



Competition in Emergency Healthcare

The Great Stockholm Challenge



By Johan Hjertqvist

The Stockholm metropolitan area has witnessed a rapid transition in the style and format of health care. The new, competition-based model of public healthcare is now about to hit the emergency room and operating theatre in that city.

Many medical support and primary care services have already been subjected to an internal market, where the health authority buys services from competing suppliers. About 2,300 contracted producers already practice in Stockholm, most of them medical practitioners. Ten percent of these providers are new companies founded by health-care personnel who have left direct employment with the public service to run their own businesses.

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Next year competition will reach into the heart of health-care – the emergency room.

What does this new development mean? Several perspectives on the matter are fighting to dominate public opinion, but that is secondary; there is no argument about the sheer size of this next step.

Seven emergency hospitals in the Stockholm region serve close to two million people. Since 1999, one of them has been privately owned. Last year, two hospitals turned themselves into publicly owned companies with formal business structures, financial statements, and a board of directors. At least two of the remaining ones plan to do the same in 2002. Converting to this type of structure is a necessary step before possible privatization. The County Council will have a freedom of choice.

Start With A Billion

Emergency health care or direct in-hospital service represents roughly forty percent of the total volume of health services in Sweden, with a budget of just over ten billion Swedish crowns a year (roughly equal to 1.5 billion Canadian dollars). Included in this category are not only catastrophic care but many other services related to emergency care or the treatment chain that links it, ranging from x-ray and lab services to outpatient services and home care. No one believes that the whole works will be subject to competition, with the government tendering for services. Many sources describe an initial goal of moving at least one billion crowns worth of emergency services into the internal market, and perhaps as much as two billion.

In the Swedish context, this is a lot of money. Few other countries use a tender system for health services, so this may represent the biggest privatization of health care services production ever in the long history of socialized medicine.

Biggest In the World

This is Sweden, the “lagom” country, not Texas. People here don’t usually talk about being the “biggest” in the world. But many are proud of the leadership role Stockholm has assumed in the field of health-care reform.

Provider competition is the key tool for moving health-care services forward by means of market incentives. The experience garnered from the earlier stages of reform demonstrates the dynamic effects of competition: an increasing number of health care enterprises, a variety of producer approaches and a dramatic revitalization of the labour market. For the first time, nurses have the opportunity to choose among employers. Most importantly, the break with old provider monopolies and behaviour has opened the door for real patient influence. (See my second Frontier newsletter, which discusses how Swedish healthcare consumers can compare waiting lists via the Internet - <http://www.fcpp.org/publications/newsletters/icyfrontiers2.html>).

Competition Model Saves 13%

Performance measurement data suggests that the force of “market influences” has racked up an impressive record in Sweden.

Councils relying on a purchaser-provider split, that is where authorities are buying services from competing suppliers, are more efficient than the ones operating with funded budgets where the authority simply produces the service itself through its public monopoly. The research indicates an efficiency gap estimated at 13 percent. In other words, the contracted sector – primarily in Stockholm -- can produce the same service for 13% less than other Councils in the country still running with the traditional monopoly model. The “fee for service” system evidently increases productivity. When Stockholm introduced the DRG (Diagnostic Related Group) mechanism for payment in 1991 where it pays a set amount for each standardized medical procedure, productivity increased by an impressive 19 percent. The mental shift, from a single-minded cost and budget focus to an income and capacity perspective, was of enormous importance.

A number of reports show that private medical specialists (on a fee for service compensation) are 10 to 20 percent more efficient than publicly employed colleagues. In most health care

sectors, the “request for offer” technique, where health authorities seek bids for specified procedures, has reduced costs quite significantly.

Defenders of the Monopoly Attack Choice

Those who fear the market openings in the publicly financed, egalitarian Swedish model offer numerous objections which will certainly be used by Canadian opponents of a competitive system as well. Here are some of their objections:

- Providing the hospitals with incentives to increase production with competitive forces will raise total health care costs.
- Adding the factor of demand for services – not only need -- to the health care toolbox puts loud, demanding patients at an advantage.
- Every new market ingredient threatens the essential principle of the welfare state: equal distribution of service.

In fact, the evidence from Sweden undermines these objections:

- Competition can lower costs overall because providers constantly seek better practices.
- Providers give better service and spend more time with all patients, because they want them to return.
- Equal distribution of service in the old system meant the equal distribution of misery while waiting for service. The reduction of waiting lists by more than 70% means everybody gets faster access.

Controlling Risk

We cannot expect competition to solve every problem. Successful competition requires stable and transparent conditions. To create these conditions, the Greater Council of Stockholm needs to look at some important structural changes.

The owner policy must be redefined. How does a single public body take responsibility for six hospitals working under different conditions? From a group perspective, how do you coordinate their activities to optimize outcomes? How do you give each hospital the maximum independence to find its own

solutions without excessive and costly duplication and overlap? What is the reasonable compromise?

Money makes the world go round. The methods used to finance providers needs to reflect the values of the reforms. The compensation system needs stronger incentives for innovation. This matter is critical to the ongoing success of the policy changes.

Several Methods of Paying for Services

A number of compensation systems are used in the Stockholm health care system. They are:

1. Diagnostic Related Groups
2. Fee for Service
3. Capitation
4. Compensation for Quality Development

Emergency care is paid for on a strict scale based on productivity. Since the early 1990's, in-hospital emergency care has been compensated by a DRG-based system. Using the privatized (and very productive) St. George Hospital as an ice-breaker, Stockholm's Council tried to lower the DRG price for all the other hospitals. This attempt failed, as these organizations could not change quickly enough to meet the goal. Today each hospital has an individual DRG-price tag derived from its true level of costs, including traditionally neglected or ignored items like the cost of capital.

The DRG mechanism consists of two parts: the actual price tag and the "weight" of the specific diagnosis. There are 500 listed treatments, and for each of them the expected cost of resources for each diagnosis. Funding authorities mix that with a "weight" based on their service objectives. So what the hospital gets in payment is a mix of the individual price tag and the "weight", which is the same for every hospital.

Out-of-hospital emergency care is also compensated by a fee-for-service system. This means that in emergency care there is no base funding. All income must be generated by a corresponding production of services. In other words, providers cannot rely on a global budget which they then allocate within the facility; they must show that they delivered specific services to generate payment. The same conditions apply in geriatric care, while psychiatric care is still mostly funded, to 75 percent, in the old way.

In primary care, a variety of funding systems co-exist. "Old style" private GPs who operated before 1993, likewise "traditional" health care stations run by the Council, are paid a fee for service. New enterprises staffed by former Council nurses and doctors and chains of contracted facilities owned

by large-scale private companies must set them by bargaining with the Council. This means that the former group remains completely independent of the Council, but this body must pay their fees. They can also use free-of-charge laboratory and X-ray services. The privatized sector must meet higher standards of accountability for its funds.

A GP having an agreement with the Council is paid in a more complicated way.

Most of the compensation – generally 70 percent – comes from capitation, a flat rate annual fee per patient. The political aim is one doctor for every 1,500 patients, but that goal is still out of reach. The local listed population is the base. To that, you add compensation for the doctors receiving unlisted patients (in Stockholm, regardless of where she is listed, every patient can make a choice). The doctor keeps the fee every patient pays out of pocket (a little less than twenty Canadian dollars a visit). A fourth income source is compensation for quality development (two percent of the total).

A Problem with Capitation?

These systems raise the question whether the support for innovation and cooperation is strong enough to ensure the goals of the Big Competition. Since less productive hospitals get paid more than those with lower costs, they have less incentive to produce services more efficiently. A high proportion of capitation-based compensation might make doctors and other providers complacent about what they already have achieved.

The Council may not manage to make all the preparations and adjustments necessary to give the Big Competition a good launch. The purchaser authority driving the process forward admits itself that this is "a high risk project", under the funding formulas in place. Certainly, the system will evolve and be fine tuned as the conversion to the competitive model progresses.

The centre-right council majority will likely go for a "safety first" strategy. That means the potential for change will not be fully exploited.

Every hospital has already been guaranteed survival, regardless of its costs and quality of services. This means that only marginal volumes will be competed. An emergency hospital has a bottom line of perhaps as much as 90 percent of the present volume. The

freedom of choice for the patient will remain, but this right conflicts with other priorities. It makes capitation-style concepts very complicated. How do you enforce a five-year contract for providing services to the inhabitants in a certain city if and when many patients instead might prefer visiting another doctor?

Welcome Sound Market Incentives

Until the health care system imports businesslike tools, the competitive market will not work. Respect for sound incentives and agreements must be built into the compensation structure. Lower prices and high quality must be rewarded. Independently operated public hospitals cannot live in a twilight zone between politics and the market.

A Challenge For All

Irrespective of the outcome of the competition, this somewhat jumpy project has created a number of positive effects:

- For the first time, the purchasers – the public authorities -- are forced to build their own clear vision of the future of health care. How can you negotiate change if you do not know where to go, to paraphrase Alice in Wonderland?
- The producers must sharpen their creative minds more than ever. How can they assist the purchasers in building integrated services for young diabetics, reduce stroke mortality or develop networks for chains of treatment serving geriatric patients? How can they become true partners in solving problems rather than just answering to technical demand?
- And most of all: the politicians must finally make their priorities public. Do they favour

freedom of choice, even if patient power might confuse the playing field? Will they respect the potential of hospital independence or manipulate it to keep control? Will the Council as an owner treat every competitor equally or in cold daylight give favours to certain producers no matter how inefficient they are?

A Year of Visions and Truth

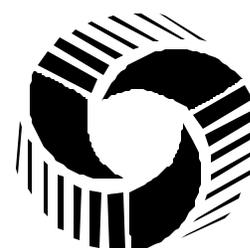
2002 will be a good year for truth and consequences in Stockholm. You cannot be half-pregnant. If you really want to use good incentives you must not at the same time create self-defeating systems.

Will public authorities manage to put a vision on paper? Can you contract dreams? The Big Competition is a risky business but the possible rewards are high. To the pragmatic observer there are no present alternatives.

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