conducted, in 2020 the Stockholm Region adjusted the Compensation model again to deal with this issue and pays now 50% more in compensation per visit for newly established providers during the first year if they have fewer than 4,000 listed patients (Forsberg & Sundström, 2020).
to come back several times to the unit to maximise their fee-for-service payment. However, the same policy also impacted the barriers to entry in the market, as anticipated by technical staff at the SRHCO, and thereby the competitive environment.

Another example of a policy that does not impact each type of provider equally is the proposal that was introduced in 2019 (Skatteverket, n.d.) to introduce VAT on interim staff to discourage the dependency on interim staff. Interviewees explained how this policy would have a disproportionate negative impact on private providers as public providers are exempted from paying VAT.

This is a policy implemented by the tax authority after a verdict by the Supreme Administrative Court in Sweden in June 2018. This also highlights that public authorities who govern the primary care quasi-market must monitor how policies and regulations that might not even be introduced by them impact the market, their direct and indirect impacts on the competitive environment, and whether the effect is different for different providers.

6.3.4 Creating a Level Playing Field

When asked whether the governance mechanisms create a level playing field, providers pointed to a few areas where they perceived unfair competition. These areas, namely treatment of losses and access to capital, transferring of profits, VAT compensation, and scrutiny, are described in more detail below.

6.3.4.1 Treatment of losses and access to capital

There is a perception amongst private providers that one imbalance in the primary care market is that public units can run negative profits as losses are covered by tax revenue. One staff member of a large private company explained: “SLSO [the public provider] has the opportunity to get support from tax money, which we do not have, but we are dependent on the shareholders’ good will if we do not reach the result” (Staff, [large] private provider).
The allowance of negative profits is said, by private providers, to impact the culture at the SLSO, as described below:

The biggest difference between publicly and privately owned operations is that in publicly owned facilities there is more of a *laissez faire* attitude. They still receive new tax funds, so it does not matter if they have a negative profit of three million for the tenth year in a row, because they still get new tax funds. (Manager, [large] private unit)

When public providers were asked about negative profits, public heads of units said that they are focused on balancing the budget (zero profit) and they cannot report negative profit to the SLSO (Staff, SLSO).

Small providers also stressed that a fundamental difference between large and small private units is that they do not have access to additional capital should they not break even. One provider described:

If you don’t have a big company behind you that can inject money. After all, we are three … who run this, so we have to break even every month because otherwise we can’t pay our wages. That is how it is. We have no buffer at all. We have no other companies that we can take money from. We have no investors. (Manager/Owner, [small] private unit)

Another profit-related matter brought up by one public head of unit is that public units cannot transfer profits from one year to the next, which limits their investment opportunities. One head of unit in a public facility, who previously worked in a private clinic, explained:

Sometimes a company has to invest in order to continue to grow and develop and so on, and then you may have to take a hardship year at some point, if you do not have the money centrally. Yes, but you may not expand or do anything unless you break even. There is no investment thinking from SLSO’s perspective, I can make an investment request, but then there will be depreciation, then I will end up with more costs. (Manager, public unit)

The one-year fiscal year also means that a public unit that is running a deficit one year is not burdened by this the following year.

6.3.4.2 VAT compensation
As mentioned in a previous section, one difference in the standardised contract between public and private providers is that private providers receive a VAT compensation since they pay VAT (public providers are exempted). In the interviews, private providers stated that the current 6% VAT compensation to private providers is not enough to compensate for the difference with regard to VAT payments between public and private providers stipulated in the entry contract in the Rulebook (Managers, private units). Private providers claimed that this is an area where the governance system gives rise to inequalities between the public and private providers.

6.3.4.3 Access to information
Information about changes in the Compensation model and other aspects of the governance system is critical for the providers to adapt their activities and business strategies. It is therefore important that all providers receive information at the same time.

Staff from the SRHCO stated that they make sure that they send out information by email at the same time to all providers. However, there is a perception amongst some small private providers that they are disadvantaged in terms of information access. One manager explained:

I experienced when I worked with a private unit, that if I have no management structure in the way that perhaps SLSO has, then I got the information considerably later ... I worked for a private staff-owned health centre and I was not in the corridors of power and didn’t get invitation to the information meetings that were going on for publicly run health centres, but I got to look for that information in a completely different way. (Manager, public unit [previously head of private unit])

One staff member at the SLSO described the importance of having a network amongst the civil servants that sets the rules of the market at the SRHCO to influence outside of the formal dialogue meetings (Central level staff, SLSO). They also mentioned that it is also advantageous for the head of the SLSO to be part of the senior management team of the Stockholm Region since that provides another opportunity for informal discussions with the public authorities. They concluded: “... in this respect, we have a small advantage over the private [providers]” (Staff, central level SLSO).
The SLSO is also advantaged because they can quickly simulate and make projections of the impact of specific changes since they have controllers centrally who use the same data as the SRHCO (Staff, central level SLSO).

6.3.4.4 Voice in the dialogue
Another challenge pertains to equal representation of owners/providers in the dialogue meetings. The SLSO and the larger private providers (e.g. Aleris, Capio) are represented in the dialogue meetings, and the small providers are represented by the association for small private providers called PIST. Thus, large constituencies (small private providers and the SLSO) are represented by only one voice although there are many providers behind those representatives who may in fact have diverging opinions. While everyone is represented in the meeting, it does not necessarily mean that everyone has an equal voice (Manager, [small] private unit).

This is also reflected in the interviews with the public authorities. The SRHCO explains that information that is shared in the dialogue meetings does not always trickle down to the provider groups that are represented in the meeting.

In discussions with providers, the dialogue meetings are often described as a “take it or leave it” situation, with little room for negotiation over terms of the entry contract.

One owner of a small private unit described that in the best-case scenario, they (the providers) would organise themselves to have a counterpart to the SRHCO in the negotiations about the contract, such as a professional association for primary care providers. This would improve their bargaining power in contract negotiations.

6.3.4.5 Monitoring
While the public authorities stated that they try to treat all providers the same when they do performance monitoring, one manager of a unit described that there was more scrutiny of private providers in the beginning when the PCCR was introduced. They described how the SRHCO suddenly could demand additional information to check if they (small private providers) were complying with the entry contract and if things were being done correctly (Manager, [small] private provider). For instance, when the private clinic, where
they worked, increased the number of listed patients dramatically, the SRHCO asked to see all 3,000 forms with information about each patient. They also visited the unit, not just to supervise but also to understand how they managed the unit. This information would then be shared, as best practice, with other units. While this happened when the reforms were introduced, these types of visits to health facilities to record best practices appear less common nowadays.

Although there is a standardised contract for everyone with equal rules on paper, one private head of unit explained that the public sector is less scrutinised. They stated: “There are lots of air requirements. They exist on paper, but no one is requiring anything” (cit. Head, [large] private unit).

6.3.4.6 Access to physicians in training

Another area mentioned where providers feel that the governance system gives rise to different standards for private and public units relates to access to physicians in training.

Physicians in training are valuable assets because these staff generate revenue to the unit but work for a lower cost than a regular physician. To host staff in training, the public authorities pay the provider 560,000 SEK per year (equivalent to the wage of a full-time staff) in compensation, but staff can generate revenue like full-time staff who are more costly to hire (Rulebook, 2018).

Private providers described how access to physicians in training is hindered and slowed down by bureaucratic rules/requirements by the SRHCO, which ultimately impedes their access to physicians in training. For instance, for the physician in training to stay, the supervisor needs to have taken a specific course that is only available on certain dates and therefore this causes disruptions and delays for private providers to access these valuable staff.
6.3.4.7 Compliance with environmental standards

Several small private units discussed the enormous challenge that they experience with regard to compliance with environmental safeguards/routines. These managers of small private units bring up that they must follow very costly and bureaucratic processes that are monopolised by certain consulting companies (Staff/Owner, [small] private unit). This, according to interviewees, take away both financial and human resources from health care delivery. Managers in larger units explained that the upfront cost for these services is handled centrally. Networked providers expressed appreciation for this as they know that compliance with environmental standards is challenging to handle without central support. Thus, for small providers, the requirements around environmental standards appear challenging and costly to meet.

6.3.4.8 Profit maximisation strategies for larger provider networks

One head of a small private provider explained how the current governance system also give rise to inequities with regard to revenue generation, where large corporations can maximise profit, not just in the primary care market, but throughout their network of providers. This was described in one of the interviews:

-[Name of large private provider] and those, they can run their finances by having all the primary care centres referring patients to [Name of large private provider] secondary care, which gets high reimbursement rates. For example, if we operate in ingrown nail in the health centre [primary care] then we will get 0 SEK for it. But if you send it to a [Name of large private provider] surgical centre to take it instead then they get 3,500 SEK. But we might as well have done it at the health centre for zero cost for the society [taxpayers] but if we send it to another [secondary care] unit then the company gets 3,500 SEK from tax money, you got it? One can do such internal referral to increase your cash flow. You can work smart and plan. But all this is all about finance. It is not about health care. But of course, it is super smart to think along these lines. If you remove a birthmark at the health centre [primary care], it costs 0 SEK, but if we send it to [Name of large private provider]'s skin care [secondary care unit], then it will cost 4,000 SEK. Then you send everyone. So, it is an abuse of the system for financial reasons. (Manager, [small] private unit)
6.3.5 What Motivates Action — Patients, Profits, or Work Environment?

What motivates provider action was often discussed in my empirical data. In interviews with public and small private providers, they expressed their views that large private providers are in general more interested in profit maximisation first and that they adapt their operations quickly to maximise reimbursements. This, according to these interviews, stands in contrast to how the public and small private providers operate. As one head of a public unit explained: “The private parties do what is stated in the agreement and what they get paid for … I do not know but I think we (SLSO) do things that we think are good for the patient” (Manager, public unit).

Similarly, one head of a small private clinic explained:

I think these big companies, they just adapt their business to how the Region wants it [i.e. what they pay for] … If SRHC0 says “do nurse visits” then they decide that a patient must not come to the health centre without first seeing a nurse. Then if you need a doctor then you must come back to see a doctor another day. And everything that comes through the door must first see a nurse. That is how the big companies are working. But that is totally crazy. Why should you operate like that? The patients get really pissed, the nurses get a completely unsustain able work situation, and people need to take extra time out of work. But that’s the way it is. We [small private unit] do not work that way, because we are not dumb like that. We work for the health of the population. (Manager, [small] private unit)

Although each health clinic in the public sector (SLSO) is a profit unit and needs to break even according to the SLSO, the profit drive seems less important in the public sector and amongst smaller private providers, where work environment gets lots of attention. This is reflected both by the heads of public units themselves and small private providers. One head of a public unit explained:

Concerning some tasks like reporting the correct diagnosis (KVÅ codes) on time and making sure that you get paid, SLSO [public] is not very good at that. I think people don’t understand the importance of doing this work, that it actually concerns money, to the unit. The financial motivation does not exist to the same extent here … we are not for profit, but if things are going well, if we increase number of listed patients, then we can add more staff and that is a carrot, because everyone wants more staff. (Manager, public unit)

They further described how they see the relationship between profit and patient care within the SLSO and for private units: They said:
We should not be as private [units] either, we should be SLSO, but we should not lag behind because we are SLSO. When it comes to certain things ... to me SLSO, it is a brand that we should stand for that provides safety for patients, both patient safety and good care, the best care and accessibility. Then I know that they [private units] also want to work that way, but they are more bloodthirsty than we are, I think, because they have the profit thinking ... we don't really have that. We must find this in a different way. (Manager, public unit)

In contrast to this view, one head of a private unit, owned by a large corporation, put more emphasis on the SLSO as loss-making and inefficient. They described:

I enjoy going to the [public] health centre’s website and seeing how many employees they [SLSO] have. It is far more than we can afford ... a health care centre with 10,000 listed patients run by SLSO that I have looked at has about 30% higher staffing of doctors and nurses, if you compare with a health care centre within the [name of large corporation] private sector company of the same size, where you have fewer employees, a higher efficiency, and that does not suffer the same loss. (Manager, [large] private unit)

One reason why large private corporations may be more motivated by profit compared to other providers is because the large private health care companies exercise more pressure through performance contracts with their staff. A head of unit who moved from the private sector (large private owner) to the public sector confirmed that there are higher production requirements set by owners in the private sector (approximately 20 visits per day) compared to the public sector (approximately 12 visits). However, production requirements are not the same for all units but vary depending on context, for instance, production requirement in the private sector was lower in poorer areas that are densely populated by immigrants as patients in those areas may need longer visits with an interpreter (12 visits).

One head of a private unit, owned by a large private company, who works with production requirements of 20 visits for day, explained how they see that this is impacting the work:

When I am going to meet a patient and make the medical decision, there is no difference [between public and private]. When looking at “how do I get money for the business”, “how should we organise it”, then you have to follow, where can money be generated ... And there I know that some private companies have pushed a lot, for instance, we have to generate money to afford having staff employed. For example, we are forced to make money to afford to have people employed. Then you have to bring in as many visits as possible. We must take 20
visits a day. And then I know that when I work with that pace of 20 visits a day with documentation, etc., then not all visits become a high quality, because it goes way too fast ... And there can sometimes be that the privately owned drive more ... In fact, I think it should not be profitable. This does not mean that units should report negative profits, but the profit should not go to the pockets of the owners, they should go back to the health care unit. For it governs how we do things. (Manager, [large] private unit)

This description is interesting because they first described that in the meeting between the professional and the patient there is no difference between public and private units. Thus, professionalism serves as assurance for quality of care. However, then they explained that because of the pressure to meet production requirements to maximise profits, the quality of care ultimately suffers when providers are prioritising profit before patients.

The high production requirements also seem to have a negative impact on the work environment and lead to challenges in the retention of staff. One owner of a private facility explained:

It’s mostly that we have a hard time retaining staff, because we have production requirements and our staff becomes even more stressed out ... as a doctor, you don’t have to work as hard at a publicly run health care centre. (Manager, [large] private unit)

With regard to the small private units, they need to break even and they often mentioned the economic pressure, but at the same time, it is interesting to notice that there are examples in the interviews where small private providers do not follow the economic logic to maximise profits but rather care about the work environment more than expansion for profit maximisation. One owner and manager of a small private unit explained:

Yes, the business logic says that we should expand, the way we perform ... but at the same time, we have the fact that we are not only business economists but we are workers on site, and this is our work environment. And we thrive in a family-friendly [unit] just the right size. So we have actually discussed that and struggled in between all the time one could say, should we try to expand? ... The premises can put their limits, but we have looked at other premises in the immediate area and we have also reasoned about the possibility of starting a subsidiary, the same concept but somewhere else, and thereby be able to keep the slightly more family-friendly size. Because we know that both those who work with us and our patients
appreciate it. That you are actually recognised when you come, that you are not … yes, that it is not so anonymous. (Manager, [small] private unit)

6.3.6 Some Collaboration Amid Competition

While a key feature of the quasi-market is competition for clients as a key driver of improving quality of care, the entry contracts also incentivise coordination/collaboration amongst providers in the same neighbourhood.

Providers stated that when the choice reform was introduced there was a shift in terms of collaboration and competition, as described below:

From having worked together very tightly, it turned into a competitive climate and this was not good. Before we helped each other on the weekends, one could take each other’s patients and if someone was sick then one could call and get help. We had meetings together, discussed, and had joint training days. This disappeared for each unit looked out for itself and there was no one else who would provide resources. (Former staff of public unit and former co-owner of [small] private unit)

Providers also described how the recent change in the Reimbursement model, with more focus on capitation payments, increased the focus on registering more patients. This has resulted in a constant fight for patients to register as there is no limit to how many times a patient can switch clinic within a year.

Providers described different strategies to increase their capitation payments. Some mail advertisements to potential clients and in areas that have a large share of immigrant populations the information is provided in several languages (Swedish and Arabic). One unit described how neighbouring units try to poach patients by registering them in their unit even if they have never officially visited the unit but just walked by to ask a question. Thus, the competitive climate that the quasi-market predicts seems to be present in the Stockholm primary care market.

Since both public and private units are their own results units, it is also interesting to notice that competition for patients is not just present in the private sector but also in the public sector and even between public providers. One interviewee, who works in the public
sector, mentioned that although they would rather take patients from the private sector, there is also competition for patients within the public sector (Manager, public unit).

As per in the Rulebook (see Chapter 5), collaboration between units in the same municipality is also happening. A manager of a large private unit described how they have meetings with the units in the same geographical areas. These meetings focus on how health care should be provided and collaboration around home-based care as well as updates on news. However, sensitive information about the business is not shared in these meetings (Manager, [large] private unit).

Beyond what is mandated in the entry contract in terms of collaboration, providers described several examples of how they collaborate. For instance, the SLSO has a large quality of care project (see Chapter 7) where they invite all providers. There is also collaboration in digitalisation and information systems, where the SLSO makes available templates for reporting in the journal system to private units, as described below:

... they [private units] connect their devices to the journal templates and others copy them and make their own variation of them. But it is almost always that they are based on our work and we think it is good ... we believe that we can work together for the patient’s best .... (Staff, SLSO central level)

Central level SLSO staff, who are not directly working in a primary care unit, noted that collaboration is needed “for the sake of the patients” (Staff, SLSO central level).

In addition to how the SLSO supports the broader network of providers, there are also informal and semi-formal forums for collaboration between private and public providers. One owner of a small private unit described that they are part of professional networks with other heads of other units, where they share information. This network they described as invaluable when they started their unit. They described the professional network as follows:

... we are not competitors. There are more than enough jobs for everyone. We would need many more health centres, many more general practitioners. It is extremely stressful, and it is becoming more and more, I now feel in Stockholm, with the whole care situation, that it is such an extreme pressure. (Staff and co-owner, [small] private unit)
One manager of a private unit owned by a large company explained how eight units in their neighbourhood have formed a network of public and private facilities to, amongst other things, have a more united voice when speaking to the purchaser. They explained:

We should not see each other as competitors in this, but we can also gather and have a common voice vis-à-vis the purchaser, or with the purchaser, because a positive development is that now they [the purchaser] come to our meetings as well ... what was fun was that they thought it was a good initiative so they are also participating in these meetings and then you get a closer dialogue with them and hopefully also a greater understanding of our challenges and could possibly impact a little ... But above all this is to have a common voice [vis-à-vis the purchaser].

(Manager, [large] private unit)

The owner of one unit that is in the same shopping mall as another unit, where you would expect competition, also talked about collaboration:

We do not actually compete in this way as normal companies do, but we actually help each other ... The manager there, I usually call and they usually call me if there are any questions or if we have a common patient. So we actually have a good cooperation.

(Manager, [small] private clinic)

Thus, several providers described that there is both collaboration and competition within the primary care market in the Stockholm Region. Competition for patients is there but so is collaboration between providers in many other areas, such as to strengthen their voice vis-à-vis the purchaser, exchange information about changes to the governance system, and for some providers “for the sake of the patients” (Staff, SLSO central level).

6.4 Concluding Discussion

The Stockholm Region phased in competition and market forces in the primary care market over time, with many years of learning about contract management and negotiations for both providers and purchasers, through previous reform initiatives that allowed contracting with private providers, before the PCCR was introduced. An important contribution of the reform and the main strategy used by public authorities to create fair competition was to use a standardised contract and Rulebook for all providers. This standardisation was guided by one of the key principles when the PCCR was introduced, both expressed by politicians and executed by the SRHCO, namely, to create competition
neutrality that results in the same conditions for all providers. This change was also phased in over time, as the previous contracts that the private providers had with the Stockholm Region prior to the PCCR expired.

In my empirical data, both providers and purchasers expressed that the governance system has achieved market competition, and that it has, according to the providers, intensified since the proportion of revenue from capitation payments to total revenue has increased. This confirms previous data from the National Competition Authority, which shows that the preconditions for competition are present in the primary care market in Sweden, with 80% of the population needing less than 5 minutes with a car to go to another health care unit than the one that is closest to where they live (Swedish Competition Authority, 2014). Interestingly, collaboration amongst providers also exists in certain areas to, for example, strengthen the provider’s voice vis-à-vis the purchaser, to exchange information, and to carry out certain tasks specified in the Rulebook.

When examining the incentive environment the governance system gives rise to, providers said that they face a level playing field, referencing the standardised contract. The technical staff at the SRHCO also expressed that they are aware of the importance of treating all the providers in the same way with regard to softer aspects of market regulation, such as information sharing, monitoring, and requirements in reporting.

However, when digging deeper and listening to the accounts of the providers, particularly the smaller private providers, it is apparent that the practice of creating a level playing field is more complex in practice than to have one Rulebook for everyone with the same conditions and rules on paper.

The idea of ‘equal conditions for all providers’ is based on several assumptions. First, it assumes that it is possible to create that level playing field amongst providers who are fundamentally different with regard to, for example, size, ownership, and geographical location, and who therefore have different starting points and operating conditions. For instance, a small provider with no credit or business history faces different conditions in the credit market than a large multinational company or a state-owned enterprise. Second, it assumes that a standardised contract is the way to create fair market conditions, when in fact a standardised contract has different impacts on different types
of providers. For instance, and as seen in this chapter, a standardised contract that only lasts for one year can make it difficult for a small provider to sign a lease, while a network of larger providers backed by private-equity capital or taxpayers’ money would have no issues with such terms. This finding raises the question if it is at all possible, in practice, to level the playing field for providers who have such diverse characteristics, and face different market conditions in related markets (e.g. rental and credit) that have a bearing on the primary care market. Thus, my empirical results, overall, show that achieving a level playing field is quite challenging in practice.

Furthermore, and as illustrated in this chapter, providers play different roles in the market, have different directives from their owners, operate in very different environments and conditions despite being in the same region, and cater to diverse patients. In these circumstances, it is even questionable if the policy adopted by public authorities, of ‘everyone should be treated the same’ (with the exception of reimbursement levels that are adjusted for patient characteristics) with a standardised market entry contract, produces the best outcome from a public interest perspective. Such policy may in practice make it difficult for, for example, smaller owners with higher costs of capital compared to larger providers to compete on equal terms and, consequently, they may disappear from the market over time.

Providers highlighted that it is important for the purchaser to understand what it takes to operate in the market for different types of providers and to regulate the market accordingly. The current governance mechanism to achieve fair competition, namely the standardised contract and same treatment for all providers, seems to give rise to incentives that create equal market conditions; however, it does not create equitable market conditions, as certain providers, notably small ones, do not perceive the market conditions as fair. This raises the question whether authorities who want to keep a diverse set of providers should strive for equity, rather than equality, in market conditions.

A surprising finding in the chapter is that despite the policy of creating the same conditions for all providers through the standardised contract, staff from the SRHCO expressed a clear preference for larger providers. Thus, it could be the case, although there are no indices of such, that the standardised contract, which seems challenging for especially
the smaller providers, serves indirectly to discourage smaller providers from staying in the market.

Despite efforts to treat all providers the same, the providers also perceived subtle differences in treatment by the public authorities between the different providers. Here the division seems to be more along the dimensions of size (small and large private owners) rather than ownership (public and private owners), where the smaller private providers complained that they receive information later than the larger private providers, and have a harder time complying with environmental standards, etc.

There are also indications in the empirical data that there may be an internal disagreement between the political and technical leadership (SRHCO) within the public authorities in the Stockholm Region, with regard to the desirable size of the providers, where politicians prefer smaller private providers and the SRHCO has a preference for larger providers as they perceive that they are more efficient and provide higher quality of care. Moreover, dealing with a few sets of providers may also be easier from the SRHCO's perspective.

Yet, the chapter also shows that there may be risk involved in exiting smaller providers and too much market consolidation. There are accounts of larger private owners using profit maximisation strategies between different levels of care, where patients are referred to higher levels of care for procedures that could be carried out in primary care because these procedures yield higher reimbursements in secondary care. This kind of profit optimisation between levels of care risks increasing the societal cost of care and highlights the importance for the market regulator to not limit their analysis and control of the market to one level of care or the primary care choice system, but rather to do a holistic analysis and keep track of internal referrals within large health care providers who operate in multiple markets.

With the current strategy used by the Stockholm Region, as will be discussed more in detail in the following chapter, where monitoring seems chiefly focused on one level of care, it may be difficult to detect these types of system abuse to maximise revenue. Thus, the importance of an observant, powerful, and sophisticated regulator, particularly as the providers grow larger in size, cannot be underemphasised.
The chapter also shows that, in some cases, policy decisions may have had unintended consequences for certain providers. One example is where the move towards a higher share of capitation payments to total payments created entry barriers to the market, which particularly impacted smaller providers. This highlights the complexity of governing this quasi-market, as policy decisions on, for example, reimbursement levels do not only impact how the providers are paid but also have secondary effects on the market structure. It is therefore important to analyse every policy option from the perspective of how it is shaping the market, the level playing field, and impacting the different actors operating in the market.

It is also interesting that providers described that motivations behind actions appear to differ by owner, where large private owners put more emphasis on revenue generation first as opposed to smaller private and public clinics that describe how they are primarily motivated by providing the best care for patients and good work environment for the staff. This confirms, to some extent, Ellegård’s (2020) finding that financial incentives are of higher value for profit maximising providers, although my data shows that there may be a difference here between smaller and larger private providers, where the latter seemed particularly driven by profit motives.

This highlights the importance of the incentives that the owner provides in the market for how the unit operates. While one could think that all private providers, as opposed to public units, would be more focused on profit generation, it is very interesting that in some private entities, particularly smaller ones, the work environment seem more important than expanding to maximise profit. This confirms previous research (see Vengberg et al., 2019) that shows that the assumption that owners of primary health care clinics in Sweden are first and foremost profit maximisers may not hold.

This is an important finding as profit maximisation underpins the theory of quasi-markets where the provider, who is assumed to maximise profit, would seek to improve the quality of care as a way to attract patients and thereby revenue. In practice, though, even amongst private providers, there are more important variables than profit, such as work environment, that the providers optimise on.
Related to the above, another important finding from this chapter is that not just the directives and values of the owners may matter but also ‘how’ the unit is owned, that is, the form of association. For instance, one interviewee explained how a legal form of association where everyone had a voice contributed to a more collaborative and participatory work environment. This is an interesting finding where more research to understand the relationship between how the unit is owned and the performance of the unit is warranted. This is also an area of policy that the Stockholm Region could explore, where the policymakers could provide incentives to explore new forms of association in the primary care market.

Perhaps the most striking finding in this chapter is that it seems as if a robust discussion around desirable ownership characteristics of the providers (private, public, small, medium, or large company size) as well as desirable market structure and related risks (e.g. market consolidation that ends up in oligopoly) seems to have largely been absent when the reform was conceptualised in Stockholm. While the budget document puts forward that “increased diversity of providers” (Stockholm Region, 2008, p. 33) was a goal for the political leadership, the document does not provide clarity regarding what “diversity” refers to — what does it mean in terms of owner characteristics or does it refer to increased choice of providers by the user/consumer?

Similarly, at the national level, Wisell et al. (2019) found in their study of the diversity rationale of the pharmacy and primary care liberalisation reforms in Sweden that policymakers “held vague and unclear definitions of diversity” (Wisell et al., 2019, p. 457). At times, diversity was seen as a consequence of competition, a goal, while at other times, it was seen as a means to achieve competition. It is also important to point out that at the national level, Wisell et al. (2019) found that increasing the number of owners was stressed as an explicit goal in both reforms (Congress.gov, 2007, p. 38) to ensure that a few actors did not gain too much market power.

The fact that ownership characteristics were not being discussed in Stockholm is peculiar, since it seems important for the market structure to maintain competition and ultimately for the performance of the quasi-market. However, treating something as a non-issue does not mean that it is not an issue. As seen from the evidence presented in this chapter,
both ownership and size, and particularly the latter, seem to matter for providers in the market. Also, the SRHCO expresses that the size of the providers matter. Data from the Swedish Competition Authority (2014) also gives indication that large corporate owners have increased their share of overall market revenue. It is time to bring more attention to these critical issues for the future of primary care in Stockholm, both in the policy dialogue as well as in future research.

6.5 Conclusion

The intention of this chapter was to dig deeper into the governance mechanisms used by the public authorities to achieve competition in the primary care quasi-market, analyse the incentives the governance system gives rise to with regard to competition, from the perspectives of both public authorities and service providers, and explore research question 2. This has been done by analysing the empirical data collected in my interviews as well as the stipulations in the Rulebook.

What this chapter reveals is that the main mechanisms used by public authorities to foster competition is to use a standardised contract and the Rulebook, designed to treat all providers the same and thereby create fair competition. Stakeholders give testimony to the fact that public authorities have succeeded in creating a competitive environment.

To achieve fair competition with the standardised approach, providers must have similar roles in the market and face similar conditions in connected markets (e.g. credit and rental markets). This research shows that, in practice, interviewees perceive that providers have different characteristics, serve different segments of the market, and face diverse market conditions in connected markets.

In this context, the chapter reveals that health care units owned by smaller private owners seem to struggle in the incentive environment that the standardised contract gives rise to. They described the challenges they face in credit and rental markets.

Public authorities are also concerned by the performance of these smaller private providers. This shows that, for public authorities, there are complexities involved in
creating fair market conditions, and it is important for them to understand the actual market conditions (including in connected markets) for different types of providers so as to not unintentionally create unfair competition. I raise the question whether authorities who want to keep a diverse set of providers should strive for equity, rather than equality, in market conditions.

Related to this, the chapter also points to risks involved in exiting smaller providers and too much market consolidation. Providers gave testimony regarding the use of strategic revenue generation strategies by large private owners, which highlights the importance of an observant, powerful, and sophisticated regulator, particularly as the providers grow larger in size. A key finding in the chapter is that strategic discussions around desirable ownership characteristics of the providers (private, public, small, medium, or large company size) as well as desirable market structure and related risks (e.g. market consolidation that ends up in oligopoly) seem to have largely been absent when the reform was conceptualised in Stockholm.
7 Governing Quasi-markets to Achieve Quality of Care

7.1 Introduction

As shown in the literature review, there appears to be some demand sluggishness in the primary care quasi-market in Sweden (Glenngård et al., 2011; Wahlstedt & Ekman, 2016), where patients are not actively choosing providers based on available data on quality of care. If user choice does not respond to changes in quality of care in the quasi-market, then providers may skimp on quality of care, particularly if providers’ preferences are such that they are under pressure to maximise profit. Given the risk that providers skimp on quality of care, a key function of the governance system is to ensure that there are incentives to maintain and improve quality of care over time, and that primary care providers are held accountable for producing quality services.

Building on previous chapters, this chapter digs deeper into the governance mechanisms used by the public authorities to oversee that primary care providers deliver quality of care. It focuses on research question 3. This is examined in the first section through my interviews with officials from the Stockholm Region. The second section focuses on how managers of primary care units perceive the incentive structures that the existing governance system gives rise to with respect to how well it holds providers accountable for delivering quality of care. It describes some of the challenges and perspectives on how the system could be improved.

7.2 The Mechanisms Used to Govern for Quality of Care — The Perspective of Public Authorities

As indicated in Chapter 5, the public authorities stipulate in the Rulebook that providers must follow the national guidelines applicable to the assignment as well as regional care and action programmes that function as decision support. These recommendations are important to guide the health care units to deliver quality services. The SRHCO plays an important role in ensuring compliance with the Rulebook, particularly with regard to quality of care, and the mechanisms used to do this will be discussed below.
7.2.1 Measuring Quality of Care in the Primary Care Market

A key mechanism used to hold providers accountable is to collect and examine data from the providers. The SRHCO triangulates data on quality of care from many different sources: (a) the National Patient Survey; (b) annual reports compiled by the SRHCO with key data and benchmarking of each clinic; (c) medical audits with anonymised data from the medical journal system; (d) routinely reported data tied to incentives, e.g. through the use of KVÅ codes; and (e) feedback from patients through email or telephone. Each one of these five sources are described in detail below.

a) The National Patient Survey has been completed in Stockholm since 2009\(^9\) and it collects patients’ views on received care. Nationally, primary care patients are surveyed every second year and sometimes more often depending on the region. There is a general module of 25 questions that focuses on measuring the patient’s perception of the experience in specific areas of the health care system (SALAR, n.d.). Then there are specific modules focusing on specific areas (e.g. primary care) to validate the information collected in the general module. A Likert scale is used with five points, Strongly Agree, Agree, No opinion, Disagree, and Strongly Disagree, as well as an alternative option of ‘not applicable’. Examples of questions are: “Were you able to visit the health centre within a reasonable time?”, “Did you get to meet the same doctor during your visits to the health unit?”, and “Were you able to ask the questions that you wanted to ask during the visit?” (SALAR, n.d.).

b) The Annual Report for each health care unit is prepared by the SRHCO once a year, based on data submitted by the providers, and it compiles specific indicators that the SRHCO monitors on a regular basis. Scores are calculated for each care unit and benchmarked with the average for the Stockholm Region as well as the previous year’s result for the individual unit and the average for the region. Indicators may shift a bit from year to year depending on the focus and often include composite indicators from different data sources, for example, a certain patient group may be monitored to see if they have received a specific recommended medicine. These are developed based on national

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\(^9\) Since the methodology of the National Patient Survey changed in 2015, it is not a panel data set that is comparable over time.
guidelines and recommendations from the National Board of Health (Swe. Socialstyrelsen). For instance, the Annual Report from 2016 (available in Annex I) has 12 areas where indicators are focused:

1. Registered patients and staffing, e.g. number of registered patients per doctor.
2. Remuneration and visits, e.g. total remuneration received, type X, Y, and Z of visit per patient).
3. Availability and continuity of care, e.g. promised response time, number of patients listed to a specific doctor.
4. Structure for quality, e.g. if unit has environmental certification, percentage of visits where diagnosis is registered, compliance with recommended prescription drugs.
5. Collaboration and prevention of emergency hospital care, including various measures of whether the unit’s patients also access emergency care.
6. Patient perceived quality, various measures from the National Patient Survey about patient perceptions from the visit to the unit.
7. Chronic diseases with indicators primarily focused on detection rates of various chronic diseases, how patients with various heart conditions have been treated, with some outcome measurements related to diabetes.
8. Prescription of antibiotic, e.g. measurements of prescription patterns of antibiotics.
9. Health promotion efforts, e.g. share of patients who report that they have been asked about various health promotional activities or lack thereof during visit. Based on Classification of Care Measures provided by providers (KVÅ codes) (see below).
10. Home-based care, e.g. share of registered patients, the cost per home-based patient.
11. Psychosocial efforts, yes/no questions regarding what instruments are used.
12. Quality Areas, yes/no questions regarding whether provider has approved clinics for, for example, asthma or elderly people. Also, measurements of whether on-service training is provided to staff.
The Annual Report is shared with each provider for them to study the data, their performance relative to the average in the region, etc. (Staff, SRHCO). Providers are also asked to reflect on three indicators where they performed well and comment on why they performed well, plus three indicators where there is room for improvement, and explain how they intend to improve performance in three lagging indicators. There are also specific questions related to how clinics are staffed with regard to medical professional categories, the use of temporary staff, and outsourcing of certain tasks as well as questions on waiting time and ways the clinic maintains accessibility (Staff, SRHCO).

The data in the Annual Report is primarily self-reported, but some data can be cross-checked through triangulation with, for example, the national pharmacy system that tracks medical prescriptions. Staff from the SRHCO stated in the interviews that when data can be cross-checked, it is more reliable than when self-reported. The fact that data is largely self-reported from the providers may affect its quality since providers (especially if certain data points generate revenue) may not be truthful in their reporting.

While this issue is recognised as a weakness by the SRHCO, it was not considered as a major issue when the PCCR was introduced. A former SRHCO staff member explained: “There has been no other way than self-reporting because you have not been able to retrieve the data in any other way than self-reporting. But it is of course never good with self-reporting.”

Staff from the SRHCO stated in the interviews that because most of the self-reported data is also reported in the patient journal (medical record), it is unlikely that providers would inflate/deflate numbers since data could potentially be cross-checked by both the SRHCO and the patient. However, when probing on this issue, it was clear that the SRHCO does not have legal access to the medical journal data because of privacy laws that protect personal data. But, they can receive anonymised data upon request (Staff, SRHCO). One interviewee explained:

We should not have that [access to patient records]. Access to patient records should be limited. Only those who need the information should have it. We would need quality cases, quality outcomes and in the best of worlds it would be downloaded from the registries so that we got it aggregated. We would like to have that, but we do not want access to the [patient] records. (Staff, SRHCO)
According to staff at the SRHCO, the Annual Report does not provide a full picture of quality of care. For instance, in its current format it is difficult to detect if a unit is, for example, over-reporting to maximise remuneration. Despite this, the public authorities said that they have a quite complete picture of provider performance with the Annual Report and thanks to other complementary information:

It is seldom that we have a look at an Annual Report and see, oh, what poor quality it [a unit] has, and that we have not known anything about this [previously]. It [the Annual Report] provides a single picture, but information is provided to us continuously. It comes from patients; it comes from other caregivers who are around, etc. We usually get signals from several quarters if there is something that is going on in a health centre. And you can see it in the Annual Report as well. (Staff, SRHCO)

Traditionally, Sweden is at the forefront in measuring quality of care through the country’s numerous disease-based quality registers covering defined diagnostics areas such as diabetes and breast cancer (OECD, 2013). While these traditional quality registers exist, they are not adapted for primary care\textsuperscript{10}.

A key challenge, described by the SRHCO interviewees, for reporting to quality registers is the set-up of the information system. Ideally, the journal system should automatically feed the quality registers, to allow for providers to only enter data in one place. Currently, this is not the case as the journal system operates independently from the quality registers. Legally, the patient can also decline having their data shared in a national quality registry. To incentivise reporting to national quality registers, the SRHCO has incentivised reporting to the quality registry for diabetes, which has made that data more reliable, and is planning to provide more incentives for reporting to other registries in the future (Staff, SRHCO).

However, the Annual Report does not currently capture any medical outcome indicators. An exception to this is in the area of diabetes, where some indicators are extracted from

\textsuperscript{10} Recently, \textit{Primärvårdskvalitet}, a national system for quality data in primary care, has been developed to cater to primary care providers; however, this system was never referred to by interviewees. As of December 2018, an estimated 156 units have access to \textit{Primärvårdskvalitet} in the Stockholm Region (SALAR, 2019).
the national diabetes quality registry (NDR) for which it is compulsory for providers to report data.

However, when studying these diabetes indicators in detail, there are only five indicators from the NDR and only one of them is a medical outcome indicator, namely 'proportion of patients under the age of 80 with high blood glucose' (Annex I). Thus, most indicators in the Annual Report are focused on measuring structural quality, that is, capturing if the health care provider has the capacity, system, and processes to provide high quality of care, as opposed to medical outcome indicators.

Medical outcomes could be accessed through the medical journal, but as explained earlier, the SRHCO does not have regular access to it. A staff member at the SRHCO explained their thinking concerning the use of process measures:

… even if it [process measures] is not a measurement of whether the patient is better or not, it is a measurement of compliance to specific care programmes. And the care programmes recommend things that are evidence-based to produce results. So, I think it is worth monitoring these measurements also. (Staff, SRHCO)

c) Medical audits are conducted if there is suspicion that something is not working in a health care unit. In such cases, the SRHCO can request access to anonymised journal data at an aggregate level for a specific area that they are auditing. Medical audits are conducted when warranted, but routine verification of data is not happening unless there is a suspicion of misconduct. One SRHCO staff member explains that this is a challenge:

… this is a dilemma for us as a purchaser. We can’t be everywhere, so we need to have a bit of trust in the providers, otherwise the system goes down. It is built on you as a provider having clean sheets. And as a purchaser we need to be so smart in our monitoring, so we can detect if a provider is starting to slide. (Staff, SRHCO)

d) Routinely reported data tied to incentives is another mechanism used by the public authorities to monitor and nudge the provider to produce quality services. As reported previously, by paying providers extra remuneration when they report a code that represents a desired measure/treatment, providers are incentivized to improve quality of care.
The National Board of Health (Swe. Socialstyrelsen) has developed KVÅ codes that are mandatory to report to the National Board of Health. Initially these codes were reported to describe the health system, but they were seldom used. Now, the SRHCO pays the providers for some of these codes to incentivise certain measures being taken by the providers.

While the specific codes and the attached amount change, the amounts are quite modest in relation to the total remuneration of the providers. For instance, an in-depth Medicine Review, that is, the doctor does a review of all medicines that a patient takes, according to specific guidelines, pays 300 SEK and an individual counselling session about physical activity conducted by a qualified nurse pays 200 SEK. There is also a ceiling, meaning that when the provider has reached the ceiling for how many codes can be registered during a certain time, they do not receive more money for that specific code.

The staff at the SRHCO described that when they attach a monetary incentive to a specific code, the providers tend to report an increase in reporting that code. Since codes are self-reported and reporting is tied to money, I asked how the public authorities would know if a provider was providing more services or just reporting more services. Staff from the SRHCO stated that it is likely that providers manipulate reporting, particularly with regard to inputting a code for, for example, a Medicine Review, but not regarding following the guidelines for a Medicine Review. They also explained that in how they currently govern, it is not possible to know if a provider changes their behaviour and provides more of the services that have a stimulus payment or just reports differently because a specific incentive is put on a specific indicator.

As part of the Compensation model, the purchaser also provides stimulation payments for certain activities that might lead to improved quality of care. As an example, if the unit sets up a clinic focused on asthma and chronic obstructive pulmonary disease (COPD) patients, diabetes patients, and elderly patients, they get extra resources. But to get access to these extra payments, the clinics need to follow detailed “must criteria” (Swe. skall krav). For instance, an asthma and COPD clinic must have a nurse specialised in asthma and COPD patients.
As the Compensation model changed over time, towards a larger share of total payment being based on capitation (number of patients listed to the clinic), results-based reimbursements also changed in character from being focused on specific indicators to quality improvement projects. Health care units are now reimbursed with 5 SEK per listed patient and year if they complete a quality of care improvement project. In these projects, the health care unit defines a challenge that they want to work on (e.g. patients’ overconsumption of alcohol) and presents what they want to do to address the problem (e.g. consulting patients about the risks of alcohol). They then work to address the challenge for 12 months and provide a progress report with measurable indicators pre- and post-intervention(s).

The public authorities then provide reimbursement for a well-documented project (yielding positive results is not necessarily a requirement) and the improvement projects are shared online for all providers to benefit from the gathered knowledge. This is an attempt by the SRHCO to support cross-unit learning and help with organisational development.

e) Feedback from patients reported directly to the SRHCO through email or phone is another key method to monitor quality of care and hold providers accountable. Patients are encouraged to first submit complaints or comments on the health care that they receive to the unit that was responsible for the case. Patients can also turn directly to the SRHCO by email or phone or to the Patient Board (https://www.1177.se/Stockholm/safungerar-varden/om-du-inte-ar-nojd/om-du-inte-ar-nojd-med-varden/). This is an independent and impartial body that does not make its own medical assessment of a care provider but rather tries to find out what has gone wrong and contributes to quality development and improvement (Region Stockholm, n.d.). Certainly, more severe events can also be reported to the Health and Social Care Inspectorate.

7.2.2 Responsibility for Changes in Measuring Quality of Care

A challenge, described by staff at the SRHCO, is that they perceive that they do not fully “own” the question of measurability and while the National Board of Health and Welfare is responsible for definitions and concepts, staff at the SRHCO stated that there is no
national agency that is responsible for measuring quality that can recommend what quality measures should be used. One staff member explained:

This measurable thing is tricky. Because we do not own the issue ourselves. If you want to start measuring, you must have terms and concepts clear. It is clear that we in Stockholm can come up with our own inventions of definitions of different terms and concepts, but then it always gets tricky when sharing information across regional boundaries. We can take the example of a digital care meeting. What is it? Is it when you are sitting live or can a digital care meeting also be an asynchronous chat? Or an email correspondence. What does a digital care meeting mean? Is it just image, or image and sound, or can it also be just sound? All in all, as long as we do not have a national infrastructure ready for terms and concepts, it is also difficult to build systems ... it is clear that it is possible, but you risk ending up very wrong when you do not have these concepts ready for you, what to measure and follow up. (Staff, SRHCO)

In interviews with staff from the SRHCO, they explained that they would govern with more effectiveness if reimbursements were based on outcome measures of quality of care. However, currently this is not possible as the quality registers are not adapted to primary care, the purchaser does not have access to patient journal data (not even aggregated and anonymised) unless requested, and there is a lack of interoperability between the different register systems.

To reach this vision of governing based on outcome measures, the SRHCO is taking a number of measures, as described below, such as procuring more robust medical record systems and incentivising the use of quality registers, although this has not yet been adopted widely in primary care:

The biggest thing we do is that we prepare a new procurement of medical record system ... we procure this journal system and at the same time we procure an integration platform and it is like a switch that allows different journal systems to start being able to talk to each other. You should be able to read information from different journal systems. And getting a modern medical record system is an important component ... Then we do several other parts. Now it is outside the health centres, but we also create incentives [for providers] to use quality registers. In the other care choices than primary care. To stimulate [use of] quality registers, we will do this in different ways in the future. It is not for sure that to add bonuses is the right method, but this is a way to pay attention to quality registers. (Staff, SRHCO)
7.2.3 Collecting Data

When asked about the responsibility of regional authorities to safeguard that the care provided in the primary care quasi-market results in better outcomes for the patient, SRHCO says: “it all depends on what kind of data we have access to, if we do not have access to outcome data, then there is not much that we can do” (cit. Staff, SRHCO).

Thus, the purchaser recognises that access to data is a challenge. For instance, they would like to measure continuity of care but cannot because they do not have access to information about individual physicians or nurses and which patients they meet. This makes it impossible to see if the patient has been going to the same physician/nurse. Continuity in primary care is important, particularly in primary care, because it is associated with increased patient satisfaction, increased take-up of health promotion, greater adherence to medical advice, and decreased use of hospital services (Pereira Gray et al., 2018).

A key issue is the trade-off that the purchasers face between measuring correctly and the burden of reporting for the providers. This means, that in practice, the SRHCO’s governance of the providers largely relies on the data that is easy to measure, even if it may not be the best measures of, for example, quality of care. One of the staff at the SRHCO explained:

A key dilemma with being a purchaser in primary care is that we have very little quality data and outcome data. What we have are measures of production. This means that governance is based on what is possible to monitor. Consequently, data on visits and waiting times are parameters that we have been able to monitor and therefore the governance is to a large extent based on these. It is a challenging balance. Because there is a strong consensus in the entire system, amongst us and amongst providers and staff, that it is not enough with these damn production measures and we don’t want to govern on this, but what shall we govern on? We can of course start to ask [for] a lot more reporting but at the same time we can’t force the providers. This would increase the administrative burden if we would come up with new measures that need to be reported on. It is a big challenge. (Staff, SRHCO)
7.3 The Mechanisms Used to Govern for Quality of Care — The Perspective of the Providers

This section discusses the incentive environment that the mechanisms used by public authorities to govern for quality of care give rise to, according to the providers.

During the interview it was clear that it is not only the public authorities who are governing for quality of care, but this is also a major focus by the larger owners, such as the SLSO and Aleris. In these organisations, the central units are often engaged in work to improve quality of care with the different units that they own.

This section, therefore, first discusses ways that the owners engage in the governance for quality of care. Thereafter, it presents the perspectives from the heads of units on the governance for quality of care and the resulting incentive structure.

7.3.1 Ways that Owners Measure Quality of Care

The SLSO (public owner) governs for quality of care by using a scorecard, as mentioned in Chapter 5, that monitors dimensions of quality of care such as working environment, quality policy, leadership, etc. An annual report is produced based on the information entered in the scorecard. The first annual report on quality was produced in 2001, before the PCCR reform, in an attempt to create transparency of medical data, and according to the staff at the central unit in the SLSO, the scorecard has also increased the correctness of reporting by health units.

The scorecard is for the overall organisation of the SLSO and includes many different health care areas, primary care being one of them. The indicators from other areas of health care within the SLSO as well as the quality indicators monitored by the SRHCO are taken into consideration when they decide which quality of indicators the SLSO monitors in the scorecard. An SLSO staff member explained:

… we need to have the freedom to pick our own indicators [not those that the SRHCO monitors] with regard to quality of care, that are not tied to money, nor with reporting to quality registries or something similar, and that is what we focus on. So I work a lot with terms and terminology. (Staff, SLSO central unit)
The SLSO also reviews medical outcome measures on a regular basis that they aggregate from their primary care units.

As discussed in Chapter 5, Aleris, a large private provider, owned by private-equity holders, also uses a balanced scorecard to drive performance. It is interesting to notice that Aleris tracks EBITDA, a financial measure, on a regular basis but not quality of care indicators, and this may be an indication what the owners value most in terms of performance.

7.3.2 How Owners Govern for Quality of Care Improvements

The interviews with SLSO staff members at the central level show that they put a lot of emphasis on a bottom-up approach to govern for quality of care, where the improvement process is owned by the health care units (as opposed to a top-driven approach where the owner drives the process through, for example, external lecturers).

Through an initiative called Värdelyftet, which is financed externally by different financiers such as the EU and SALAR, the SLSO is trying to drive quality improvement bottom-up. This initiative started when it was recognised that heads of units could not drive the quality improvement work alone but needed support. The SLSO has established a system of ‘process groups’ composed of specialised medical staff but also with representation from patient associations that discuss certain areas of care, such as diabetes, in network seminars. This initiative engages approximately 120 staff in SLSO’s organisation of 3,600 staff. In these discussions, they focus on mapping out the process for handling a specific patient (e.g. with diabetes) and discuss what happens in each moment of care and why.

Best practices are captured in the discussion and noted down on a PowerPoint that is then shared with the health units within the SLSO that have dialogue seminars that focus on providing feedback and suggestions for improving the process.

The idea is to extract knowledge about quality improvements from the professionals who work in primary care but also to help disseminate best practices and standardise work between all SLSO primary care units. It also helps to harmonise quality of care
performance indicators between SLSO units. The work of the process groups informs the quality of care performance indicators and is shared in an external website.

Even private sector providers are invited to participate in the discussions since resources for the project come from the EU and target primary care in the Stockholm Region, not only SLSO units. However, my interview data with private providers indicates that they did not participate in nor were they aware about this ongoing work by the SLSO to improve quality of care.

The staff who engage in the process groups get their time reimbursed and they spend about 2–3 hours per month on this. However, the SLSO recognises that this might not be enough to do in-depth research on the latest evidence of care in a specific area and that it will have to be done in parallel to regular work at the health unit.

Within the SLSO another way to share best practices between units is in meetings between the primary care managers and the heads of units and SLSO central unit. There are also ‘on-the-job training’ meetings and other occasions when specific professional cadres (e.g. all nurses, or all physicians) meet to exchange on best practices. SLSO staff also have access to on-the-job training, but how this is arranged differs between the units and is ultimately up to the unit manager. Some managers refer to the guidelines by the professional association for physicians that recommend 10 days, at a minimum, per year for training (Staff, SLSO central unit).

The SLSO does extensive quality of care work that is beyond what the SRHCO asks for. When asked why they do that, a staff from the central unit at the SLSO explained:

We do this because we need to do this … this makes it fun to work in health care, you are part of business development … and you are passionate about constantly making health care a little better for our patients and implementing best practice all the time. (Staff, SLSO central unit)

In addition, the staff referenced that it is their role to figure out the ‘how’ of providing health care, while the SRHCO is responsible for the ‘what’.

At the large private provider, Aleris, the regional head of primary care, shares information with the heads of units in the Stockholm Region, on a regular basis, including information
about new research on quality of care and information shared by politicians or the SRHCO.

This is a way to foster cross-unit dissemination of important information. Aleris has also established processes for the most common diagnoses (e.g. asthma, diabetes) developed by a network of physicians, specialist nurses, and heads of units. These processes are algorithms that describe how the visits should look, how often the patient should be called, and how the unit follows up with a patient. According to the providers owned by Aleris, these practical processes benefit the organisation. A head of unit explained: “we don’t develop these processes for profitability, we do it to make the work more fun and to attract people who want to work in our organisation … these things can determine if someone takes a job or not” (Staff, private provider).

The larger owners (such as Aleris and the SLSO) have both quality and environmental audits by external auditors every year, which is a way to ensure that they comply with quality measures. Aleris mentioned that the main work they do around quality of care, beyond making sure that they comply with all requirements from the Stockholm Region, is to ensure that they recruit good unit managers as this has a big impact on the staff satisfaction and thereby quality of care.

7.3.3 The Mechanisms Used to Govern for Quality of Care — The Perspective of the Heads of Units

During the interviews, head of units, working at the SLSO and Praktikertjänst, expressed some concerns around centrally managed quality of care improvement initiatives, whereas heads of units, working at Aleris, seemed more positive.

One interviewee explained: “[the central units] just increase with time and it is uncontrollable, and it doesn’t help to increase the productivity at all” (Manager, private unit).

SLSO heads of units rarely referred to the SLSO scorecard or the annual report on quality, which may be an indication of its limited impact on the day-to-day activities in the health
care units. When asked if the scorecard influenced the work in the unit, one manager responded:

... no, it doesn't influence my work, no ... there are so many monitoring systems, there are internal systems from SLSO and on the computer, we could monitor many different parameters, but we can't spend time following all these different details, we have to focus on running the whole thing, that is what I think as the manager and this has worked so far. (Manager, public unit)

Another manager for a public unit shared their perspective about centrally managed quality improvement initiatives:

... the disadvantage with them (SLSO) and SRHCO is that they create a lot of things [instruments and processes] but then they do not put a lot of effort and energy in implementing these things properly, that is really missing ... And then it is sort of a waste of time to create these things. (Manager, public unit)

When asked why things don't get implemented, the providers described that what is needed is for the creators of these quality improvement programmes to visit the units and support them and give the providers more time:

... it is not enough to send out a paper that says, do this and do that, when people in the health facilities already work extremely hard in the field, there is so little time. So a lot of this is based on the lack of resources. We should have time for quality improvement. If we had that time, primary care would probably improve and most likely it would be cheaper also in the long run. (Manager, public unit)

This view that more dedicated time for quality improvement is needed was prevalent amongst the heads of units. Interviewees mentioned that there is little “air in the system” (Staff, private unit) because of the high pressure as well as micro-management, and this is needed to improve quality of care and develop primary care overall. One provider described:

You should be aware of micro-management, too much [of that], because it is already very micro-managed as it is, so you need ... a little more air in the system to generally be able to reflect on how we improve the quality of our care in our clinic. One is just busy making things happen all the time and dealing with everything that pours over you. (Staff, private unit)

Some heads of units seem to have engaged in working groups within their unit to improve quality of care beyond what is asked for by the owners. But how heads of units engage
in quality of care work and analyse and discuss data seem to depend on the individual manager. Some use routine data on outcome measures for monitoring and developing strategies for dealing with medical issues or challenges. Some described that data are often discussed when all physicians in the unit meet or in regular staff meetings.

Some managers did not mention that they study data on a regular basis, while others described how they know very detailed information about each and every listed patient (if they smoke, do physical activities, are depressed, if they got nutrition counselling, etc.). One manager, from the SLSO, mentioned that they had also hired an external “quality consultant” who helps with analysis and quality improvement work. Another manager from the SLSO mentioned that they have working groups amongst the staff that are addressing some quality of care issues where they themselves think that they can do better (e.g. coordination, communication, and home-based care) and that these working groups report on progress in the weekly staff meeting.

7.3.4 Focus on What is Easy to Measure Rather Than What is Important to Measure

Regarding the governance system, heads of units expressed that it focuses on measuring the “wrong things”, rather than what matters for quality of care for the patients. A few examples that were brought up during the interviews include the capturing of indicators on structural measures of quality (related to access) rather than those capturing actual quality of care (medical outcome indicators), complex environment certification rather than spending time with patients, and submission before the deadline rather than studying what actual quality work is being done.

As mentioned in the previous chapter, one head of unit described how they worked in a unit that had a requirement for the physicians to take 20 patients per day and how this was not safe for patients as the physicians did not have time for journal notes or to explain to a patient what medicine they had prescribed. When asked if the SRHCO would not notice this kind of behaviour, they responded:
No, they don’t. They send out a questionnaire. Do you have this? Do you have a t-loop near the reception so that deaf people can hear what you say?, do you have a lift?, do you have wide doors?, do you have a project on quality of care? … that is what they [SRHCO] are interested in. They do not see the casual impact, that if one doesn’t pay people, then some people will start to take shortcuts to get paid. Excuse the language, but it’s actually what happens in Sweden. (Manager, private unit)

Heads of units described how the mechanisms used to govern for quality of care by the public authorities provide an incentive structure that focuses on ensuring access to care rather than providing quality of care to patients, as illustrated by the following quotes:

… they have prioritised that the availability, the telephone availability, should be high. We are so short of nurses, so to get the money we need, we have to monitor the phone to have high availability. And that is positive, but then we cannot receive the patients who come, we have to reduce the number of visits, so those who are more seriously ill, the elderly and things like this, who need changes, etc., they get a different priority then. (Manager, private unit)

[They focus] on measuring what is easy to measure: number of visits, waiting time for return visits, waiting time for first visit, if you have a website for time booking so the patient can book for an emergency visit from home. Now there is nothing that directly measures quality in care or treatment results. Which I think it would be very interesting to measure if the sickness rate goes down in the immediate area and treatment. But it is considerably more complex … It is almost stupid what they [SRHCO] are measuring now. (Staff, private unit)

… in many cases they measure the wrong things. They measure things to measure something, but you do not measure treatment results or quality [of care] at all. They choose parameters that can be checked and there is no guarantee of good quality. (Manager, private unit)

There seems to be a general perception amongst heads of units that only limited priority is given to the quality of care by the public authorities with the current governance mechanisms they use and that more can be done, and some even claim that the governance system does not promote quality of care. These two quotes illustrate this: “Certainly, we work with quality of care but it is not rewarded by the purchaser and that is boring. Because it reaches a limit … we could do even more” (Manager, private unit), and “the governance system … it gives no benefit to quality” (Manager, private unit).
When probed why providers think the SRHCO does not measure outcome indicators, they mentioned that the providers have brought it up with the SRHCO, but that they say it is too complicated.

Heads of units describe their frustration with the myopic focus on ‘access’ and explain that several times a day there is a person who calls all clinics in the Stockholm Region to check how reachable they are on the phone line. Providers complain that this is a waste of taxpayers’ money to have people sitting and calling them to check if they respond on the phone.

They also say that this focus on access is largely driven by politicians. The final decision-making power with regard to the design of the governance system, and particularly the Compensation model, sits with the elected officials, who give instructions to the SRHCO. This means that elected officials get involved in very detailed decisions about incentive payments, etc. One manager of a unit explained:

… the politicians govern the reimbursement system and that is a challenge since they are only elected for four years. It means that it is populistic how that system is designed, to respond to the citizen. Access is something that appeals to everyone. (Manager, private unit)

In the absence of measuring outcome indicators, the heads of units confirmed that it is tricky to know if an increase in a certain measure, such as accessibility, means an actual improvement in a quality of care indicator, with the current system, as per below:

I cannot claim that there are any clear quality outcomes in the governance system, so to speak … except for maybe the rather blunt and fairly simple measures of accessibility … where we saw an improvement … The patients got shorter waiting times as we could produce more visits. But these visits were shorter … you understand. So basically, accessibility increases because of the way we measure it, put it simply. (Manager, public unit)

The heads of units also described access as a determining factor for where the patient decides to list themselves rather than quality of care (as predicted in the theoretical model about quasi-markets), as patients list themselves where they get quickest access to care. As one head of unit described: “we strive hard to become the best at what we are doing,
but it is not what we get paid for, we get paid to deliver times quickly, because otherwise patients list themselves elsewhere” (Manager, private unit).

7.3.5 Detection of Misconduct Primarily through Feedback from Patients

During the interviewees with heads of units, numerous stories were shared about providers who are skimping on quality of care in different ways and are a risk for patient safety.

One interviewee described a primary care unit where staff prescribed heavy drugs (narcotics), and some discussed how certain units push their doctors to take 20 patients per day, where there is no time to write a medical journal, etc. It is difficult to say if these accounts were stories that travelled around or a reflection of reality. Given that the SRHCO primarily collects indicators that are focused on structural quality, I asked providers if they think the SRHCO knows which providers are skimping on quality of care.

There were different perceptions amongst the providers about this. Some said that certain strategies used by providers, such as striving to prioritise healthier populations (cream-skimming), that require shorter visits do not raise any ‘red flags’ in the governance system. When the PCCR was first introduced with the initial Compensation model, with high (as a percentage of total compensation) fee-for-service payments, some providers described that their impression was that the quality of care dropped at this time as all units were focused on producing many visits. Therefore, heads of units welcomed the revision of the Compensation model towards a larger share of reimbursement from capitation.

However, most providers expressed that they think the current governance system will detect more serious misconduct over time. Here, heads of units mentioned patient reporting and the National Patient Survey as crucial instruments for detecting fraud. One head of unit described:

It comes through [if a provider engages in misconduct], I mean primarily from patient surveys, patients are not stupid. Although they cannot, in every case, understand the medical qualities of a treatment or an assessment, there is much more to a visit than that ... Then there is so much data that is reported [to the SRHCO] on how much visits we do, what kind of compensation you get, etc., and
SRHCO works a lot with this data to see if there are any outliers from the average. If so, you get questions. But I also think that people cheat with the billing and get twice as much paid and so on. But the cases we know of are the ones that have been revealed so it is hard to say that it is a guarantee that no one can do it. (Manager, private unit)

While it is plausible that there is a risk for a highly profit-driven provider to skimp on quality to maximise profit, when asked, heads of units did not seem to think there is a direct trade-off between profit and quality of care. One head of unit, with experience managing both public and private units, explained: “if you want profit fast, then quality decreases. … but I think quality is positively related to profit [in a longer-term perspective]. It is easier to be profitable if you have good quality” (Manager, public unit).

The interviewee went on to explain that quality of care is very important for the brand name, as private clinics do not want to be perceived as having worse quality of care than a public provider:

    We were so fond of our brand as [name of private provider], so it was not on the map that we would do quick fixes and ignore quality. There [at the private provider] it was more precise than I think it is here [at the SLSO]. (Manager, public unit)

7.3.6  Incentivising Quality of Care

Interviewing the heads of units, one understands the complexities involved in creating a governance system that incentivises quality of care. With regard to the KVÅ codes that the public authorities use to nudge the providers to take certain measures, heads of units said that these codes are good because they reward tasks completed. However, providers also expressed frustration over the ceilings set as they seemed illogical since they would only get reimbursed up to an arbitrary set threshold. Other heads of units stated that they did not care much about these codes because they “don’t impact our finances at all” and therefore it was “not worth it to run after all these stimulus payments.”

Similarly, it was also clear from the interviews that financial incentives are not always motivation to do more for intrinsically motivated health care workers. A staff member at
the SLSO explained why it is difficult to encourage public care units to report KVÅ codes to gain more money:

... many people who work in health care do not care about that [financial incentives]. But I try to motivate them by saying that it is great if you use KVÅ codes because then we can see what you do during the days and this helps the nurses to understand why it is important to do this. (Manager, public unit)

Another head of unit found these KVÅ codes “completely idiotic”, and explained:

... it is my professional responsibility to do a review of a patient’s medicines. If I don’t do that then I commit a medical error, that is my job [to make sure it does not happen] ... So I think they [public authorities] are getting involved in areas that is none of their business ... So when we have a drive to increase those numbers, then the lady in the reception writes in the booking a reminder about doing a review of the patient’s medicine … but in reality, I am not doing anything differently than before. (Manager, private unit)

Heads of units also explained that the frequent change in codes that has money attached to them means that they need to constantly teach the staff thousands of different codes.

Interviewees also described that the current mechanism to govern for quality of care, with its indicators, does not provide the full picture of which providers are producing good quality of care and which ones are not. This description from a head of unit puts emphasis on the real challenge involved in capturing subtle aspects of quality of care that may be very important for the patient, and the quality outcome, but not necessarily measurable and easy to capture in an indicator:

If we take for example talks about alcohol, we can register that we have had talks about alcohol, but what does SRHCO really know about the content of them? What do you know about how I might notice something, that I am a good listener and responsive? If I notice that someone is overweight and reddish, and I then start a talk about alcohol, this will not show up, not with these indicators. You catch a little corner of it and you may have to settle for that. A little corner of quality of care. (Manager, private unit)
7.3.7 More Communication Around Quality of Care with the SRHCO

Similarly to the finding in Chapter 5 that heads of units seem keen to engage in dialogue with the SRHCO around the governance system overall, this also seems to hold for the part of the system regulating quality of care.

Providers described that the dialogue around quality of care is focused on how the quality measurements of one specific unit compare with other units. Providers described the dialogue as quite formal and called for more feedback from the purchaser and a more dynamic and lively dialogue around quality of care. As one provider described it:

… no one asks what we really think about the governance system … whether the remuneration model has a positive effect, that kind of question we never get. Can you improve quality given the way we reimburse you? That question we do not get but I do write my own thesis about it in this blank space where they ask about any miscellaneous comment, but no one reads it. (Manager, private unit)

This dialogue seems particularly important as providers described that it is important for the SRHCO to understand the day-to-day activities of the providers, as one head of unit described it:

I do not know what kind of backgrounds they have but you have to have some insight into health care before deciding everything. Because it is so complex. It’s not just producing. Health care is not like designing a factory. There are so many obstacles on the way because it is patients that we are dealing with. (Manager, public unit)

7.3.8 Measures to Improve Quality of Care

From the providers’ perspective, the SRHCO is already doing lots of micro-management and, as mentioned previously, providers call for more “air in the system” as the main way to improve quality of care. Providers described the following:

We need more air in the system for us to be able to reflect on how we improve quality of care in our unit. Now, we are overwhelmed just with running the health unit and handle everything that is coming our way … they should reduce the level of detail and focus more on what is really important. Now we are so busy reporting and changing the business after all these details in the Rulebook, when we should
really focus on thinking through how we should work with a specific patient group. (Manager, private unit)

Time to work with quality is needed. When you work with the noose around your neck to make the business work, the days are filled with patient work so time is not enough … To have access to close and good guidance that helps to produce statistics and data and helps in the problem formulations and so on … Continued formulation of quality indicators and sharpening them. It’s a very important piece too. (Manager, private unit)

Other ways described by providers to improve quality of care were: a more lively dialogue around quality of care with public authorities, including improved quality indicators; fostering inclusion of new ways of working/innovations; and creation of a culture of ‘learning’ in the health unit where professionals can carry out their work in the way that they have learned to do it.

### 7.4 Concluding Discussion

The SRHCO’s primary mechanism for governing to achieve quality of care is by collecting and triangulating data from different sources, including the National Patient Survey, self-reported data from the primary health care units, complaints data from users and audit data (from risk-based audits), and anonymised data from the medical journal system. To collect such data, large efforts are required from the purchasers and providers as well as the patients/users of services. The different data sources are compiled and analysed in an annual report by the SRHCO, which is shared with the providers.

What is striking when studying this data in detail is the absence of data on medical outcomes in the Stockholm Region, except for one indicator related to diabetes. It appears that authorities are focusing on collecting data that is accessible, rather than designing a system that collects the most meaningful data for monitoring quality of care. This is also confirmed by heads of units, who stated that the purchasers are focused on the “wrong” things, on what is easy to measure with a myopic focus on “access”. While access is one important aspect of quality of care, it is only one dimension of quality of care, that if any, is the dimension that the market mechanism will deliver on, as providers described that patient choice is driven by quickly getting an appointment. If both patients
and the regional authorities focus primarily on the “access” dimension of quality of care, there is a risk of racing to improve access rather than other crucial quality of care dimensions.

The research shows that the SRHCO is faced with challenges in accessing key data points. Due to legal restrictions, anonymised patient records are not used for day-to-day analysis, there is a fragmentation in information management systems, where, for example, the quality registers are managed separately, and SRHCO does not want to impose increased reporting requirements on the providers, who are already overburdened.

As there appears to be limitations to how patient choice, and the market mechanism, can drive all dimensions of quality of care in the quasi-market, it is critical to ensure that market regulators have access to the right type of data to hold providers accountable for delivering quality services. The regulation of the market can only be as good as the available data is.

Moreover, if the regulator does not have access to data to determine whether a health clinic is providing quality care, it seems unreasonable to expect service users to have enough information to choose the health care unit that provides the highest quality of care. This was also confirmed when the PCCR was introduced — the budget document (Stockholm Region, 2018), as highlighted in Chapter 2, recognises that patients need access to information about accessibility, patient-perceived quality in care, and medical quality indicators that describe treatment results in order to make informed decisions. Thus, the premise that underpins the quasi-market, namely that quality will improve as providers will compete on quality to attract users, seems to be at risk when patient medical outcome data is not available to the patient nor to the purchaser at the aggregate level.

The lack of access to medical outcome indicators is also problematic as it makes it difficult to know if efforts to improve quality of care, such as the quality improvement works conducted both by owners and SRHCO, have any impact on the indicators they seek to improve (Kruk & Nimako, 2020). As an illustrative example, although in a very different setting in Uttar Pradesh in India, a large matched-paid, cluster-randomised control trial in 60 pairs of facilities tested the effect of the BetterBirth programme, an eight-month
coaching-based programme to improve safe childbirth practices, and found process measures of delivery care improved while maternal and newborn outcomes did not (Semrau et al., 2017). Thus, without outcome indicators, it is impossible to say if quality improvement programmes work and if process and efficiency indicators (e.g. number of visits per population) represent an actual improvement in quality of care, as they could represent anything from an increase in the cost for taxpayers (unnecessary visits that are supplier-induced) to better medical outcomes. It is simply not possible to know.

In my data, from the interviews with the providers, there are indications that providers do indeed adapt their strategies to the compensation system, that is, reporting what they get paid for, for example, with regard to KVÅ codes. This raise questions if improved reporting represents real changes in behaviours, in how patients are treated, or if providers inflate the numbers as a revenue generation strategy. The fact that I find that most data that the public authorities collect is self-reported by the providers does not help the situation.

While my empirical data from providers indicates that they think the governance system is able to detect cheating over time, through patient feedback, for example, still the governance system could benefit from more focus on medical outcome indicators.

Users, or patients, appear to be important for governing for quality of care in the Stockholm primary care quasi-market, but perhaps not exactly as predicted in the quasi-market. According to the underlying theory of quasi-markets (see Chapter 3), users/patients would drive quality of care through their choices of the providers who produce the highest quality of care. However, in Stockholm, the providers described how patient choice is primarily guided by how quickly users can get access to services rather than the quality of care provided. So how then is patient feedback important?

Patient feedback appears to be crucial for the SRHCO’s work to weave out poor-quality providers, who skimp on quality, over time. Both the SRHCO and heads of units described that while provider behaviours such as focusing only on healthier populations or skimping on quality of care do not directly raise any red flags in, for example, data reported by providers, patients’ feedback helps to detect providers who adopt these kinds of behaviours over time. This shows the importance of patient feedback for the governance system. Thus, it is critical that even in a governance system with patient choice, regular
and high-quality patient surveys at the level of the health unit are needed to hear the voices of the users/patients. Functioning and user-friendly complaints mechanisms, that collect detailed and timely feedback from patients/users, that market regulators have access to and can use in their decision-making are also critical for the functioning of this market. This is particularly important in this market, as medical outcome measures are not collected systematically.

As mentioned in the chapter, the owners, at least the large ones (both public and private), also collect quality of care indicators and sometimes outcome indicators, but these are not shared with the SRHCO. On the one hand, it may be inefficient that both the regional authorities and the owners collect indicators of quality of care, particularly if there is limited coordination between the two. This is if this leads to too many indicators to report on and there is a risk of reporting fatigue of health care workers, which in turn could compromise data quality. Provider interviews indicate that they find it inefficient with different types of monitoring systems and that instead of feeding data into these systems, they try to stay focused on “managing the unit”. On the other hand, various monitoring systems could potentially be beneficial if they provide different types of knowledge about quality of care and are well coordinated. For instance, owners have access to medical journal data, that the SRHCO does not have regular access to, and therefore an active owner could monitor and govern their units on more detailed outcome measures than the regional level can.

In the Stockholm Region, size of owner seems to matter for how much quality monitoring and quality improvement work is being done. At the operational level, the large owners (e.g. the SLSO and large private owners) have specific programmes for improving and monitoring quality of care in the units that they own. However, it is unclear how effective these programmes are, as some providers describe that they do not engage extensively with quality improvement programmes that are centrally managed. Ultimately, what happens in terms of efforts to improve quality of care and using data to monitor progress seems largely dependent on the manager of the health units, which stresses the importance of leadership for quality of care. Some managers described that they use unit meetings to study outcome data and define actions to improve quality of care, while others
seem to be less active. Smaller owners (who work in the unit, for example) often refer to that guaranteeing “continuity of care” is their main strategy to ensure quality of care.

Both providers and the SRHCO seemed to agree that it would be beneficial for the system to focus increasingly on medical outcome measures. So why is there not more focus on outcome measures in the governance system? Providers mentioned that they think the SRHCO is not focusing on outcome measures because it is complex. This may be true. Outcome indicators are multifactorial and influenced by other factors, such as social context and socio-economic status, that are beyond the control of the primary health care providers. Furthermore, outcome indicators may also change more slowly than process indicators. For these reasons, there are challenges involved in paying providers based on these indicators as they are not fully in the control of the providers. If they were used as a basis for payments, then providers would need to be evaluated based on the change in the indicators rather than their levels to avoid punishing providers working in areas that have lower health outcomes at baseline. Thus, these are not the easiest data to collect, and certainly complex to base payments on, but still they are needed to measure quality of care.

Additionally, providers mentioned that because the representatives of the Stockholm Region are elected officials, they have a short-term time span, where the focus is on getting re-elected. Therefore, the governance system focuses on something that appeals to everyone, such as access to care. This may also be a contributing reason why other indicators, which are harder to explain to the electorate, get less attention.

Representatives from the SRHCO said that the reason they do not focus on outcome data is because there is no system in place to collect outcomes measures, as illustrated in this quote: “it all depends on what kind of data we have access to, if we do not have access to outcome data, then there is not much that we can do” (Staff, SRHCO).

This view expressed by the SRHCO is quite surprising given that the Stockholm Region is ultimately in charge of designing the oversight system and could put in place a governance system that is more focused on outcome measures. The quote above indicates that the SRHCO takes a passive role as a public authority with regard to
designing and putting in place mechanisms to hold the units accountable for delivering quality of care.

If the SRHCO does not have access to outcome measures data, which they perceive important to effectively govern the market, and they are in charge of governing the primary care market, why is it that they do not create a system that gives them access to this type of data? A staff member from the SRHCO noted: “there is no government agency that oversees measuring quality and defining terms and concepts related to quality at the national level.”

This shows that there is a gap here. Whether it is true or not that there is no one in charge of this, it is striking that this gap is perceived by the Stockholm Region, the biggest purchaser of care in Sweden.

Ironically, while the SRHCO perceives that the national level of governance should define concepts and terms, the SLSO, the public owner, which is a lower governance level than the SRHCO, described how they spend a lot of time to work on definitions and concepts in their own quality monitoring and improvement programme.

This finding shows a confusion in responsibilities between the different levels of governance and is consistent with previous research. A recent study on the governance of health care in Sweden concluded that “there are tendencies for the state to deal with the problems that the regions should solve. At the same time, the regions are trying together to solve the problems that should essentially be a national level concern” (Anell, 2020, p. 11). Anell (2020) described the region’s work to create a structure for knowledge management is one such example of something that should be handled at the national level. My research indicates that the development of common quality of care indicators may be another area that would benefit from more work at the national (and regional) level, particularly with regard to defining terms and concepts and less work at the ownership level.

Another challenge mentioned by the SRHCO with regard to governing for quality of care is that collecting medical outcome data would overburden the providers with reporting requirements. This is an important concern as increasing reporting requirements takes
providers away from their patient-facing time and provider interviews show that they already perceive the reporting requirements as overwhelming. However, this is not a reason for not collecting these critical indicators. An alternative approach by the SRHCO would be to commit to ensuring that for every new indicator introduced, an old indicator is dropped, with the intention to streamline reporting requirements over time or at least not increase number of indicators collected.

Despite these concerns raised by the SRHCO, both providers and the SRHCO seemed to think it is possible and desirable to increasingly monitor quality outcome indicators. This is particularly important in a market where there is free establishment for any type of owner to enter, including those highly focused on maximising profits. Because in such markets, there maybe is a higher risk that these providers skimp on quality, although my data shows, as presented in Chapter 5, that professionalism may cushion the profit drive in the quasi-market for primary care in Stockholm. Still, when there is a higher risk, there is also a higher need to understand how well providers deliver on the ultimate outcomes that the market seeks to produce, namely the health of the population.

An important finding of this chapter is that the data collected from the providers is largely self-reported. This also holds for data that the SRHCO bases payments on. The SRHCO interviewees recognised that this is not good but stated that this is the only way that they have been able to retrieve the data. While medical audits are used by the SRHCO, this is only when they are suspicious about the activities of a provider. Thus, there is no regular verification mechanism of self-reported data before payments are made to the providers.

The fact that the system pays based on self-reported data without regular verification shows that the governance system assumes that providers are honest and do their job and report according to the services that they provide. This is also confirmed in the interviews with staff from the SRHCO, which show that the governance system is largely trust-based and built on the provider acting with integrity.

This raises the question if the system is robust enough for providers who deliberately want to find loopholes in the governance system to, for example, maximise profits and break current norms for service provision. As of now, it seems that the system is able to
hold providers accountable for delivering quality of care to the population by detecting providers who skimp on quality, at least per what both the providers and purchasers say, partly thanks to data directly reported to the SRHCO from the users of services. But the types of providers in the quasi-market have changed with time, and it is possible that while there are few such profit-hungry providers in the system currently, more could enter. Furthermore, with advanced technologies, business strategies could become more sophisticated. This raises the question whether the current governance system, and mechanisms used, largely trust-based, would be strong enough for a situation with more profit-hungry and sophisticated providers.

It is not surprising that the system is largely trust-based in Sweden, a country where trust, a critical ingredient of social capital, is high compared to other countries. For instance, according to the World Value Survey (2014), 60% of Swedes think that people can be trusted compared to, for example, Colombia and Brazil where 10% think this is the case (Ortiz-Ospina & Roser, 2016). But for another country, with a different culture, that is considering implementing a Choice model, a stricter governance system may be warranted where self-reported data is verified on a regular basis, with its accompanying costs.

Another important finding in this chapter is that there is an inherent contradiction in the theory of quasi-markets with regard to quality of care. On the one hand, that patients choose a provider is critical to create competition for patients in the market, and thereby drive quality of care. This means that users who switch providers frequently are healthy for the functioning of the market. On the other hand, the frequency of switching providers may have a negative relationship to the quality of care provided, as switching leads to less continuity of care. There is accumulated evidence that continuity of care reduces hospital admission, emergency department visits, and medical costs (Alyafei & Al Marri et al., 2020).

Further, recent research confirms that the share of adults who say that they have a fixed physician contact decreased during the 2010s in Sweden. A 2019 national representative survey of Swedish adults shows that only one third of adults (26%) have a fixed contact at primary health care unit, while 8 out of 10 Swedes think that it is important to have a
fixed contact, but only 5 out of the 10 perceive that they are able to have a fixed contact. The survey also showed that people with a permanent contact at a health centre have better experiences of care when it comes to higher accessibility, participation, and continuity (Swedish Agency for Health and Care Services Analysis, 2020).

Thus, there are two forces in different directions and it is therefore too simplistic to say, as economists predict, that switching drives quality of care as it may also have negative impact on quality of care, and ultimately it is an empirical issue beyond the scope of this thesis to investigate. That choice also seems to have a cost in terms of continuity of care is rarely discussed in economic literature on quasi-markets.

Finally, and as mentioned previously, the general perception from the heads of units is that the mechanisms used for governing for quality of care create an incentive structure that is overly focused on the access to care, rather than meaningful outcome indicators. In the eyes of the providers, the public authorities focus on measuring the “wrong things”. Heads of units also found the SRHCO too involved in micro-management, through, for example, incentivising KVÅ codes, which only captures one small corner of quality of care, while their perspective is that “more air in the system” and time for reflection would be needed to advance quality of care outcomes.

Furthermore, and consistent with my findings in the previous results chapter, providers called for more frank and less formal dialogue with the purchaser around how they could improve quality of care indicators that focuses on new ways of working and innovations, to build a culture of learning. Providers also expressed a desire for more feedback from the purchaser and stressed that it is important for the purchaser to have a good understanding of health care provision when designing the monitoring system.

Overall, this chapter points to the challenge involved in implementing governance mechanisms that hold providers accountable for delivering quality of care in the primary care quasi-market. As the market mechanisms cannot be trusted, alone, as a driver for all dimensions of quality of care, ensuring that providers live up to their commitments with regard to quality of care becomes an important function of the governance system in the quasi-market. This challenge in measuring quality of care is not stressed enough in the theoretical literature in quasi-markets. Furthermore, in the Stockholm context it was often
argued, for instance in the budget document, that when the PCCR was introduced, extending patient choice would automatically improve quality of health care, without recognising the challenges involved in measuring quality of care. This chapter clearly shows that the devil is in the detail when designing robust monitoring systems and holding providers accountable for delivering quality primary health care services.

7.5 Conclusion

The intention of this chapter was to further examine the mechanisms used by public authorities to govern for quality of care and to examine how managers of primary care units perceive the incentive structures that the existing governance system gives rise to with respect to how well it holds providers accountable for delivering quality of care. In this chapter I have focused on research question 3.

This has been done by analysing the empirical data collected in my interviews as well as carefully studying the different sources of data that the public authorities collect on quality of care. I examined the topic of this chapter by first discussing the mechanisms used by public authorities. I then discussed mechanisms that the owners use to govern for quality. Finally, I brought in the providers’ perspectives on these mechanisms and the incentives they give rise to.

This chapter reveals that the main governance mechanism used is performance monitoring, through the collection of data on providers, triangulated from different sources. There is a strong focus on data on access to care and a notable lack of data on medical outcomes (perhaps the most meaningful indicators of primary care performance). Most data, even that which triggers payments to the providers, is self-reported by providers. Public officials see the governance system as highly dependent on trust amongst market players. It assumes that providers do not have deceitful intentions.

The chapter also reveals that public officials also struggle to access key data on quality of care. There is confusion concerning who should do what in the governance system, which creates an impasse for creating a performance monitoring system that collects fewer and more relevant indicators on quality of care.
Providers expressed considerable scepticism that the output of primary care services is appropriately measured by the public authorities and they perceived that public authorities focus on the “wrong things” (e.g. quick access to care), which are easy to measure rather than factors that are the most important from a quality of care perspective (e.g. continuity of care, medical outcome indicators). At the same time, they call for more “air” in the system for reflection and less micro-management to enhance quality of care.
8 Concluding Chapter

8.1 Introduction

In this chapter, I identify the most important findings of the thesis in relation to the research questions and explain how my research contributes to existing knowledge and policy dialogue. First, I address the three research questions and highlight my key findings in relation to the aim of the thesis. I also relate key findings to previous research and show my contributions. Second, I discuss my key findings in light of the theoretical frameworks used in this thesis and my contribution to scholarship. Third, I make observations about critical policy questions that my findings give rise to and explore the implications of my conclusions for policy, at both national and international levels. Finally, I reflect on the strengths and limitations of my research as well as identify potential directions for future research.

8.2 Addressing the Research Questions

Chapter 4 presented a structured narrative literature review, which I conducted with the objective to give an account of relevant strands of theoretical literature and to provide a comprehensive overview of the empirical research on the governance of primary care quasi-markets. The literature review was undertaken to understand the state of existing knowledge and identify important gaps that this thesis then aimed to fill.

My conclusion from reading the theoretical literature on quasi-markets is that although the move from a more hierarchical governance mode to a quasi-market appears straightforward in the theoretical economics literature, it rests on several assumptions. These assumptions, both on the demand side (e.g. there is good information on quality of care to users and no demand sluggishness) and the supply side (e.g. there is no cream-skimming, no skimping on quality, providers respond to incentives to increase quality of care), depend on how the quasi-market is governed and how individuals respond to the governance systems they operate in. Ultimately, markets are made of individuals and what drives their action remains uncertain. Thus, empirical investigation of the
governance system of the market and the incentive structure it gives rise to is warranted to understand and determine the functioning of a quasi-market.

Given that I study providers of different ownership characteristics, I also reviewed the theoretical literature on the impact of ownership in primary care. This literature predicts that ownership of government services does not matter if you have complete contracts and competition (Hart et al., 1997). For health care services, however, the characteristics of these services/markets (e.g. limited ability of consumers to assess quality of care, the risk of cream-skimming by providers and since the damage to quality from reducing costs is large, etc. [Hart et al., 1997]) are such that it is reasonable to believe that complete contracts are difficult to obtain as it is challenging to specify what is needed, to monitor the output, and given the risk of opportunism (Allen, 2009).

Turning to the empirical literature I find that the existing body of literature on the governance of primary care quasi-markets is growing (e.g. Blomberg & Winblad, 2020; Glenngård, 2019), yet research on this topic is still scarce, particularly in primary care (Glenngård, 2019). Three key gaps in previous research were identified. First, more research on the governance of quasi-markets is needed and particularly on the practical mechanisms used to govern, and that takes a holistic perspective on governance and uses a qualitative research approach that allows for better understanding of the interactions between different elements (purchasing, quality regulation, etc.) (Hartman, 2017) and levels (micro, meso, and macro) of the governance system (Saltman & Duran, 2016). Second, few studies focus on provider behaviour and the provider's perspective of the governance system and more research is needed (Glenngård, 2019), particularly as the studies that exist on supplier behaviour (Vengberg et al., 2021; Vengberg et al., 2019) indicate that suppliers do not necessarily act according to economic theory that is underpinning the theory of the quasi-market. Third, while there is recent research (Ellegård, 2020) indicating that providers of different ownership characteristics may respond to the incentive environment differently, there is limited research that includes providers of different ownership characteristics, although theory predicts that ownership status matters (Hart et al., 1997). Thus, more research is needed that includes providers
with different ownership characteristics to understand potential differences between different types of providers, in terms of their perceptions of market regulation.

This thesis captures the governance system of the primary care quasi-market from the perspectives of public authorities as well as providers with different ownership characteristics (small, large, private, and public) as suggested in the latest research and to fill existing knowledge gaps.

The results chapters were organised to address the research aim of exploring the governance system of the primary care quasi-market in the Stockholm Region, Sweden, and examine how this system is perceived by different stakeholders.

To achieve this, the following research questions have been answered:

(i) What mechanisms are used to govern the quasi-market and how do these influence the incentive environment in which primary care providers operate?
(ii) How do stakeholders perceive the impact of the governance system on the achievement of competition across providers in a context of diverse ownership characteristics?
(iii) How do stakeholders perceive the impact of the governance system on quality of primary care services?

I used Ahrne et al.'s (2015) theoretical framework (and the extension of it by Andersson et al. [2017]) of the mechanisms of governance — in their words, the market organisation — for organising my empirical data around market mechanisms used by public authorities to govern the primary care quasi-market in Stockholm in Chapter 5. It was also important to better understand what mechanisms are used to exercise important governance functions, such as priority setting, performance monitoring, and accountability arrangements (Smith et al., 2012).

Ahrne et al.'s (2015) theoretical framework was a helpful tool to study the various components of the market and how the market is governed. It could also be advantageous to use for tracking changes in the governance system over time as it provides a structured approach to study the market and its governance. A challenge with this theoretical
framework was that it did not provide any insights related to how to identify market failures and make the market work well, which is critical for policymakers.

I found the theories by Hart et al (1997) on economics of contracting and ownership and Brekke et al.’s (2014) theories regarding the functioning (or not) of the quasi-market more helpful for these purposes. This theoretical literature points to areas that are key to study in a market/quasi-market in general (e.g. can services be monitored and measured?) and particularly in health care markets (are market actors engaging in cream-skimming or skimping on quality?). Thus, I used different theoretical frameworks in this thesis for different purposes.

The main findings of the research are presented below. I first respond to the three research questions and then discuss my key findings in relation to the aim of the thesis. Subsequently, I discuss my key findings in relation to theory and the main contribution of this thesis to scholarship.

### 8.2.1 Research Question 1: What mechanisms are used to govern the quasi-market and how do these influence the incentive environment in which primary care providers operate?

Summary of main findings:

- A range of mechanisms are used by public authorities, who actively govern the market, including written rules, market entry/exit criteria, performance monitoring, the use of knowledge management, and sanctions. According to stakeholders, both the public authorities and the providers, the Compensation model is perceived as the most important mechanism driving the incentive structure.

- Yet, providers state that the effect of the incentives from this mechanism is moderated by other factors. Providers perceived their actions to be influenced by a range of mechanisms employed by a variety of principals at different levels — public authorities, organisational owners, and the professional ethics associated with their medical profession.
• This creates layers of governance and pressures from different principals that are often in conflict and creates internal stress amongst the providers. When reflecting on this resulting complexity, providers emphasised their values and professional ethics as the primary influence on their behaviours.

• Providers also expressed frustration with those who govern the market because of limited opportunities for dialogue and perceived a feeling of “we and them” when describing the provider–purchaser relationship and said the governance system would improve with more dialogue.

Chapter 5 analyses the overall mechanisms used by public authorities to govern the primary care quasi-market. A range of mechanisms are employed by public authorities, including detailed written rules (stipulated in the Rulebook), market entry/exit criteria, performance monitoring, the use of knowledge management (e.g. recommended use of Vårdgivarguiden, VISS, and Janusinfo), and sanctions (e.g. the Compensation model). Of the different mechanisms, positive sanctions, or more precisely, the Compensation model, is the most potent mechanism the public authorities have, to incentivise the providers, according to all stakeholders in the market.

The public authorities also combine various mechanisms. Through rules and financial incentives, they exercise priority setting, through collecting and analysis of data and consumer feedback they monitor performance, and they also hold providers accountable, for example, by applying sanctions and exclude providers from the market, although exclusion, which is a key function of governing, appears to be one of the weakest links in the governance system. It demonstrates that public authorities actively govern the market and constantly tinker with the governance mechanisms and particularly the Compensation model. The rules of the game, at least on paper, change at least on a yearly basis but sometimes even more often.

My findings are largely congruent with previous research. Andersson et al. (2017) have shown that, in general, public authorities in Sweden have been active and developed new instruments for managing the market as market reforms have been implemented in the country. Forsell and Norén (2018) and Malmkvist and Redic (2012) have shown that the primary care market in Sweden is also highly organised and regulated. Consistent with
the theory about quasi-markets that says that they are a hybrid between market structure and traditional form of hierarchical structure (Lewis, 2017), I find that this is true in practice; the Stockholm primary care market resembles a hybrid between market and hierarchy given its high degree of regulation, where the state shapes the incentives for buyers and sellers but also exercises top-down direct control through rules and regulations (Smith et al., 2012). The public authorities are also involved in knowledge management, a key feature of network governance, but seem less involved in establishing common values in the market. This is also consistent with international literature (e.g. Bean & Wilson, 2013) that shows that modes of governance, including accountability measures (Benish & Mattei, 2019) (e.g. hierarchy/bureaucratic, market, and network), are often combined in practice. My findings add to existing literature by showing that this is also the case in the Stockholm primary care market.

My results regarding governance mechanisms used by public authorities are overall in line with Glenngård (2019) with regard to the fact that multiple mechanisms are used to govern the market and that there is an interplay between different mechanisms, but I add to her work by showing that the Stockholm Region seems to differ from other regions with regard to what stakeholders perceive as the most prominent mechanisms for governance. In Glenngård’s (2019) national study of governance models in primary care in Sweden, the most common responses at the national level when asking public authorities about their most important mechanisms for governing were dialogue and the tender document, followed by performance monitoring and, lastly, the reimbursement system. In Stockholm, stakeholders answered the Compensation model. Thus, my thesis shows that the national average does not seem to hold for the Stockholm Region, where dialogue seems less prominent according to stakeholders, than in other regions, and financial incentives are more prominent. This is likely due to the fact that in comparison with other regions in the country, a large share of reimbursement to providers was tied to fee-for-service payments when the quasi-market was introduced in Stockholm. In other regions, capitation payments were more prominent as a payment method.

This thesis further shows that the public authorities describe their role in the market as formulators of the ‘what’ rather than the ‘how’ of service delivery, i.e. to steer rather than
to row, to use the vocabulary of Osborne and Gaebler (1992), and that they have, in their own words, no operational responsibility. Yet, the Rulebook, which is the main framework for governance, contains detailed rules on the “how” of service provision, including regulations on opening hours of health units and how services should be provided (e.g. that patients should participate). This indicates that while the public authorities intend to steer rather than row, it seems complicated as a market regulator to pull back from the “rowing”. The public authorities say that to only steer can be challenging. This indicates that finding a balance between rowing and steering in a quasi-market may be more complicated in practice than in theory. The public authorities’ involvement in the “how” of service provision is also confirmed in my interviews with providers, who state that the public authorities are micro-managing them.

Yet, despite detailed rules on paper that are regulating the “how” of service provision, it remains unclear from Chapter 5 if the public authorities are able to hold providers accountable to comply with the rules. This pertains to key aspects of the contract, such as ensuring that providers maintain standards of quality of care and are refraining from cream-skimming, that is, not deprioritising more “costly” users such as elderly people with large and complex care needs. What I show in Chapter 5 is to the contrary, that there are indications that some key aspects of market regulation, such as exiting providers from the market, who do not comply with the contract, have been challenging to enforce in practice. In my interviews with staff from public authorities, they say that at least in the first years of the introduction of the quasi-market, it was difficult to exclude providers from the market because of long legal proceedings. Having accountability mechanisms is one of three fundamental functions of leadership and governance (Smith et al., 2012) and these findings regarding accountability are important as it puts the functioning of the market system in question.

From the providers’ perspective, they mention the Compensation model as an important shaper of their incentive structure, which is consistent with Vengberg et al. (2021), which shows that payments can influence provider behaviour. Yet, they perceive their incentive environment to be influenced by a range of mechanisms employed by a variety of principals at different levels — public authorities, organisational owners, and the
professional ethics associated with their medical profession. This finding is consistent with Saltman and Duran’s (2016) conceptual model that shows that when the state moves from provider to steerer, governance relationships happen at different levels — macro (the national-level policy function), meso (the institutional-level decision-making function), and micro (operational issues at the clinic or organisational level). Yet, my findings add to their analysis by highlighting that the inner value system of the professionals is also critical to the governance system as it, according to providers, influences their behaviour, as will be discussed in the following section.

Providers state that the different layers of governance are often in conflict. My empirical data from interviewing the providers shows that certain owners, particularly large private ones, pressure the heads of units to generate profits, in an environment where public authorities only provide limited revenue, and that this goes against heads of units' professional ethos. When they experience these kinds of conflicts, providers describe how their professional logic guides their actions more than higher-level rules and directions from owners. This is in line with previous research showing that belonging to a professional group (Freidson, 2001; Mosher, 1968; Roberts & Dietrich, 1999) and intrinsic motivation are major drivers of behaviour in the health care sector (Besley & Ghatak, 2005).

While I have not examined if the providers act according to what they say, my findings may indicate that, in practice, the rules on paper may only have limited impact on provider behaviour, if they are inconsistent with the professional ethos both in privately and publicly owned units. Thus, even in private units, which one could imagine would be more driven by profit maximisation, the professional ethos seems to guide providers and may therefore cushion against opportunistic behaviour at the expense of patient safety. This is consistent with Andersen and Jacobsen’s (2010) finding that professionalism of the staff off-sets opportunistic behaviour with adverse impact on quality and some of the ownership differences.

Furthermore, there are indications in my data that even within the current governance mechanisms, designed and exercised by public authorities, there are conflicting incentives. For instance, the Rulebook states clearly that providers must prioritise elderly
people with large and complex care needs, people with extensive disabilities, and chronically ill people and even provide support to their relatives. However, the Reimbursement model does not give any extra reimbursements for supporting relatives to elderly people. This dissonance in the governance system matters because it then becomes up to the individual patient-facing staff (or possibly the owner) to decide what is the right thing to do in each situation.

My research shows the primary care facility managers find this challenging and describe that the different directions by different principals creates internal stress. This finding is key as a recent study showed that Swedish GPs are already the most stressed GPs amongst 10 other OECD countries, while they also see the fewest number of patients per worked hours and that the number of GPs feeling stressed has also increased over time in Sweden (Swedish Agency for Health and Care Services Analysis, 2020). However, this recent study stated that one explanation for the level of stress amongst GPs could be because they spend a lot of their time in administrative tasks. My findings enrich this analysis by showing that the current governance system and the incentive environment it gives rise to for the providers, according to them, is pulling them in different directions, and sometimes against their professional ethos, which is another factor adding to their levels of stress.

Similar to my finding with regard to managers experiencing conflicting directives, Falkenström (2010) wrote that managers in the health care sector in Sweden experience a conflict between the management logic and professional ethics, and several researchers (e.g. Bornemark, 2018; Kälvemark Sporrong, 2007) have pointed to the presence of ethical dilemmas and “moral stress” amongst health professionals. I add to these findings by showing that the conflicting directives originate in the different levels and from the different principals in the governance system and the incentive environment it creates for the providers.

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11 Moral stress is described as a situation where the professional has a clear idea about what to do in a specific situation, but they cannot do it because of organisational obstacles such as time constraints or the pressure from other tasks that are not part of the core activities of the organisation (Bornemark, 2018).
In this context, I contribute to previous research by showing that the providers perceive the owners as important in the governance system. Jakab et al. (2002) showed, in their study on hospitals in eastern Europe, that one of the four sources of performance pressures in the external environment is the owner. I show that this is also the case for primary care in the Stockholm Region. More concretely, my evidence shows that larger owners, which own several health care units, influence their providers both through explicit (e.g. use of balanced scorecards) and implicit governance mechanisms (e.g. culture). For instance, with regard to setting cultures, a head of unit of a large public provider described that their brand stands for security for patients, patient safety, good care, the best care, and accessibility, and another head of unit of a large private provider described how their brand is for them associated with quality of care. I also show that the public providers experience different directions from the SRHCO and their public owner (SLSO), showing that even within the public sector, the owner’s (SLSO) direction is influential.

Building on this, I show in Chapter 7 that the SLSO, the public owner, has an extensive programme for monitoring and improving quality. Although Jakab et al. (2002) recognised in their conceptual framework that the relationship with the owner influences the behaviours of hospitals in their study in eastern Europe, the role of the owners in shaping the governance system has largely been neglected in the literature (Hallin & Siverbo, 2002). Yet, it is clear from my research that the owners’ directives influence the providers, in pressures they feel from the owners (e.g. to generate revenue) and how they absorb new evidence that impacts quality of care (larger owners have organised quality improvement programmes for their providers) as well as how they report on their work (e.g. through specific indicators in balanced scorecards). This may explain findings in previous research (e.g. Ellegård, 2020) that show that public and private providers respond differently to rules created by public authorities (e.g. the compliance with guidelines) and it adds to existing calls (Crampton, 2005; Ellegård, 2020) for ownership frameworks being used more frequently in health policy.

Another key finding, is the providers’ frustration with the lack of dialogue with the public authorities. As mentioned in the previous section, this adds to Glenngård’s (2019) national
study that found that the dialogue was the most important governance mechanism according to the public authorities. Perhaps as a result of the lack of dialogue between the purchaser and the provider in the Stockholm Region, the providers perceived a gap between those who design/formulate the governance system and the wise people who work in the reality of the primary health care environment. Providers gave voice to a feeling of “we and them” when referring to the public authorities.

Interestingly, both providers and staff from the SRHCO agree that the governance system would improve if there was more dialogue between the public authorities and the providers. Both groups highlight that in a model where revenue is primarily generated from patient care, time for these types of engagements, including dialogue, must be reimbursed otherwise it does not happen.

8.2.2 Research Question 2: How do stakeholders perceive the impact of the governance system on the achievement of competition across providers in a context of diverse ownership characteristics?

Summary of main findings:

- Regarding competition, rules on paper are designed to treat all providers the same and thereby create fair competition. The underlying assumption in achieving fair competition through a standardised contract is that all providers have the same characteristics (e.g. serve similar clientele) and face similar conditions in connected markets (e.g. capital and rental markets). Yet, in practice, interviewees perceived that providers have different characteristics, serve different segments of the market, and face diverse market conditions in connected markets.

- Health care units owned by smaller privately owned providers seem to struggle in the incentive environment that the standardised contract gives rise to. They described the challenges they face in credit and rental markets. They perceived that they were unfairly treated by the public authorities and questioned if they are wanted in the market. Providers also give testimony to the use of strategic revenue
generation strategies by large private owners, which highlights the risk with the exiting of smaller providers and market consolidation.

- Public authorities expressed concern whether small privately owned providers meet the requirements in the contract. This shows that for public authorities, there are complexities involved in creating fair market conditions, and that it is important for them to understand the actual market conditions (including in connected markets) for different types of providers to not unintentionally create unfair competition.

The key finding of Chapter 6, on how public authorities govern for competition, is that the main mechanism used by public authorities to create fair competition is by creating the same conditions for all providers to ensure a level playing field. The standardised contract and Rulebook, which strive to be the same for all providers, is a manifestation of this philosophy of governance.

This way of governing appears to achieve competition in the market, based on stakeholders’ perceptions. However, whether it generates a level playing field or fair competition is more questionable as it assumes that prior to signing the contract all providers have similar characteristics and face the same market conditions in markets that are linked to the primary care market. My empirical data, however, shows that in practice the providers have diverse characteristics, even play different roles in the market (the SLSO is the provider of last resort), and face dissimilar conditions in connected markets linked to the primary care market (e.g. credit and rental markets).

The standardised approach to all providers gives, according to the smaller private owners of health care units, rise to an incentive environment, where smaller units are, according to them, treated unfairly by public authorities. In their words, they are struggling in, for example, rental and credit markets, because of current payment terms, the short length of the contract, and uncertain contract conditions that are constantly subject to change. The uncertainty is easier for a large owner to handle as such an owner can move money between business units and has better credit conditions.

The smaller private owners also describe a tough attitude towards them, which erodes the trust in the provider–purchaser dialogue. They mentioned, for instance, that they
receive information later than larger providers and have a harder time complying with environmental standards, etc. They perceived that they may not be wanted in the market by public authorities.

Interestingly, my interviews with representatives from public authorities also revealed that while they say their overall governance approach aims to create the same market conditions for all, representatives of public authorities expressed concerns over the performance of the smaller privately owned providers in terms of delivering on the contract. Thus, the standardised contract and the challenges it brings to small privately owned providers may be an intentional way of exiting smaller owners from the market.

The providers, particularly those with small private owners, stress that it is important for the purchaser to understand what it takes to operate in the market for different types of providers and to regulate the market accordingly. This finding poses the question of whether the regional authorities, if they want to keep a diverse set of providers, and particularly the smaller owners that have had superior patient satisfaction in the National Patient Survey (Glenngård, 2013), should strive for equity, rather than equality, in market conditions.

Based on these observations, I raise the question if a standardised approach is the best way, in practice, to level the playing field, and I stress the importance for the purchaser to understand what it takes to operate in the market (including connected markets) for different types of providers to not unintentionally exclude a certain type of provider, who is providing value in the market for the consumer, but is struggling with standardised market terms. To my knowledge, this question has not been asked in previous research.

In line with previous research in Sweden (e.g. Glenngård & Anell, 2012; Rehnberg et al., 2010), public authorities stated in my interviews that they do not find any difference in the performance between public and private providers, with the available data they have. I add to existing literature by showing that providers describe how motivation behind action differs somewhat by ownership of the units, where I find that the perception amongst heads of units is that large private owners put more emphasis on revenue generation first as opposed to smaller private and public clinics that describe how they are primarily motivated by providing the best care for patients and a good work environment for the
staff. Providers also describe that how they are owned, with regard to the form of association, matters for their work environment.

The findings regarding motivation behind action confirm previous research (see Vengberg et al., 2019) that shows that the assumption that owners of primary health care clinics in Sweden are first and foremost profit maximisers, as stipulated in the theoretical assumptions of the quasi-market model, does not hold.

Notably, I show that the private sector group of providers is not homogenous, and that size of owner may matter more than if the owner is public or private, where private providers, with large owners (sometimes private-equity owned), are, according to interviewees, more motivated by revenue generation than private providers owned by small owners (who often work in the health care practice) who, for instance, are more concerned about the work environment. Similarly, Karlsson and Lilja (2013) highlighted performance differences between private providers, between owners who worked in the primary care unit and those owned by larger owners.

Lastly, I find that discussions around what type of owners and size of the units that were desirable for the primary care quasi-market when the reform was introduced and thereafter have been absent in the policy debate in the Stockholm Region. Yet, I show that both ownership and size, and particularly the latter, seem to matter for providers in the market and public authorities who regulate the market.

Chapter 6 also highlights the risks involved if the smaller providers would exit the market, and the market would consolidate, as there are indications in my interviews with the providers that large private owners use profit maximisation strategies that span different health care markets. For instance, patients are referred within the same health care company from primary care to secondary care, even if the issue should be treated in primary care, because treatment in secondary care generates higher reimbursement.

These strategic and opportunistic behaviours of large for-profit–driven health companies may currently be cushioned by the professional ethos of the providers, but they highlight the importance of an attentive and authoritative regulator that does not look at one market (e.g. primary care) in isolation but across health care markets (to, for example, secondary
care, but also across geographies beyond the regional level), particularly as the providers
grow larger in size and become more powerful as well as sophisticated.

Related to this finding, the chapter also shows the complexity of policymaking in this
quasi-market, as policy decisions do not only impact how the providers are paid but also
have secondary effects on the market structure. For instance, when fee-for-service
payments were reduced, it created a barrier to enter the market for providers that did not
yet have a list of patients that generated capitation payments and did not have access to
start-up capital from other sources (e.g. providers with small private owners).

8.2.3 Research question 3: How do stakeholders perceive the impact of the
governance system on quality of primary care services?

Summary of main findings:

- Regarding quality of care, the main governance mechanism used is performance
monitoring, through the collection of data on providers, triangulated from different
sources, that is analysed and communicated to the providers on a yearly basis. There is a strong focus on data on access to care and a notable lack of data on medical outcomes (perhaps the most meaningful indicators of primary care performance).

- Public officials also struggle to access key data. There is confusion concerning
who should do what in the governance system, which creates an impasse for creating a performance monitoring system that collects fewer and more relevant indicators on quality of care.

- Most data, even that which triggers payments to the providers, is self-reported by providers. Public officials see the governance system as highly dependent on trust amongst market players. It assumes that providers do not have deceitful intentions.

- Providers expressed considerable scepticism that the output of primary care services is appropriately measured by the public authorities and perceived that public authorities focus on the “wrong things” (e.g. quick access to care), which are easy to measure, rather than factors that are the most important from a quality
of care perspective (e.g. continuity of care, medical outcome indicators). At the same time, they call for more “air” in the system for reflection and less micro-management to enhance quality of care.

With regard to governance mechanisms used by public authorities to achieve quality of care, I found that the primary mechanism is performance monitoring. The SRHCO collects data from different sources, analyses this data, and communicates it to the providers on a yearly basis. What is striking when studying this data in detail is the absence of data on medical outcomes in the Stockholm Region, except for one indicator related to diabetes. It appears that authorities are focusing on collecting data that is accessible (primarily process indicators) rather than designing a system that collects the most meaningful data for monitoring quality of care. Due to legal restrictions and the fragmentation of the information management systems, they also face challenges in accessing key data points. The lack of medical outcome data makes it challenging to know if quality of care improvement programmes are effective.

Another key observation in Chapter 7 is that most indicators that the public authorities collect are self-reported by providers, including those that generate payments. Thus, there is no regular verification mechanism of self-reported data before payments are made to the providers. The SRHCO only does verification upon suspicion and states that the governance system relies on trust and providers having “clean sheets” (interview with staff at the SRHCO).

While stakeholders perceive that the mechanisms of governance are able to detect providers who engage in misappropriate behaviours over time, largely thanks to user feedback and professional norms, the finding that the governance system mainly relies on trust and that the providers do the right thing is concerning. It raises the question whether the system is robust enough for providers that deliberately want to find loopholes in the governance system to, for example, engage in opportunistic behaviour, and who break current norms and professional conduct.

Another important finding with regard to governing for quality of care is that the purchaser takes a rather passive role in developing a governance system that is able to monitor providers and hold them accountable for providing quality of care, in the sense that they
call on other government agencies to, for example, define terms and concepts related to quality of care. At the same time, the larger owners of services providers are engaged in these type of activities (defining concepts and terms of monitoring indicators), which would benefit from regional and national harmonisation.

This finding in my data is consistent with previous research at the national level, which shows that “there are tendencies for the state to deal with the problems that the regions should solve. At the same time, the regions are trying together to solve the problems that should essentially be a national level concern” (Anell, 2020, p. 11). I add to this observation by showing that in the Stockholm Region there is confusion concerning who should do what in the governance system, between national and regional as well as organisational (owners) levels, which creates an impasse for creating a performance monitoring system that collects fewer and more relevant indicators on quality of care, ideally comparable across regions. Currently, stakeholders at lower levels of governance (e.g. owners) have taken on tasks that would benefit from being solved at a level higher up in the governance system.

The heads of units perceive that the public authorities are focused on the “wrong” things in their data collection to ensure quality of care. They state that the Stockholm Region is focused on what is easy to measure rather than what is meaningful to measure, with a myopic focus on patient “access”, which is only one dimension of quality of care. This finding is in line with Vengberg et al. (2019), who found that the only aspect of quality that providers mention as key for attracting patients was user accessibility.

With regard to quality improvement programmes, the providers call for less micro-management by the purchasers and more “air” in the system for them to be able to reflect on how quality of care could be improved. Both owners and public authorities collect quality indicators from the providers. Unit managers indicate that they find it inefficient with different types of monitoring systems, and, over time, the lack of coordination between owners and public authorities could undermine data quality if it leads to reporting fatigue amongst providers.

Finally, providers perceived a challenge with the current system being the constant switching of patients from one provider to another. Based on this, I discuss the inherent
contradiction in the Choice model with regard to quality of care, namely that while the switching between providers is in theory driving quality of care, as providers compete for revenue, it may in practice have a negative impact on quality of care as it leads to less continuity of care, a critical predictor for quality of care at the primary care level. In fact, recent research (Swedish Agency for Health and Care Services Analysis, 2021) confirmed that the share of adults who say that they have a fixed physician contact decreased during the 2010s in Sweden as the PCCRs were introduced. I conclude that the fact that choice also seems to have a cost in terms of continuity of care is rarely discussed in economic literature on quasi-markets.

8.2.4 Answering the Aim of this Thesis

In summary, my exploration of the governance system of the primary care quasi-market in the Stockholm Region, as perceived by different stakeholders, shows that financing (in the form of supply-side financing determined by the Compensation model) is the main driver of incentives, yet these appear to be moderated by the inner compass of medical professionals, highlighting the importance of professional values and ethos in shaping the governance system. The governance system consists of detailed rules on paper that are to some degree replicated in use, although the public authorities have limited accountability mechanisms and seem largely dependent on trusting that the providers act according to these rules, especially in the early years of the PCCR when the public authorities struggled to exclude providers, who did not comply with the rules, from the market.

With regard to competition and quality of care, the governance system has succeeded in creating market competition that in turn has helped to sustain choice and possibly also quality (although it is difficult to know as medical outcomes are hardly measured and most indicators are self-reported) overtime. However, with smaller private owners expressing that they feel treated unfairly, there are concerns that they will eventually exit the market, and the risks involved with market consolidation, and less competition, could erode good outcomes over time as well as patient choice.
My examination highlights the complexity involved in governing a quasi-market for public authorities. Key challenges include establishing meaningful measures of quality of care, holding providers accountable for complying with rules on paper in practice, creating a level playing field in the face of providers who play different roles and are subject to different market conditions in connected markets, and the risks associated with business-driven behaviours by profit-maximising agents.

The providers also give testimony to the complex task of governing quasi-markets, as they perceive their actions to be influenced by different accountability relationships they have with various principals — public authorities, organisational owners, and their own professional ethics associated with their medical profession, which do not always pull in the same direction. When reflecting on this resulting complexity, providers emphasised their values and professional ethics as the primary influence on their behaviours. Both providers and public authorities perceive that the governance system could improve with more dialogue between the two and this could possibly be a way to overcome the perception by the providers of not being on the same team as the public authorities and a means to build trust.

8.2.5 My Findings in Light of Existing Theory

Considering my key empirical findings on the governance system in the primary care quasi-market in Sweden, in light of existing theory used in this thesis, I find that actors in this market do not necessarily act according to the theory of the quasi-market.

On the demand side, it is first important to stress that this thesis does not interview consumers/users of primary care. Consequently, my discussion on the demand draws on interviews with providers and the purchaser. Yet, from the providers’ perspective there are indications from my empirical data that demand for services does not respond to variations in quality of care but rather to accessibility of care. Access is an observable dimension of quality that is easy to measure, and this finding is in line with Dixit’s (2002) theoretical prediction that when public services are exposed to competition and privatised, focus may shift to observable dimensions in the eye of the consumer, while some
unobservable dimensions may suffer. This finding is also in line with Winblad et al. (2017), who find that private providers seem to focus on service aspects (e.g. offering different food alternatives) rather than structural prerequisites for good care (e.g. number of employees per resident) in the quasi-market for elderly care in Sweden.

I cannot claim based on my data that other unobservable, yet important dimensions of quality, receive less focus in the primary care quasi-market, since that question was not explored in my research. This is also difficult to determine given the paucity of medical outcome data in this market. But it is plausible, given the strong focus on timely access to care in the governance system. Should it be the case that unobservable, but important dimensions of quality, are neglected, then the fact that service providers stress that they are primarily guided by their professional ethos, and serving the patients, is likely cushioning against adverse impact on quality of care from the shift in focus to observable dimensions.

Now, turning to the supply side, the theoretical prediction of the quasi-market theory, that providers are profit maximisers in response to competition does not hold. Similar to Vengberg et al. (2019), I find that it is more complex than that in my case study. My empirical data shows that providers perceive their actions to be influenced by a range of mechanisms employed by a variety of principals at different levels — public authorities, organisational owners, and the professional ethics associated with their medical profession. When reflecting on this resulting complexity, providers emphasised their values and professional ethics as the primary influence on their behaviours. This is also in line with previous research that emphasises the belonging to a professional group (Freidson, 2001; Mosher, 1968; Roberts & Dietrich, 1999) and intrinsic motivation as major drivers of behaviour in the health care sector (Besley & Ghatak, 2005). Even in private units, which one would expect to be more motivated by profit, the professional ethos, according to the providers, guides them more than higher-level rules. Another prediction of the theoretical model, that is, that providers meet whatever demand is generated (Brekke et al., 2014), also does not seem to hold completely as work environment seems more important for public providers and small private providers than to expand the organisation to gain more profit.
Notwithstanding the finding that professional ethos (intrinsic motivation) primarily drives provider behaviour, according to providers themselves, both providers and the purchaser state that the Compensation model (i.e. financial incentives) is the most powerful mechanism that the public authorities have to govern the market. That financial incentives, and not professional ethos, is mentioned as the most important instrument for governing by all stakeholders may be because professional ethos is not considered by stakeholders as a governance mechanism, although it appears to be an influential indirect tool of governance, as providers describe that it influences their behaviour substantively. However, this mechanism is practically very challenging to use for the purchaser to change provider behaviour — it is neither easy nor fast to change professional ethos.

With regard to the governance of quasi-markets, my research gives testimony to the complexity involved in and effort needed to steer these markets. Public authorities actively govern through multiple mechanisms and are constantly tinkering with the rules of the game. Yet, it remains unclear if the public authorities are able to hold providers accountable to comply with the rules with regard to ensuring that providers maintain standards of quality of care and refrain from cream-skimming. These findings confirm the predictions of the theoretical literature on economics of contracting, which point to the issues (and consequently high transaction costs) involved in contracting complex services such as health care. This includes in specifying need, monitoring output, and in creating contracts that regulate opportunistic behaviour (Allen, 2009) in a sector where the damage in quality of services from reducing cost is high, and where there is limited ability for consumers to assess quality of services (Hart et al., 1997).

In line with Allen (2009), I show the challenges face by the purchaser in monitoring quality of output (Chapter 7) with regard to, for example, accessing key data (outcome indicators) and collecting objective data (not self-reported). This is also confirmed by providers, who express considerable scepticism that the quality of services is appropriately measured by the public authorities, where they perceive a focus on the “wrong things” (e.g. quick access to care), which are easy to measure, rather than factors that are the most important from a quality of care perspective (e.g. continuity of care, medical outcome...
indicators). Another challenge is that both owners and public authorities collect quality indicator data from the providers, which unit managers find inefficient.

Turning to the question on ownership, Hart et al. (1997) stipulate that ownership of government services does not matter for government services if there are complete contracts. Judging by my findings, this does not appear to be the case for the primary care quasi-market in Stockholm, as explained above.

According to theory, the case for privatisation is stronger when quality-reducing cost reductions can be controlled through contract or competition, when quality innovations are important, and when powerful unions are a problem inside government (Hart et al., 1997). My empirical data did not reveal much with regard to how private ownership has impacted quality innovation, though it is possible that it has had a positive impact. I also do not explore the influence of unions inside the government. It is however clear from my findings that it is challenging to control quality-reducing cost reductions through contract in this market. Yet, my findings indicate that a combination of pressures from competition and professional ethos has hindered quality reductions in the Stockholm primary care quasi-market. I highlight that there is a risk that there will be less pressure from competition if more market consolidation happens. I stress that small private providers describe how they are struggling in this market, where the public authorities strive for equity rather than equality in market conditions. The risk for increased consolidation is concerning, because according to theory, it is critical to maintain a high level of competition in this market.

8.2.6 Contribution to Scholarship

Previous sections in this chapter discuss the main findings of this thesis, and how they relate to previous research and existing theory. In this section I summarise the most important broader intellectual contribution of the thesis.

Inspired by Saltman and Duran’s (2016) conceptualisation of governance, as happening on different levels (micro, meso, and macro), and Glenngård’s (2019) call for more research on governance that captures the perspective of actors that are being governed,
I included providers with different ownership characteristics in my sample. This included both public and private providers, but also small and large owners within the private group. The empirical evidence from the interviews with these providers of different ownership characteristics revealed some of my key findings, namely that ownership is an important variable in relation to quasi-market governance. I find that providers perceive their incentive environment to be influenced by a range of mechanisms employed by various principals including the owners and it is clear from my research that the owners’ directives influence the providers. This is also confirmed by my interviews with owners that show that larger owners, which own several health care units, influence their providers both through explicit (e.g. use of balanced scorecards) and implicit (e.g. culture) governance mechanisms; this pertains to both large public and private owners.

While Jakab et al. (2002) showed, in their study on hospitals in eastern Europe, that one of the four sources of performance pressures in the external environment is the owner, the role of the owners in shaping the governance system, and particularly in quasi-markets, has largely been neglected in the literature. My study is one of the first to show that ownership pressure is an important variable to consider in the primary care quasi-market in the Stockholm Region.

Another important contribution to scholarship is that I find that motivation behind action differs somewhat by ownership of the unit, where the perception amongst heads of units is that large private owners put more emphasis on revenue generation first as opposed to smaller private and public clinics that describe how they are primarily motivated by providing the best care for patients and a good work environment for the staff.

This finding is important in itself, but also because it shows that the private sector group of providers is not homogenous, the size of the owner within the private provider group seems to matter for behaviour. There are numerous empirical studies comparing how public and private providers perform on various outcome variables (see Section 3.3.4). Based on my results, this dichotomous way of seeing ownership, where the private providers are often assumed to be driven by profit maximisation, may not be a helpful way of describing reality. Rather, more nuanced approaches when studying motivation of actors regardless of ownership and ownership differentials would be helpful.
Related to the above and as mentioned previously, a key contribution of this research is that I show the complexities involved for the public purchaser to govern the quasi-market. Key challenges including establishing meaningful measures of quality of care, holding providers accountable for complying with rules on paper in practice, creating a level playing field in the face of providers who play different roles and are subject to different market conditions in connected markets, and the risks associated with business-driven behaviours by profit-maximising agents. I also show that policy decisions, for example, in the Compensation model also have secondary effects on the market structure. The complexity is further highlighted by the finding that there are different layers of governance that influence the behaviour of the providers. The providers perceive pressures from different principals: their own professional logic, the owners, and the public authorities, which, according to the providers, are not always aligned.

The providers stress that their professional logic is more important for their action than higher-level rules. The finding that the inner value system of the professionals is key to the governance system is an important contribution to scholarship. In practice, this means that the governance tools from the purchaser and the owner may only have limited impact on provider behaviour, if these rules are not consistent with their professional ethos.

This is an important finding because on the one hand it can safeguard consumers and the society at large from opportunistic behaviour by specific owners, for example, cutting cost at the expense of quality of care. On the other hand, it may also mean that attempts to manage the market in a certain direction that is not in line with the professional ethos may be ineffective.

While I see that the professional ethos influences the functioning of the quasi-market, my research begs the question if the quasi-market also influences the professional ethos and how it evolves. What influences it? And, are there breaking points when providers start to abandon their inner compass for other motivations? These are critical questions to study in the future, and particularly important to consider in contexts where the governance system is largely trust-based, as reported by public authorities in the Stockholm primary care quasi-market.
8.3 Policy Questions That My Key Findings Give Rise To

In the subsequent sections I reflect on my key findings and the policy questions that they give rise to.

8.3.1 Interest Holders in the Primary Care Quasi-market Governance System and their Power

A cross-cutting and underlying theme of the key findings in this thesis is that there are various interest holders in the governance of the primary care system in the Stockholm Region, and whose different perspectives often, as observed in Chapter 5, create conflicting pressures that are perceived amongst staff who work close to patients and managers of health care units.

As mentioned in Chapter 4, Alford (1975) categorised interest holders in western health care systems and the political relationship between them and identified three major categories: (1) professional monopolists (e.g. doctors in clinical practice); (2) corporate rationalisers (e.g. civil servants in government carrying out the political directions); and (3) the community (e.g. users and patient advocates) (Alford, 1975).

These categories of interest holders, described by Alford (1975), also appear as shapers of the governance system in the primary care quasi-market in Stockholm. What Alford called the professional monopolists, which includes the managers of the health care units who often are still practicing primary care, or at least have a clinical background, have a strong professional ethos of putting the patient first and they say this guides their behaviour, particularly when there are conflicting values in the governance system. The staff at the SRHCO are what Alford called corporate rationalisers as they are carrying out the political direction through various mechanisms of governance that give rise to the incentive structures, through, for example, the compensation system. The community, particularly users, shape the governance system through submitting complaints to the SRHCO regarding providers who are not acting appropriately, as well as through their choice of caregiver, which drives revenue and therefore competition amongst providers.
The findings of this thesis also highlight that in the primary care quasi-market in Stockholm there is a fourth interest holder, not included in Alford’s analysis, that is shaping the governance of the primary care quasi-market system. These are the owners of the primary care health care units. Sometimes they are one or a group of professionals who have come together to start a clinic, sometimes they are large organisations, owned by holders of private equity, or the government (as is the case of the SLSO). As seen throughout my empirical data, the owners, particularly the larger ones and both public and private, govern their units with regard to, for example, programmes for improving quality of care, business strategies, and culture and they also collect performance indicators, which in turn influence the providers’ behaviour.

My empirical data also indicates that the motivations of providers differ by ownership status, where small private owners, for instance, are more motivated to create a good working environment than larger private corporate owners that are more focused on maximising profits. Thus, the owners are important interest holders in the primary care quasi-market in Stockholm. My findings are in line with Williamson (2008), who, in applying Alford’s framework on the UK National Health Service, also recognised that health care services have become more complex since Alford’s categorisation was presented, where, for example, pharmaceutical industry and private health care have become important stakeholders.

The empirical chapters also show how the state has different roles in the primary care quasi-market in Stockholm. It is no longer just a health care provider (through the SLSO), but a financier of health service and a regulator of the primary care market (through the Healthcare Committee SRHCO). This observation based on my empirical data, of a state that is playing many different roles, is in line with Moran’s (1995) article ‘Three Faces of the Health Care State’, which examines the multifaced roles the state plays in the health care system.

He described the health care state as a sub-system to the welfare state that assumes three forms, namely the state “as the regulator of patient care conditions, as the participant in competition among producers of health care goods and services; and as the arena in which distributional conflicts occur” (Moran, 1995, p. 770). In other words, the
state balances its role as a regulator of the market that puts the patient first, a supporter of large national health care companies that compete in a global economy and employ a large number of citizens, and distributor of economic resources, including money, jobs, and prestige in the society. Moran described the tensions between these three faces of the health care state and the balancing act between these different roles.

Moran’s conceptualisation of the state’s different roles helps to understand the complexities involved in managing health care for the state. And those are likely to intensify in the face of competition, in a quasi-market, where the state on the one hand must make sure that the market delivers to patients, but also to the owners of the private companies as well as to the professionals, and other beneficiaries of public resources.

It is important that the Stockholm Region is aware of these dynamics and related complexities and realise that by serving the public interest objective they will be subject to push-back from different interest groups that may have other objectives. This implies that public authorities will get push-back from interest groups, whatever policy options they pursue. If they ask for more quality of care indicators, the capital owners, and the providers, will push back, but this is not necessarily bad, as it may serve the public interest objective to have better measurements of quality of care.

It is also important to realise that by opening the market to private providers, their power increases and so also may their resistance to critical reforms in the public interest. In this “dance”, it needs to be crystal clear where the public authorities stand and what public interest objectives they want to achieve, as this will help in advancing critical reforms to improve the market’s fit for purpose, although they may not be liked by all stakeholders.

8.3.2 Can the Choice Model Ultimately Limit Patients’ Choices?

The prominence of the private owners as an interest group increased with the introduction of the PCCR, as the number of privately owned clinics in the Stockholm Region grew (Dahlgren et al., 2013). Despite this, a surprising finding of this thesis is that staff at the SRHCO indicate in the interview data that there were limited discussions, when the reform was designed, about this or related issues such as desirable characteristics of owners
and market structure, although market structure is critical to achieve competition, a key requirement for the functioning of the quasi-market and for reaping the benefits of private provision.

This finding is curious. This may be because of naivete and limited experience with market forces from the public authorities. However, technical staff at the SRHCO say that they foresaw certain structural changes in the market, such as market consolidation because of acquisitions of private providers with small owners (who often worked in the practice).

The absence of discussions about the potential increase in prominence of private owners and large commercial entities in the market, when the reform was designed, and how the public authorities should handle that, may also have been deliberate. It could be an example of what has been described in the literature (e.g. Chung, 2019; Mounk, 2018) as a tendency for neoliberalism to depoliticise by “pushing out issues beyond the scope of political decision-making” (Chung, 2019, p. 54) and reducing moral and political decisions to economic calculations (Brown, 2009), where markets are rational, apolitical, and unrelated to powershifts (Wong, 2020). Mounk (2018) described this type of phenomenon as a creeping erosion of democracy as it reduces the population’s ability to understand and influence policy.

Connected to this issue is also the use of vague concepts such as “diversity” (as shown in Chapter 2) rather than more precise terms such as an increase in private options or smaller owners, in key documents used when the PCCR was introduced. Wisell et al. (2019) found that policymakers held different ideas about what “diversity” meant in the context of the pharmacy and primary care liberalisation reforms in Sweden.

This missing narrative about increasing the number of private providers, and thereby the power of private companies when the reforms were introduced, may have been a calculated move by governing politicians — by keeping the language and concepts around the PCCR ambiguous, it diverted attention from important and complicated issues such as privatisation, power dynamics, and market structures. Through the creation of a narrative around “choice” rather than, for example, privatisation, the reform most likely met less resistance. Who does not want to have choice? However, this lack of focus on these important and complicated issues, may have also led to the development of a
A governance system that is primarily focused on standardised treatment of all providers, rather than shaping the market structure in the public interest, taking into consideration the size of different providers and what conditions they face.

An important finding of my research is that despite the policy of creating the same conditions for all providers, private providers with smaller owners complained that they received information later than larger providers, and have a harder time complying with environmental standards, etc. Overall, they felt unfairly treated in the current governance system and questioned if they are wanted in the market. At the same time, public authorities expressed a preference for larger providers. Here, the inequity in treatment from the purchaser seems to be more along the dimensions of size of owners (small and large) rather than ownership (public and private), where smaller providers fare worse.

As described in this thesis, the nature of primary care business and the initial conditions of the Stockholm market when the reform was introduced were such that relatively little capital was needed to enter the market, which in turn facilitated market consolidation. The market had low barriers to entry. But after a few years, when a health care unit had listed many patients, the value of the business increased substantially. At this stage, it was challenging for a single or a group of health workers to purchase the unit, and more likely it would be acquired by a larger commercial entity, sometimes owned by private-equity holders.

Given the purchaser's current way of governing the market, where smaller providers perceive that larger organisations are advantaged, and where there is limited focus on regulating market structure, the nature of the primary care business, and indications of market consolidation (National Competition Authority, 2014), there is a risk that without intentional policies to keep smaller providers in the market, horizontal integration could continue as large commercial entities, keen to grow market share, would continue to acquire smaller private providers. Eventually, this could lead to the market structure changing towards more of an oligopolistic market structure with reduced competition.

In a market dominated by a few large providers, choice could quickly evaporate. This would be an ironic outcome, which goes against one of the fundamental principles of the PCCR, when it was introduced (see Chapter 2), namely the freedom of choice through a
diverse set of providers. The market could turn from monopolistic competition to oligarchy, with powerful large companies exercising more and more leverage on policy decisions. What appeared like an expansion of freedom, where each individual can choose their provider, suddenly risks turning into a limitation of freedom, and even a worse situation than previously, where the state is dependent on a few large influential corporations to provide primary care to the population.

Most importantly, the current staff working in the Stockholm Region seemed unaware of these issues as they were never raised as major challenges. The current governance system does not seem designed to head off this problem as authorities seemed to have assumed a market in equilibrium, but markets are unpredictable. More than a decade since the PCCR was first introduced, the market has already changed in many unpredicted ways — for instance, digital or hybrid digital/physical providers now make up a large share of service providers.

This raises a question about the public authorities’ ability to regulate the market for less rather than more market consolidation and thereby shape market structure and safeguard patient choice and interests. To protect the public interest over the long term, public authorities need to be able to address this issue.

The National Competition Authority would be well placed to support the regional authorities in these matters. After the national law was passed that introduced the PCCR, the National Competition Authority had three different assignments to monitor the introduction in the reform between 2009 and 2014. During this time, data was collected nationally on the size of the different owners and their influence to monitor market structures. However, since this time, the National Competition Authority is not involved in supporting the regional authorities to manage these markets (written communication, 2021) nor are they collecting the data centrally. They could become more involved and support the regional authorities and this would, in my view, be desirable.

Moreover, as shown previously, my research indicates that larger private corporate providers (often private-equity owned) are using profit maximisation strategies between different levels of care, where patients are referred to higher levels of care for procedures that could be carried out in primary care because these procedures yield higher
reimbursements in secondary care. This is something that the regulators need to pay more attention to, and given how the SRHCO is organised, where one department regulates, for example, primary care, it might be more difficult to detect these types of business strategies for a regulator that is only seeing part of the system. Similarly, it may be difficult for the public authorities, with their current set-up, to detect vertical integration business strategies, where businesses expand and gain a market advantage by acquiring other companies that operate in other areas of care.

There is actually a recent example in the Stockholm Region where a large private primary care provider (Kry) was very close to acquiring a firm that manages the centrally managed and publicly funded health care counselling business in Stockholm (called 1177), which would have given the provider an information advantage in the primary care market (Isacson & Awad, 2021). This acquisition did not initially raise any red flags on the part of the public authorities. However, after public pressure, the politicians in the Stockholm Region stopped the acquisition (Swedish Radio, 2021). Yet, the fact that this acquisition was only obstructed once the public raised their concerns, provides signs that the current market regulatory function is not sufficiently strong for the complexities involved in managing several health care markets with aggressive owners and providers who use profit maximisation strategies.

### 8.3.3 Putting Patient Outcome Before Patient Choice

A key finding of Chapter 7 is that few outcome variables are collected in the governance system and that the SRHCO takes a rather passive approach to designing the monitoring system, where they focus on available data rather than mandating the providers to report the data they need to hold the providers accountable for delivering quality care to patients. Moreover, my research shows that certain principles such as that all providers must have the same conditions have been important for guiding the governance system.

Reflecting on these findings, and the fact that the budget document clearly states that patient choice is in the first room, raises the question if the public authorities were and are still more concerned with putting patient choice and market dogma first rather than
patient outcomes. This is also confirmed in national level research, with Wisell et al. (2019) pointing out that patient health was never a topic of focus in the parliamentary debates leading up to the national primary care liberalisation reform.

For, if the Stockholm Region were primarily focused on implementing the Health and Medical Service Act (Sveriges Riksdag, 1982), which stipulates that the most important goal for Swedish health care is good health for the entire population on equal terms with respect and dignity of all human beings, then why is it that the Stockholm Region is not more interested collecting data to determine if this policy objective is met? A key question becomes if the market is working to achieve the policy objective stipulated in the law, or if the policy objective is being sacrificed for ideological principles or a market doctrine.

If the latter holds, the state is abdicating its responsibility and accountability to enforce the Health and Medical Service Act. Wendy Brown (2019), drawing on Lemke (2002), discussed how neoliberalism shifts “the regulatory competence of the state onto ‘responsible’, ‘rational’ individuals [with the aim of] encourage[ing] individuals to give their lives a specific entrepreneurial form” (Lemke, 2002, p. 202). There is some shift of responsibility from the state to the individual in the primary care market in Stockholm, as the individual is, in this governance system, responsible for choosing the provider with highest quality of care and, as my empirical data shows, plays an important role in reporting non-performing providers through grievance mechanisms.

There is also a shift in the state’s responsibility for providing quality care, onto the owners/providers, evidenced by the fact that the governance system is largely trust based and lacks robust mechanisms for monitoring quality of care and for holding the providers accountable for delivering good health to the entire population. Moreover, and as pointed out by Fredriksson (2013), the political representation at regional level relinquished their power to, for example, decide where to set up a new primary care centre, as a result of the creation of a quasi-market for primary care.

While this thesis did not examine the state’s responsibility and accountability for implementation the Health and Medical Service Act, my findings indicate that in the current governance system, responsibility lies with different actors and accountability is blurred. This makes it more difficult for the state to ensure the law is implemented.
An important observation made in this examination of the governance system of the quasi-market in Stockholm and related to the above discussion, is that Sweden’s overarching current decentralised model of governance, where the 21 regions are running regional health care systems, seems more appropriate for a hierarchical governance structure, where it is important that elected leaders have better knowledge of the local context, than for a quasi-market type of model. This is because in a quasi-market governance is highly complex and it is of critical importance for the public authorities to regulate it well to meet public interest objectives and to have leverage in negotiations with large corporate owners, whose businesses stretch across regions. Thus, this raises the question whether the primary care quasi-market governance system would perhaps improve if it was managed at the national level or at least that the regional authorities received more structured support in their regulatory function, from key national authorities such as the Swedish National Competition Authority.

The debate about abolishing the 21 regions and making health care a responsibility of the Ministry of Health and Social Affairs has come to the fore again during the COVID-19 pandemic in Sweden (e.g. DN, 2020a), when the three levels of government pointed fingers at each other and it was difficult to know who to hold accountable. If this leads to a change in the overall governance system in Sweden in the future, where more power is consolidated at the national level, this may also contribute to more leverage for the state in negotiations with the providers, and particularly larger owners, and consequently improve the governance system of the quasi-markets in primary care.

8.4 Contribution to Policy Debates at National and International Levels

The proponents of the quasi-markets often argue that whether the provider is public or private does not matter if the market is well governed, and if the same rules apply to all providers, or in Hart et al.’s (1997) words if there are complete contracts. This thesis has provided important knowledge about the governance of the primary health care quasi-market and the practice of governance from the perspective of those who govern the market and those who are being governed, based on the Stockholm Region case study.
Overall, it does not challenge the idea of a quasi-market or of private sector participation in primary health care markets per se, as the latter could be potentially positive, perhaps even necessary, to reach public health objectives. The thesis does, however, suggest that for quasi-markets to deliver on public interest objectives, a strong governance system, with strong performance monitoring and accountability functions, is a sine qua non.

While providing policy recommendations is beyond the scope of this project, the thesis points to several areas of critical importance for policymakers in both Sweden and elsewhere to consider. Main contributions to the policy debates at national and international levels are discussed in subsequent sections and summarised below:

Recommendations for public authorities in Stockholm:

- Strengthen the measurements of quality of care and make data publicly available to better hold providers accountable for delivering quality services and support patients in their choice process.
- Systematically explore if value systems of owners are aligned with public interest objectives.
- Limit presence of owners that, for example, constantly seek loopholes in the regulatory framework because of high-profit hunger and/or step up regulatory capacity to curb these behaviours.
- Examine and encourage potential new forms of associations that may be conducive to, for example, better working environments for staff.
- Strengthen the dialogue with the providers to, for example, monitor impact of policy decisions and systematically bring in the professionals’ perspectives when formulating and evaluating policy.

Recommendations for policymakers considering a quasi-market reform:

- Have clarity around the public interest objective and a strategy for measuring the output that the providers are expected to deliver to reach that public interest objective. See patient choice and the quasi-market as a means rather than an end goal.
• Contemplate what kind of owners and forms of associates are desirable in the market to achieve public interest objectives and formulate policies to encourage entry of these owners.

• Ensure that market regulators are fit for purpose and have the required skills and data (see above), including expertise in, for example, antitrust economics or competition policy.

• Develop strong dialogue with professionals to ensure efficient market regulations. Time spent in dialogue with providers must be reimbursed by public authorities as it takes providers away from revenue generating activities.

8.4.1 Performance Monitoring

Despite large efforts by both providers and the public authorities to capture a large number of indicators, Chapter 7 shows that it remains challenging to collect meaningful and objective (not self-reported) indicators on quality of care, which offers an indication to the purchaser as to whether or not quality services are provided in the market. The SRHCO and the providers agree performance monitoring systems need to evolve and enhance focus on medical outcome measures.

Thus, for policymakers considering a quasi-market choice reform, it is important to learn from this example, and before embarking on implementation have clarity around the public interest objective and a strategy for measuring the output that the providers are expected to deliver to reach that public interest objective.

This is particularly important if demand is sluggish and policymakers for some reason suspect that patients’ ability to know where they will receive best quality of care is challenged, and therefore the market mechanism may not work fully. A critical question for policymakers to contemplate is also if certain types of providers may take advantage of such a situation and engage in opportunistic behaviour, by, for example, skimping on quality of care, and in such a case, limit their entry in the market (see subsequent section).
In the case of Stockholm, where the PCCR has already been implemented, it is of critical importance to improve the measurements of quality of care and make data on provider performance publicly and easily accessible. This will help both the public authorities and the users to exercise their choice of the providers who provide highest quality care. As mentioned previously, the urgency of strengthening this part of the governance system seems higher in a market such as in Stockholm, where there are limited restrictions on ownership, where market forces are strong and there is a high risk that providers skimp on quality.

As expressed by the SRHCO, mandating and incentivising primary health care providers to report on more outcome measures (currently, providers are only obliged to report to the diabetes registry) and improving the information system and data infrastructure so that, for example, the purchaser has easy access to anonymised medical journal data from all providers, are steps in the right direction. It is important that an inclusion of more meaningful indicators is coupled with dropping the collection of other indicators that are burdening the providers but are not necessary in helping to understand if the providers deliver on the public interest objective.

SALAR has a promising initiative called Primary Care Quality (Swe. Primärvårdskvalitet) that produces evidence-based primary care quality indicators consistent with national guidelines, together with medical professionals. The indicators are extracted automatically based on data in existing sources, such as medical records data, drug data, and patient administration systems (Primarvardskvalitet, n.d.). As of now, these quality indicators aim to provide a broad picture of primary care operations and support local quality improvement work (Primarvardskvalitet, n.d.). In the future, they could be a starting point for collecting and monitoring a standard set of indicators on quality of care across the country.

Many of the recommendations from the OECD’s Review of Health Care Quality in Sweden (2013) still seem relevant for the Stockholm Region; these include: establishing a broader range of quality indicators in the primary care and community health services that are comparable across regions, better using the quality indicators that exist, developing comprehensive data standards, classification systems, and data sets for
primary care, and reforming quality registers so the necessary information is pulled directly from medical journals/consultation notes, rather than requiring separate submissions for each disease.

The Stockholm Region could also glance at other quasi-markets for inspiration when strengthening the performance monitoring system. For instance, for elderly care in the Stockholm Region, the quality monitoring system seems more developed than in primary care. It collects data on structural, process, and results measurements, through regular monitoring of the unit, quality observations, and patient surveys as well as inspections. Furthermore, the elderly care quality assessment has a clear roadmap for coming up with actions that the providers need to take and for communicating the results, including: (1) analysis of results; (2) dialogue with the provider; (3) assessment; and (4) formulation of measures of correction (Stockholm City, 2019). The data in the assessment is shared with the provider, at the political level, and also with the public.

Surveys using clinical vignettes and unannounced standardised patients, or so-called mystery patients, could also be used in the primary care system to complement existing efforts and measure the quality of physicians’ practices as well as unnecessary care (Peabody, 2014).

A similar system for monitoring quality of care as the one used in elderly care could also improve the dialogue between purchaser and providers, as requested by the stakeholders, and help bridge the perceived divide, expressed by unit managers, between those who regulate the market and those who work in “the reality” as it would bring staff at the SRHCO closer to the units through, for example, inspections and monitoring visits.

8.4.2 Ownership Matters

The thesis shows that the owners have a bearing on the action of the providers and the governance system in the primary care quasi-market in Stockholm. It is therefore critical for policymakers to understand if the value systems of the owners are in alignment with achievement of the public interest objectives and how the owners manage the providers. Furthermore, it is important for public authorities to have a clear vision for what types of
owners and market structure are suitable for delivering on the public interest objectives and set objectives and market rules accordingly. This type of work by the public authorities of creating a common set of values and knowledge is common in the network governance mode (as described in Chapter 1). While common values seem to exist amongst the medical professionals and heads of units, most likely instilled in them through their medical education, there are indications in my data that the owners of primary care facilities may not have the same common values.

Furthermore, my data shows that private providers are not a homogenic group in this market, so it is important to go beyond the simple dichotomy of public and private and encourage those providers who are most likely to deliver on the public interest objective (e.g. those who put purpose or patients before profit), whether public or private, to operate and stay in the market.

Ownership and management reviews are conducted in other parts of the Swedish welfare system. In 2018, the Swedish Parliament adopted a new law (Sveriges Riksdag, 2018) that increased requirements for procurements in the welfare sector, including a requirement of ownership and management review of providers in areas such as home care, companion service, and education. The health sector was not included in this law as further examination was needed to determine whether an ownership and management review was needed in this welfare area (Sveriges Riksdag, 2018, p. 11), but this could be included in the future.

Having strict control of what type of owners one lets enter the market is also common in other countries. Vlachos (2019), in his research on quasi-market reforms in the education sector in Sweden, has compared Sweden’s education market to the US charter school market. With regard to market entry of charter schools, he pointed to 12 essential success factors that NACSA, an organisation that promotes better authorisation of charter schools in the US, lists as key to pave the way for high-quality charter schools. Amongst these are that interviews are conducted with qualified charter applicants, the use of an expert panel to review applications, and requirement of independent financial audits as well as that quality authorisers provide an annual report on performance, including areas needing improvements.
Vlachos (2019) pointed out that the Swedish model in the education sector is very different to the US model, where it is rather seen as a right to run independent schools and the onus is on the licensing authority, to provide evidence that a school is not suitable. Based on my empirical findings, there seems to be a similar view in the primary care quasi-market in Stockholm. It would be important for the public authorities in Stockholm to learn from above-mentioned experiences in the US and to, for example, conduct in-depth interviews with the owners to understand their value systems to ensure that they are aligned with the public interest objectives.

Data should also be collected on what governance mechanisms the owners use to manage their units to, for example, enhance quality performance. This could help public authorities to benefit from particularly capable and sophisticated owners and identify best practices.

Providers also describe that how they are owned, with regard to the form of association, matters for their work environment. Thus, there may also be an opportunity for the state to regulate ownership by encouraging certain forms of associations that are conducive to delivering on the public interest objective. More policy research is needed in this area to better understand what forms of associations are positively associated with, for example, a good working environment, less turnover of staff, and improved output and outcome measures.

Finally, the regulator must anticipate that if owners that are under high pressure to deliver financial results (e.g. private-equity–owned companies, and/or companies using high-growth strategies, which tend to operate with short-term planning horizons), it may be more likely that they will seek loopholes in the regulatory framework, in order to increase their market share, revenues, and/ or profits (thereby increasing the value of their equity, or their companies). The regulator has a choice here, either to limit the presence of these types of providers in the market by regulation (through ownership restrictions or indirectly by, for example, limiting the size of profit in quasi-markets in the welfare sectors), or to constantly be “one step ahead” of the providers by expanding regulatory capacity or do both.
8.4.3 Market Regulator Capacity and Commitment

Chapter 6 showed that smaller private providers do not perceive market conditions are fair based on existing policy of equal treatment of all providers. More attention must be paid to how purchasing strategies and policies impact different providers in diverse ways and how these differential impacts ultimately affect the market structure and power relations amongst the actors in the market. Furthermore, the chapter also highlighted that large private owners appear to use profit maximisation strategies across different levels of care and the risks involved in market consolidation.

Policymakers considering implementing a quasi-market reform must ensure that market regulators are fit for purpose when it comes to market regulation and that they have the data that they need (see above). For instance, experienced professionals in, for example, antitrust economics or competition policy should be part of the teams that input into policy proposals in the primary health care quasi-market. Or alternatively, an agency such as the National Competition Authority should be mandated to support market regulation in the welfare sectors.

Furthermore, collecting data on changes of providers in the market and market structure is important. A similar recommendation was proposed by the National Competition Authority in 2014, when they proposed that “an authority (for example, the Swedish Competition Authority) should be commissioned to collect information on the PCCRs and which suppliers are in these choice systems” (National Competition Authority, 2014, p. 9). To my knowledge, there is no public authority that currently collects data on the owners of primary care providers that is comparable across regions and thereby monitor market structure. This is, however, needed.

Of the interviewees I interviewed at the regional authorities, including politicians and staff at the SRHCO, some had no higher educational background, while others had degrees in public health, law, and engineering, as examples. None of the interviewees had an educational and professional background in antitrust economics or competition policy, and few had experience either working in the health sector (e.g. medical background). Although my sample is not representative, it may give an indication that there is a lack of skills in these critical areas for being able to manage the market effectively.
It is also interesting to notice that, if there are skill gaps in Stockholm, the largest region in the country and where it is relatively easy to attract staff, the situation in other parts of the country with regard to this important skillset for market regulation is likely to be worse. It is important that this regulatory capacity expands and improves.

8.4.4 Involving the Professionals and Managers in Decision-making

Echoing previous research (Glenngård, 2019) that points to the importance of dialogue and trust between providers and public authorities, this thesis shows that both providers and staff from the SRHCO agree that the governance system would improve if there was more dialogue between them. Thus, more involvement and more dialogue with the professionals and in monitoring impact of policy decisions would be valuable. Bringing in the perspectives of a diverse set of stakeholders when formulating new policy becomes important for the governance of the quasi-market.

This observation is in line with other observers. Anell (2020), in his recent report on governance of Swedish health care, concluded: "Healthcare professionals as well as business-oriented managers need to have greater influence over development but also be the subject of monitoring systems that creates a driving force for change" (Anell, 2020, p. 15).

An important finding with regard to the dialogue between the purchaser and providers is that where revenue is primarily generated from patient care, rational providers are likely to become more transaction focused and start to refrain from doing activities that are not reimbursed. Thus, to get a functioning dialogue time spent in dialogue must be reimbursed or mandated as this takes the providers away from revenue generating activities.
8.5 Strengths and Limitations of the Thesis

Chapter 4 discusses some of the methodological limitations of this thesis. In addition to these, there are several strengths and limitations of the work that presented over the course of conducting this research.

With regard to the strengths, this research is contributing to better understanding of a policy area where policymakers are struggling to devise policy. The focus of the project was conceptualised based on my own professional experience of encountering policymakers’ struggles to design governance systems inclusive of private providers, a formative case study as well as the literature. From the inception of this research, it was made to inform policy and was grounded in important policy issues that I knew policymakers across the globe were faced with. Moreover, the data collected for this project was collected around the 10-year anniversary of the introduction of the PCCR in the Stockholm Region, which means that the quasi-market governance system was well established and many of my interviewees had experienced the governance system for a while and could provide detailed accounts of the system and even describe adjustment to it over time.

With the COVID-19 pandemic, being declared in the midst of this thesis being conducted, the importance of the topic of this research has only heightened (Hellowell Myburgh et al., 2020; WHO, 2020) and the research has become even more timely, given the need to rapidly expand the capacity of many health care systems to both treat and prevent epidemics/pandemics, including COVID-19, while maintaining the delivery of essential services and the need to therefore create governance regimes inclusive of both public and private providers.

Methodologically, a key strength of this thesis is that I conducted a large number of in-depth interviews with providers with various ownership characteristics as well as with a diverse set of policymakers, who operate in different levels of the governance system (macro, meso, and micro). This gave me rich empirical data and allowed me to better understand how the governance system worked in practice and was perceived by different stakeholders.
Another important strength was the use of a qualitative embedded case study approach including providers with different ownership characteristics (public, private-equity owned, and privately owned [not private-equity owned], as well as small and large owners) that allowed me to understand how the governance system was perceived by different types of primary health care managers, who operated in relatively wealthy and poor socio-economic contexts of the region.

There are also several limitations with my research approach. With regard to my in-depth interviews, I interviewed few politicians and especially current politicians, compared to SRHCO staff, which potentially could mean that my research is slightly biased towards the technocratic perspective rather than the political perspective.

One of the reasons why I opted for this strategy was because I noticed when conducting my first interview with a politician that the answers were polished and that they did not provide great insights into the details of the governance system. Furthermore, I saw a risk of seeing the governance system from a too-politicised lens from the outset, had I interviewed more politicians. However, to overcome this potential bias, I included several strategic documents, of political nature, in my documentary study.

As in any empirical research, my approach could have been conducted differently. Another weakness of my study is that I did not interview any of the providers who are primarily digital providers (e.g. Kry, Min Doktor, and Doktor.se). This was a deliberate decision when the study was designed, because at the time, these providers only operated as digital providers and I therefore perceived them as non-comparable to a physical health care unit. However, after the sample was designed, Kry, Min Doktor, and Doktor.se started to operate physical units in the Stockholm Region. In hindsight, I recognise that interviews with these providers may have provided me with further insights into their perspectives of the governance system. This may be an interesting area to study for future research.
8.6 Avenues for Future Research

My findings provide different avenues for future research.

With regard to method and approach, as noted above, other stakeholders, such as more politicians and providers who were originally only providing digital care, could be included in future studies. This could provide better insights into how these primarily digital care providers differ from other types of providers included in this study. Furthermore, including more politicians, or, for example, observing the meetings of the Regional Health Committee, and subordinate committees, could provide further insights into the relationship between the SRHCO and politicians as they shape the governance system.

Moreover, future research could complement qualitative data on the governance system with available quantitative data on, for example, performance of different providers, along various dimensions such as quality of care and financial performance variables. This was beyond the scope of this study but would have provided interesting complementary insights into whether what the providers say is consistent with their action.

There is also an opportunity to replicate this study in other regions in Sweden, which would provide insights into any regional differences with regard to governance and provider perception of governance. It would also be interesting to conduct a comparative study of quasi-market governance systems in primary care with other countries that have implemented similar reforms. This would be useful to understand what parts of the governance system in Stockholm are culturally or nationally influenced (e.g. trust-based nature of the system) that may be more difficult to export elsewhere.

As it seems that there could be lessons learned in terms of, for example, governing for quality of care, from other welfare areas, such as elderly care, another avenue for future research is to replicate the study in other welfare markets in Stockholm (e.g. elderly care, education), or even within the health sector (there are a number of health care areas where quasi-markets have been implemented in the Stockholm Region), and draw lessons in governance from across all these markets. This would also contribute with knowledge about how the governance system must adapt depending on the nature of the
goods provided. It might also provide insights into market-specific challenges in governance.

8.7 Conclusion

This thesis provides critical insights into the governance of primary care quasi-markets and the many challenges involved in influencing provider behaviour in ways that benefit patients and the wider public interest. Key challenges include the creation of mutually beneficial incentive structures in the context of multiple (and competitive) accountability relationships, establishing meaningful measures of quality of care, and the risks associated with business-driven behaviours by profit-maximising agents and market consolidation that over time may limit patient choice, in a context of limited capacity and commitment amongst public authorities to curb these behaviours. The findings also highlight the importance of considering the owners as influencing the governance system in quasi-markets, examining the value systems of owners, and the need to carefully incentivise owners to enter the quasi-market that are likely to deliver on public interest objectives.

In future reform efforts (in Sweden and elsewhere), policymakers will need to balance the potential benefits of choice and competition as a means of improving health system performance against the risks and costs involved. This thesis provides indicative evidence that the need for public sector capacity to create governance systems capable of achieving public interest objectives is likely to be particularly high when certain types of for-profit providers are present in the quasi-market. Strong regulatory functions are needed in quasi-markets; market regulators must have strong capacity and commitment, involve health care professionals and managers in policymaking to perfect the reach of their policies, and create governance systems that are primarily focused on delivering on public interest objectives.
References


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Pitchbook. (2021, June 9). *What is private equity and how does it work?* https://pitchbook.com/blog/what-is-private-equity


https://skr.se/tjanster/kommunerochregioner/faktakommunerochregioner.432.htm

http://primarvardskvalitet.skl.se/omprimarvardskvalitet/anslutningsgrad.986.html


https://www.doi.org/10.4135/9781446218730


Skatteverket. (n.d.). Moms vid uthyrning av vårdpersonal.
https://www.skatteverket.se/foretag/moms/sarskildamomsregler/vardforetagochpersonalluthyrning.4.8cd61f61691938ed1ae29.html


Annex A – Empirical Literature on the Relationship between Quasi-markets and Various Outcome Measures

As mentioned previously, the literature review detected a large economics-based body of literature on the relationship between quasi-markets/competition and different outcome variables such as quality of care, equity, and productivity. This literature is not directly related to the research objectives of this thesis, but given its prominence in the literature on quasi-markets and as it is important as a background to understand the type of issues that the governance system needs to manage to deliver on public health outcomes, I decided to briefly summarise this literature in this Annex.

**Competition and Quality of Care**

Studies on the relationship between competition and quality of care in primary care are scarce (Dietrichson et al., 2020; Propper, 2012; Vengberg et al., 2019).

Existing studies on primary care have found a positive relationship between competition and care quality (Berlin et al., 2014; Jürges & Pohl, 2012; Pike, 2010; Rosano et al., 2013; Stroka-Wetsch et al., 2016), but these studies lack exogenous variation, which makes it difficult to claim causal association and validity is therefore being questioned (e.g. Dietrichson et al., 2020).

Gravelle et al. (2019) and Dietrichson et al. (2020) used identification strategies and both found in the UK and Sweden, respectively, that competition is associated with only a modest increase in patient satisfaction and an even smaller positive impact on clinical quality of primary care. For Sweden, Dietrichson et al. (2020) used “avoidable hospital rate” and a constructed variable that captures “satisfaction with access to care”, from the user’s perspective, as outcome measures of quality of primary care are not available. The authors concluded: “we find small improvements of patients’ overall satisfaction with care, but not consistently significant effects on avoidable hospitalization rates or satisfaction with access to care” (Dietrichson et al., 2020, p. 716) as a result of the introduction of the quasi-market, with competition, in primary care in Sweden.
Studying quality of care in the quasi-markets in primary care in Sweden is complicated by the fact that there are few quality indicators, specifically with regard to medical quality, that are comparable across regions (Glenngård, 2016; Swedish Agency for Health and Care Services Analysis, 2017), as discussed in detail in Chapter 7. The existing ones, related to diabetes care, have had positive development since 2011, prior to the introduction of quasi-market reforms, but it is not possible to attribute this to the Choice Reforms (Swedish Agency for Health and Care Services Analysis, 2017). There seem to be no signs that continuity of care (the degree to which the individual sees the same physician), which is an important proxy for quality of primary care, has improved with Choice Reforms (Swedish Agency for Health and Care Services Analysis, 2021). The annual National Patient Survey, in fact, showed that continuity and coordination of care is one of the dimensions that has the worst performance compared to other dimensions of quality of care (Swedish Agency for Health and Care Services Analysis, 2017).

Beyond primary care, and touched upon earlier, there is literature studying the relationship between competition and quality of care with focus on hospital markets (Propper et al., 2006), financed through the US Medicare programme or the English National Health Service. Kessler and McClellan (2000), one of the first studies, found that the degree of competition had a large impact on (risk-adjusted one-year) mortality from acute myocardial infarction (AMI, i.e. a heart attack) for Medicare patients. Mortality from AMI was much higher in concentrated markets (when larger hospitals account for a large percentage of the total market, i.e. where there is less competition) and that production costs also were lower in less concentrated markets. The literature shows overwhelmingly that where competition exists with fixed prices, more (less) competition is correlated with higher (lower) quality of care, as measured by clinical outcomes (Gaynor et al., 2015; Gaynor & Town, 2012). Similarly, in a summary of the empirical evidence of the UK reforms, Propper (2012, 2017) concluded that in the UK competition with centrally set prices has had positive effects and resulted in improvement of quality without increased costs and without any large impacts on inequity in access\textsuperscript{12}. However, some studies are

\textsuperscript{12} It is important to point out in this context that the literature shows that more competition is better than less in markets; however, it does not necessarily address the question whether markets are better than hierarchy in terms of mode of governance for delivering services.
more ambiguous. Gowrisankaran and Town (2003) found a negative relationship between competition and quality, and others still have had mixed results (Mukamel et al., 2002; Shen, 2003; Shortell & Hughes, 1988)\textsuperscript{13}. Thus, while there seems to be limited impact of competition on quality of care in primary care judging by evidence from Sweden and the UK (Dietrichson et al., 2020; Gravelle et al., 2019), there appears to be a positive relationship between the same variables in hospital markets, although it is still being debated.

**Competition and Equity**

Burström et al. (2017), in their scoping review, containing six scientific articles and nine publications of grey literature, focusing on reviewing the evidence on the impact on the Choice Reforms in primary care in Sweden on equity, found that the average number of visits to primary care providers had increased, particularly amongst patients with lesser needs. It remains uncertain, however, if this is a good indication of improvements of primary care for patients, as it is unclear what happens during the visits and since there is anecdotal evidence, in Stockholm, that providers cut longer visits into several shorter visits to maximise revenue (Burström et al., 2017).

There are also indications that citizens with higher socio-economic status and education have a larger share of visits to private health care units (Swedish Agency for Health and Care Services Analysis, 2015), while sicker citizens, who have higher health care needs, have a higher probability of visiting public health care units (National Competition Authority, 2014). Isaksson et al. (2018) found in their national study that after controlling for municipality and household, people with higher socio-economic status were more likely to be listed with a private primary care provider compared to individuals in the lowest income bracket. The authors stated that the distribution of patients in the primary care market in Sweden is skewed and that risk selection behaviour occurs in this market.

\textsuperscript{13} Pauly et al. (2011) speculated that the different results in the study by Gowrisankaran and Town (2003) may be due to the Medicare price being below the marginal costs (on average for the hospitals) or that it may be explained by the fact that not identical instrumental variables are used in the different studies to identify the relationship between competition and mortality.
Burström et al. (2017) concluded that service provision to persons with complex care needs has suffered, particularly in the Stockholm Region (see Agerholm et al., 2015; Swedish Agency for Health and Care Services Analysis, 2015), and that this is likely to be due to the combined effect of the Choice Reform and the changes to the reimbursement systems the first years of the PCCR, with an increasing importance of fee-for-service reimbursement without socio-economically weighted capitation payment. The scoping review concluded that “the Primary Health Care Choice Reform may have damaged equity of primary health care provision, contrary to the tenets of the Swedish Health and Medical Service Act. This situation needs to be carefully monitored” (Burström et al., 2017, p. 1.)

These findings are confirmed in a more recent study (Svereus et al., 2018) that analysed changes in socio-economic distribution of GP visits following the patient choice reform. It found that the reform led to increased access to GP visits, but implied small changes in their socio-economic distribution.

**Competition and Productivity**

Cost control was practiced when the primary care quasi-market was implemented, and an early study from Stockholm found that the cost for primary care has in fixed prices been largely unchanged from 2006 to 2012, with a decrease in the per capita cost (Dahlgren et al., 2015). This study also found, based on a Data Envelopment Analysis, that where the visits to primary care were put in relation to the cost, there had been a positive development in productivity (Dahlgren et al., 2013). However, Glenngård (2015), in her review of the impact of the Choice Reform, cautioned that it is difficult to make any statement regarding productivity changes, as there is limited data on medical outcomes of each visit (Glenngård, 2015).

A more recent analysis of how the number of visits per physician per day has evolved over time with the implementation of the reform shows that it decreased from 10.8 visits per day in 2011 to 9.8 in 2015, which represents a decrease in productivity of about 9%.
(Swedish Agency for Health and Care Services Analysis, 2017). There are large differences in this productivity measure between regions.
Annex B – Search Strings and References Retrieved per Database by Research Questions (including duplicates)

(i) What is known from the existing literature about the governance of primary care quasi-markets?

<table>
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(ii) What is known from existing research of the effect of ownership of primary health care facilities?

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(iii) What is known from existing research, in the Swedish context, about quasi-markets?

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### Web of Science Core Collection

\[
\text{TS=(Stockholm OR Sweden)} \hspace{1cm} \text{AND TS=("quasi*market" OR "new*public*management" OR "patient-choice")}\hspace{1cm} \text{AND LANGUAGE: (English OR Swedish)}
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Total: 37
Relevant: 24

### EBSCOhost Databases:

CINAHL Plus, Academic Search Complete, EconLit, Humanities International Complete, Library, Information Science & Technology Abstracts, Political Science Complete, Sociology Source Ultimate

\[
\text{("Stockholm" OR "Sweden") AND ("quasi*market" OR "new*public*management" OR "patient*choice")}
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Total: 40
Relevant: 5

### ProQuest Social Science, Dissertations & Theses Global, Social Science Premium Collection (Politics Collection, Social Science Database, Sociology Collection)

\[
\text{ABSTRACT("Stockholm" OR "Sweden") AND ("new*public management" OR "quasi*markets" OR "patient-choice")}
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Total: 10
Relevant: 8

Note: sub-question (iii) was dropped and was not reported on in the literature review.
### Annex C – Actor Mapping

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<td>Market shapers, regulators</td>
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<td>Researchers</td>
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<td>Aleris (private equity owned)</td>
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Annex D – Informed Consent Form

Consent to participate in research study:
The Governance of Primary Care Quasi-markets:
A Case Study of the Stockholm Region in Sweden

Read this carefully and give your consent by signing at the bottom:

Consent:

- I have read information about the study and am aware of how it will be conducted and the time it requires.
- I have had the opportunity to have my questions regarding the study answered and I know who to turn to with further questions.
- I participate in this study completely voluntarily and have been informed about why I have been asked and what the purpose of the participation is.
- I am aware that I can interrupt my participation at any time during the study without having to explain why.
- I give my consent for the doctoral student to record and then transcribe the interview.
- I’m aware that personal information about me will be anonymised. Once the information has been anonymised, the contents of the interview will be analysed.
- I give my consent that the results of the interview, as well as quotes from the interview, can be used in the research study as well as presentations and publications.
- I am aware that my name or personal information that may identify me will not be presented. However, professional title (e.g. official, nurse) and my workplace (e.g. Stockholm Region Health Care Office, privately owned health center) may occur in connection with quotes from the interview.

Stockholm on ............... 2018

Signature:

Name clarification:
Annex E – Interview Guide

1. Where do you work and what is your background?

Present:

2. What tools and processes does the Stockholm Region Health Care Office (SRHCO) use today to manage the primary care health centres?

3. Of the various parts of the governance system, which do you think have the greatest effect on how the care is provided to patients?

4. How and where does the dialogue between SRHCO and the providers take place?

5. How do the providers participate in this dialogue? How are they organised?

6. Are there any differences in how public and private health centres are being governed? Of the private health centres, do you manage private health centres that are owned by venture capital companies in a different way than the health centres where the owners still work in the unit (e.g. Praktikertjänst)?

7. How do you perceive that the players in the market perceive the different parts of the governance system? What works well? What works less well?
8. How is quality measured in primary care? What challenges do you see in this area?

Historical:

9. How did the governance system change when the Choice reform was introduced in primary care? What new processes, tools, forums and features were introduced? Why were these processes, tools and functions introduced?

10. How did people think about ownership when the Choice reform was introduced in primary care?

11. Since the Choice reform was introduced in primary care, have there been any major adjustments in the governance system (e.g. in the Rulebook)? Why were these adjustments made?

Other:

12. What is your own view on the research question?

13. Do you know someone you think I should interview?
Annex F – Thematic Framework

Box 1. Thematic Framework

1. Background
1.1 Sampling details (name of unit, size of unit, area of unit, ownership status)
1.2 Employment history

2. Governance system used by the Stockholm Region
2.1 General/instrument
2.2 Reimbursement model
2.3 Agreement (FFU)
2.4 Supervision
2.5 Dialogue between provider and purchaser
2.6 The governance system’s impact on primary care
2.7 Main challenges of governance system
2.8 Main changes in governance system since choice reform introduction

3. Governance system used by owner
3.1 Quality of care measures by owner
3.2 Specific goals/instructions from owner
3.3 Profit goals from owner

4. Competition
4.1 Discrimination against private owner from the SRHCO
4.2 Differences in working for public or private
4.3 Difference in provider–purchaser dialogue amongst public and private

5. Quality of care
5.1 Definition of quality of care
5.2 Measurement of quality of care
5.3 Ways to improve measurement of quality of care
5.4 Responsibility for quality of care
5.5 Challenges in quality of care
Annex G – Ethical Approval

Dear Mirja,

Your Research Ethics form submission ("Governing primary care quasi-markets: A case study of a county council in Sweden" [ID: 244649]) has been reviewed.

Category: Approved

Level: TBA

Additional comments:

None

The University of Edinburgh is a charitable body, registered in Scotland, with registration number SC005336.
# Annex H – Summary of Main Content of the Rulebook

<table>
<thead>
<tr>
<th>Section</th>
<th>Detailed Content (summary of section headings)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Introduction</strong></td>
<td><em>Description of key features of the Choice system.</em> Explanation that the system aims to increase diversity of care providers, that all applicants have the same conditions to achieve a level playing field and that agreements are signed with all applicants.*</td>
</tr>
</tbody>
</table>
| **2. Instructions for submitting the application** | *Description of how the application is submitted.* Indication that there is an open application process and that all “must” requirements need to be met to be approved.  
*Description of decision-making process for market entry.* Decision will be made within 4 months, and it is possible to seek for correction if provider perceives to be wrongly treated.  
*Basis for the assessment of the provider applicant.* Description of ownership, stable economic base, criminal record, start of operation, business description, staff, manager of unit and medical responsible, premises of unit, completion of checklist for premises, certification (including launch meeting with initial checking by government authorities).* |
| **3. Terms for approval of agreement** | *Application:* Economic stability and seriousness, the Business, Other conditions. Reasons for not being approved.* |
4. **Agreement according to the Choice System**

   - Scope of the Agreement, definitions, period of the agreement, Changes in ownership status, Transfer of business, Deficiencies in the execution and commitment of sanctions, Early termination, Force Majeure, Contact persons, Applicable law and disputes, After the termination of the agreement, Meeting before start-up, Amendments to the Agreement, Misc.

5. **Specific assignment description**

   - Patient-centred network health care in the region, Content of assignment, target group, prioritisation of patient groups, responsibility for geographical area, description of services included in the assignment (including reference to guidelines), reporting to quality registry, cooperation in the interest of the patient, minimum requirements for staff and skills, opening hours, environmental regulations, research, development and education, pharmaceuticals, medical services, rules regarding registration of patients.

6. **Annual follow-up**

   - Rationale and design of annual follow-up, reporting via web-based reporting system (WIM).

7. **Compensation terms**

   - Reimbursement system, Reimbursement model (fee-for-service, treatment codes, capitation adjusted for Care Need Index and Adjusted Clinical Groups), compensation for: home visits, cooperation, on-call, results-based compensation, fine for processes and activities, compensation for patients living outside Stockholm Region, compensation ceiling, user-
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>fees, cost responsibility, premises, equipment and interpreters etc., education commitments, invoicing, terms of payment, late fees.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td><strong>Information management</strong></td>
<td>Digitalisation as a strategic tool, information security, conditions for treatment of patient data, terms, concepts, semantics, e-services (supporting links).</td>
</tr>
<tr>
<td>9.</td>
<td><strong>General terms and conditions from January 1, 2017</strong></td>
<td>General starting points, Laws and rules, guidelines and policies, patient board, access, information and marketing, follow-up, patient journals, staff, suppliers, insurance, liability, and obligations, Serious incident with changed state of emergency, extraordinary situation and high preparedness</td>
</tr>
</tbody>
</table>

Source: Author adapted from Rulebook (2018).
Annex I – Annual Report from 2016 (translated from Swedish)

Contract Monitoring 2016
XXX Health Care Centre – General practitioner with basic home-based health care
Head of unit: xxx
Contract manager: xxx
HSN: xxx
ADA: xxx

<table>
<thead>
<tr>
<th>Nr</th>
<th>Measure</th>
<th>Results 2015</th>
<th>Regional average 2015</th>
<th>Results 2016</th>
<th>Regional average 2016</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tr>
<tr>
<td>1.</td>
<td>Listing and the staffing</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1.1 Number of listed [patients]</td>
<td>10,078</td>
<td>9,435</td>
<td><strong>10,144</strong></td>
<td>9,622</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2 Number of doctors in ListOn in December 2016</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.3 Degree of service (measure of productivity) in ListOn in December 2016</td>
<td>3.8</td>
<td>3.8</td>
<td><strong>3.5</strong></td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.4 Number of patients listed per doctor (degree of service)</td>
<td>2,652</td>
<td>2,505</td>
<td><strong>2,898</strong></td>
<td>2,650</td>
<td></td>
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<tr>
<td>2.</td>
<td>Costs and visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1 Total compensation received (listing compensation + visitor compensation)</td>
<td>19,385,681 kr</td>
<td>19,167,830 kr</td>
<td><strong>20,639,882</strong> kr</td>
<td>19,634,693 kr</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2 Total compensation received per listed (as of 31 December)</td>
<td>1,924 kr</td>
<td>2,007 kr</td>
<td><strong>2,035 kr</strong></td>
<td>2,015 kr</td>
<td></td>
</tr>
</tbody>
</table>
2.3 Age-standardised cost for basic medicines per listed - - 459 kr 357 kr

2.4 Visitor quota according to ceiling: doctor visits per listed 1.57 1.72 1.52 1.55

2.5 Visitor quota according to ceiling: district and nurse visits per listed 0.59 0.38 0.53 0.42

2.6 Visitor quota according to ceiling: psychosocial interventions visits per listed 0.09 0.13 0.10 0.14

2.7 Visitor quota according to ceiling: home care (not doctor visits) visits per listed 3.56 3.91 4.32 4.08

2.8 Proportion of psychosocial visits out of the total number of visits to health care unit - - 4% 6%

2.9 Proportion of usk visits of total number of visits to health care unit - - 0% 2%

2.10 Proportion of ssk / dsk visits of total number of visits to health care unit - - 26% 20%

2.11 Percentage of doctor visits out of total number of visits to health care unit - - 70% 72%

2.12 Number of individuals who visited the health care unit per number listed 0.65 0.66 0.65 0.65

2.13 Number of visits per individual for psychosocial interventions 3.5 3.4 3.3 3.3

3. Availability and continuity

3.1 Proportion of all telephone calls answered within the approved time (target level: 85%) 93% 88% 81% 84%
### 3.2 Percentage listed by named doctor

| Percentage listed by named doctor | 36% | 49% | 35% | 46% |

### 3.3 The clinic is connected to 1177 Vårdguiden’s e-services

| The clinic is connected to 1177 Vårdguiden’s e-services | Yes | - | Yes | - |

### 3.4 Percentage of doctors at the clinic who worked at the clinic for 1 year or longer

| Percentage of doctors at the clinic who worked at the clinic for 1 year or longer | - | - | 50% | 80% |

### 3.5 Proportion satisfied with telephone availability

| Proportion satisfied with telephone availability | - | - | 57% | 70% |

### 3.6 Promised response time for the case type

**Order time in 1177 Vårdguiden’s e-services in number of days**

| Promised response time for the case type | - | - | 3 | 2 |

### 3.7 Promised response time for the case type

**Cancel and rebook time 1177 Vårdguiden’s e-services in number of days**

| Promised response time for the case type | - | - | 3 | 1 |

### 3.8 Promised response time for the case type

**Renew prescriptions in 1177 Vårdguiden’s e-services in number of days**

| Promised response time for the case type | - | - | 3 | 3 |

### 4. Structure for quality

#### 4.1 Diagnosis registration rate (target level: 90%)

| Diagnosis registration rate (target level: 90%) | 99% | 99% | 99% | 98% |

#### 4.2 Proportion of Z diagnoses of all diagnoses

| Proportion of Z diagnoses of all diagnoses | 25% | 18% | 25% | 17% |

#### 4.3 Adherence to the Wise list (Swe. Kloka listan, is a list with cost-effective approved drugs) (DU90%) (target level: 80%)

| Adherence to the Wise list (Swe. Kloka listan, is a list with cost-effective approved drugs) (DU90%) (target level: 80%) | 92% | 91% | 93% | 89% |

#### 4.4 The caregiver has a patient safety report

| The caregiver has a patient safety report | Yes | - | Yes | - |

#### 4.5 Number of reports to the Patient Board

| Number of reports to the Patient Board | 9 | - | 12 | - |
4.6 The health care unit has received nursing students and the quality and focus is without remark

| Yes | - | Yes | - |

4.7 The health care unit has received medical students and the quality and focus is without remark

| Yes | - | Yes | - |

4.8 Proportion of staff with the right to prescribe who have taken the course 'Pharmaceutical environmental impact'

| - | - | 33% | 71% |

4.9 The caregiver is environmentally certified / with diploma

| Yes | - | Yes | - |

5. **Collaboration & prevention of emergency hospital care**

5.1 Number of visits per listed by a doctor in care external to the own clinic (target level: 2.5 or lower)

| 2.2 | 2.2 | 2.1 | 2.2 |

5.2 Proportion of avoidable inpatient care opportunities for listed 65 years and older

| 28% | 18% | 24% | 17% |

5.3 Proportion of emergency visits that did not lead to hospitalisation, 65 years and older

| 71% | 64% | 71% | 66% |

5.4 Proportion of patients 65 years and older in acute inpatient care who had contact in primary care within seven days of discharge

| 41% | 38% | 33% | 35% |

5.5 Proportion of listed patients 65 years and older who obtained prescriptions from more than 3 care providers within a 4-month period

| 13% | 15% | 12% | 16% |
### 6. Patient-perceived quality

| 6.1 Participation and involvement | 72% | 76% | 74% | 81% |
| 6.2 Emotional support             | 71% | 75% | 65% | 72% |
| 6.3 Overall impression            | 72% | 82% | 68% | 80% |
| 6.4 Information and knowledge     | 72% | 76% | 67% | 75% |
| 6.5 Continuity and coordination   | 71% | 76% | 69% | 74% |
| 6.6 Respect and treatment         | 77% | 86% | 74% | 85% |
| 6.7 Availability                  | 81% | 84% | 76% | 82% |

### 7. Chronic diseases

<p>| 7.1 Asthma, degree of detection   | 33% | 40% | 27% | 39% |
| 7.2 COPD, degree of detection     | 60% | 60% | 56% | 62% |
| 7.3 COPD, percentage of registered spirometries per listed patients 7 years and older | 0.60% | 1.55% | 0.55% | 1.71% |
| 7.4 Dementia, degree of detection | 32% | 55% | 38% | 57% |
| 7.5 Dementia, treatment with antipsychosis_Lm | - | - | 12% | 7% |
| 7.6 Diabetes, degree of detection | 90% | 82% | 89% | 84% |
| 7.7 Diabetes, proportion of patients registered in the national diabetes register NDR (target level: 90%) | - | - | 97% | 90% |
| 7.8 Diabetes, treatment with statin | - | - | 61% | 55% |
| 7.9 Diabetes, proportion of patients with completed foot status examination reported in NDR (target level: 75%) | 80% | 88% | 77% | 79% |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.10</td>
<td>Diabetes, proportion of patients with information on smoking (NDR) (target level: 75%)</td>
<td>79% 92% 78% 82%</td>
</tr>
<tr>
<td>7.11</td>
<td>Diabetes, proportion of patients under the age of 80 with high blood glucose (NDR)</td>
<td>- - 15% 10%</td>
</tr>
<tr>
<td>7.12</td>
<td>Diabetes, proportion of patients with information on height and weight or BMI in NDR (target level: 80%)</td>
<td>88% 92% 96% 86%</td>
</tr>
<tr>
<td>7.13</td>
<td>Obesity, degree of detection</td>
<td>32% 25% 31% 25%</td>
</tr>
<tr>
<td>7.14</td>
<td>Atrial fibrillation, degree of detection</td>
<td>66% 65% 62% 68%</td>
</tr>
<tr>
<td>7.15</td>
<td>Atrial fibrillation, treatment with anticoagulants</td>
<td>- - 73% 75%</td>
</tr>
<tr>
<td>7.16</td>
<td>Heart failure, degree of detection</td>
<td>40% 38% 40% 43%</td>
</tr>
<tr>
<td>7.17</td>
<td>Heart failure, treatment with ACE_ARB</td>
<td>- - 82% 77%</td>
</tr>
<tr>
<td>7.18</td>
<td>Heart failure, treatment with ACE_ARB_B_blockers</td>
<td>- - 74% 66%</td>
</tr>
<tr>
<td>7.19</td>
<td>Heart failure, treatment with B_blocker</td>
<td>- - 84% 80%</td>
</tr>
<tr>
<td>7.20</td>
<td>Hypertension, degree of detection</td>
<td>87% 74% 86% 74%</td>
</tr>
<tr>
<td>7.21</td>
<td>Ischaemic heart disease, degree of detection</td>
<td>54% 37% 46% 41%</td>
</tr>
<tr>
<td>7.22</td>
<td>Ischaemic heart disease, treatment with AKTrc</td>
<td>- - 89% 86%</td>
</tr>
<tr>
<td>7.23</td>
<td>Ischaemic heart disease, treatment with B_blocker</td>
<td>- - 82% 75%</td>
</tr>
<tr>
<td>7.24</td>
<td>Ischaemic heart disease, treatment with statin</td>
<td>- - 83% 73%</td>
</tr>
<tr>
<td>7.25</td>
<td>Ischaemic heart disease, treatment with Trc_inhibitors</td>
<td>- - 77% 71%</td>
</tr>
<tr>
<td>7.26</td>
<td>Osteoporosis, degree of detection</td>
<td>18% 32% 22% 33%</td>
</tr>
<tr>
<td>7.27</td>
<td>TIA / Ischaemic stroke, degree of detection</td>
<td>35% 34% 29% 37%</td>
</tr>
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</tr>
<tr>
<td>7.28</td>
<td>TIA / Ischaemic stroke, treatment with AKTrc</td>
<td>-</td>
</tr>
<tr>
<td>7.29</td>
<td>TIA / Ischaemic stroke, treatment with statin</td>
<td>-</td>
</tr>
<tr>
<td>7.30</td>
<td>FF_TIA_Istr, treatment with anticoagulants</td>
<td>-</td>
</tr>
<tr>
<td><strong>8. Antibiotic prescription</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td>Proportion of female patients aged 18–79 years with lower urinary tract infection (UTI) treated with non-quinolones (target level: 95%)</td>
<td>99%</td>
</tr>
<tr>
<td>8.2</td>
<td>Proportion of PcV of antibiotic treatment of patients 0–6 years with respiratory infection (target level: 80%)</td>
<td>87%</td>
</tr>
<tr>
<td>8.3</td>
<td>Proportion of non-antibiotic treatment of patients 18 years and older with acute bronchitis (target level: 80%)</td>
<td>63%</td>
</tr>
<tr>
<td>8.4</td>
<td>Proportion of non-antibiotic treatment of patients with uncomplicated upper respiratory tract infection (target level: 90%)</td>
<td>86%</td>
</tr>
<tr>
<td>8.5</td>
<td>Total number of antibiotic prescriptions collected per 1,000 listed</td>
<td>135</td>
</tr>
<tr>
<td><strong>9. Health promotion initiatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.1</td>
<td>Proportion of patients who stated that eating habits were brought up during a visit in the last 6 months</td>
<td>36%</td>
</tr>
<tr>
<td>9.2</td>
<td>Proportion of listed patients identified with unhealthy eating habits</td>
<td>0.25%</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>1.07%</td>
</tr>
<tr>
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</tr>
<tr>
<td>9.3</td>
<td>Proportion of visits with qualified advisory conversation about eating habits of all dsk / ssk visits to health care unit</td>
<td></td>
</tr>
<tr>
<td>9.4</td>
<td>Proportion of patients who stated that exercise habits were brought up during a visit in the last 6 months</td>
<td>42%</td>
</tr>
<tr>
<td>9.5</td>
<td>Proportion of listed patients identified with insufficient physical activity</td>
<td>4.00%</td>
</tr>
<tr>
<td>9.6</td>
<td>Proportion of visits with advisory conversations about physical activity of all dsk / ssk visits to health care unit</td>
<td>1.04%</td>
</tr>
<tr>
<td>9.7</td>
<td>Proportion of patients who stated that tobacco habits were brought up during a visit in the last 6 months</td>
<td>28%</td>
</tr>
<tr>
<td>9.8</td>
<td>Proportion of listed patients identified with tobacco use</td>
<td>3.53%</td>
</tr>
<tr>
<td>9.9</td>
<td>Proportion of visits with qualified advisory conversation about tobacco use of all dsk / ssk visits to health care unit</td>
<td>1.13%</td>
</tr>
<tr>
<td>9.10</td>
<td>Proportion of patients who stated that alcohol habits had been raised during a visit in the last 6 months</td>
<td>28%</td>
</tr>
<tr>
<td>9.11</td>
<td>Proportion of listed patients identified with risky use of alcohol</td>
<td>0.14%</td>
</tr>
<tr>
<td></td>
<td>Proportion of visits with advisory conversations about alcohol habits of all dsk / ssk visits to health care unit</td>
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<tr>
<td></td>
<td>0.00%</td>
<td>0.26%</td>
</tr>
</tbody>
</table>

### 10. Home health care

| 10.1 | Number of registered patients in home care 31 December | 44 | 72 | 50 | 74 |
|      | Proportion registered in home health care of listed 65 years and older | 4% | 5% | 4% | 5% |
| 10.2 | Proportion of home care patients with at least 2 visits per month (target level: 90%) | 77% | 87% | **83%** | 90% |
| 10.3 | Proportion of annual in-depth drug review for home care patients (target level: 90%) | 2% | 56% | **0%** | 63% |
| 10.4 | Proportion of patients ready for discharge where the care plan is adjusted (target level: 65%) | 18% | 59% | **0%** | 56% |
| 10.5 | Proportion of registered home care patients 65 years and older where there is information about height and weight or BMI in the record (target level: 70%) | 100% | 93% | **95%** | 100% |
| 10.6 | Cost per home care patient (as of 31 December) | 29,047 kr | 27,778 kr | **29,499 kr** | 30,507 kr |
## 11. Psychosocial interventions

| 11.1 | Is the self-assessment instrument AUDIT used in screening for alcohol dependence? | - | - | Yes | - |
| 11.2 | Is the GAD-7 self-assessment tool used to screen for anxiety disorders? | - | - | No | - |
| 11.3 | Is PhQ9 used in screening for depression and estimating the degree of depression? | - | - | No | - |
| 11.4 | Are there established routines in accordance with violence in close relationships (SOSFS, 2014, p. 4)? | - | - | Yes | - |

## 12. Quality areas

| 12.1 | Approved asthma-CARB in the health care unit | - | - | Yes | - |
| 12.2 | Approved elderly clinic | - | - | Yes | - |
| 12.3 | Approved for extended e-health | - | - | Yes | - |
| 12.4 | Approved own control hygiene | - | - | Yes | - |
| 12.5 | Continuing education at the health care unit | - | - | Yes | - |
| 12.6 | Reporting of competence development initiatives | - | - | Yes | - |