



Competition Council

# WELL-FUNCTIONING MARKETS

02 | 2017

## SWEDISH EXPERIENCES WITH MORE FREEDOM IN THE PRACTICE SECTOR

**Sweden implemented a health care reform which creates the opportunity for more effective competition in the practice sector. With the reform, health care providers received the right to freedom of establishment, and ownership restrictions have been removed, allowing anyone to own a health centre.**

After the reform, there are more health centres, and many Swedes have thus seen reduced travel times to the centres.

There are no immediate signs that the reform has caused increased expenses. Since the reform, there has been approximately zero growth in the number of consultations, and the cost per consultation follows the general wage development. Furthermore, the patients' experienced quality remained largely unchanged in the period 2009-2013.

These lessons from the reform of the Swedish practice sector have been compiled as a follow-up to an analysis of the markets for private chiropractors and physical therapists, published by the Competition and Consumer Authority in 2013.

The analysis shows that the regulation of the Danish practice sector resembles the one the Swedes had before the reform, and simultaneously points to there being potential societal gains from easing restrictions on the establishment and ownership in physiotherapy and chiropractic, respectively.

Read the full article on the next page<sup>1</sup> →

In Sweden, the practice sector's health services are generally rooted in multidisciplinary health centres ("vårdcentral"), to which doctors and other health professionals such as nurses and physiotherapists are connected.

The Swedish reform (the Vårdval reform) has been designed to give citizens a choice between health services and better accessibility of health centres.<sup>2</sup> At the same time, it was desired to create competition within the regulated supply of the practice sector.

The Vårdval reform was implemented in 2007-10 and gave citizens a free choice of health providers. Since 1 January 2010, all citizens have thus been free to choose which health centre they want to be associated with, cf. Box 1.<sup>3</sup> Health centres can thus attract citizens by offering higher quality.

#### Box 1 Health Centres in Sweden

Health centres in Sweden have historically been primarily government-run, but since the reform bringing freedom of choice and freedom of establishment more centres are privately run. All health centres are financed by the regions. Before the reform, public funding was fixed at a national rate, while the newly created health centres are currently funded by regional tariffs and user fees. Thus, the rates are the same within each region, but vary in size and structure between regions. The patients' co-payment per consultation is determined in a decentralised manner by the regions and varies from between SEK 100 and 250, yet cannot exceed SEK 1100 per year.

The health centres can be owned by anyone, including i.e. private equity funds, as long as the regional requirements for the centres are observed. For example, half of the regions require the health centre to employ a physiotherapist or have one affiliated through a collaborative agreement.

*Incentive, Deregulation of the practice sector – experiences from Sweden, 2016.*

While the reform was primarily aimed at medical practitioners, it also included other therapists such as physiotherapists.

The Vårdval reform has meant that everyone is free to own and establish health centres. Establishment may take place if the centres meet a number of conditions set out by the län (region) in which the health centre is located (so-called accreditation conditions).

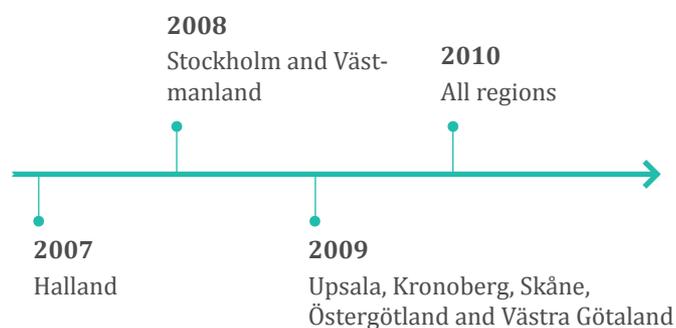
Once the health centre meets the region's conditions, the health centre's patients also have the right to public subsidies.<sup>5</sup>

The conditions for accreditation primarily focus on ensuring a minimum level of healthcare competences.<sup>6</sup>

Regions could choose to implement the Vårdval reform before 1 January 2010, the deadline for implementation. Three regions opted to implement the reform as early as 2007, while the last had implemented the new rules by January 1, 2010, cf. Figure 1.<sup>7</sup>

**Figure 1**

Timeline of the implementation of the Vårdval reform in Sweden:



*Source: Incentive, Deregulation of the practice sector – experiences from Sweden, 2016.*

#### Swedish experiences

Following up on the Competition and Consumer Authority's analysis of the markets for private chiropractors and physiotherapists from 2013, experiences from the Swedish reform have been compiled, i.a. with the help of Incentive,<sup>8</sup> cf. Box 2 at the end of the article.

The analysis of the Swedish reform shows that many Swedes have shorter distances to health centres since the reform. Specifically, the proportion of Swedes, who had no more than five minutes to the second nearest health centre increased by 5.5 percentage points (from 2009-2010), while the proportion of Swedes who had more than 30 minutes to the next nearest health centre fell by 0.5 percentage points.

The greater accessibility reflects that the reform has led to the emergence of more health centres. From 2007 to 2015, the number of health centres increased by 14 percent, see Figure 2a. Most new health centres opened shortly after the reform came into force in the län in question.

The number of health centres increased in almost all läns, but there are big differences between individual läns, see Figure 2b. The largest increase in the number of health centres happened in Skåne, Stockholm and Västra Götaland. These are the three most populous läns and among the most prosperous areas in Sweden. These are also the läns where elements of the reform have been worked with for the longest time.

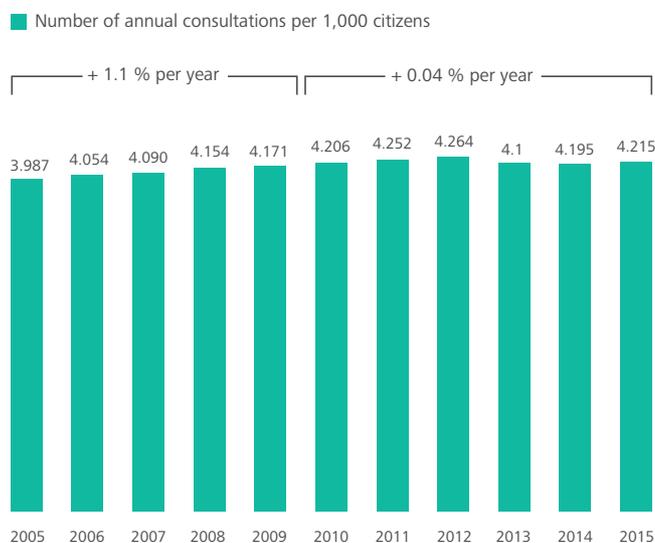
**Figure 2a**  
Development in number of private and public health centres



Source: Swedish Municipalities and Parliament *Statistics on health and medical care and regional development – activity and economy in parliament and regions, 2006-2015*.

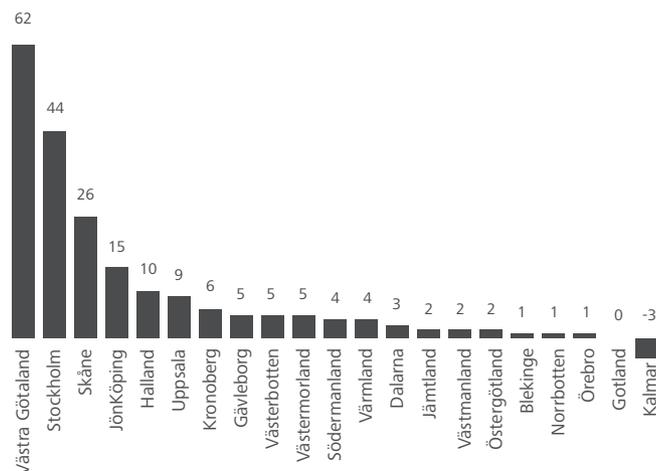
In other läns, (e.g., Blekinge, Norrbotten and Örebro), there has been a slight increase in the number of health centres, and in Gotland there has been no change. As the only län, Kalmar saw an actual decrease in the number of health centres after the reform. These län all have small populations.

**Figure 3**  
Total annual consultations in primary care sector in Sweden per 1,000 citizens



Source: Swedish Municipalities and Parliament *Statistics on health and medical care as well as regional developments – Activity and economy in parliament and regions, 2005-2015*.

**Figure 2b**  
Evolution of the total number of health centres in the 21 regions following the reform



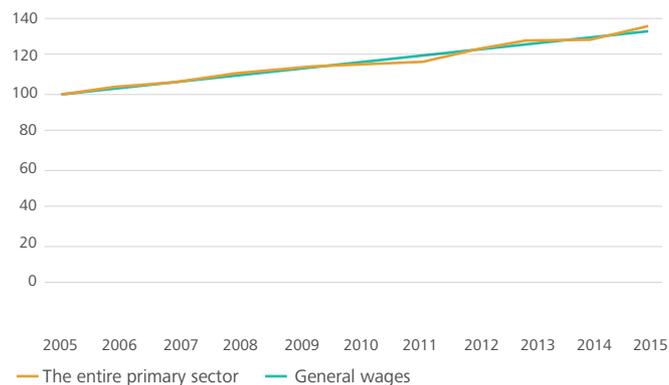
Source: The Swedish National Audit Office, *Administration of primary care – as needed or as retired, 2014*.

The reason that the accessibility of health centres also seems to have improved in sparsely populated areas may be that there are still publicly owned and supported health centres in these areas. Virtually all the new centres which have emerged after the reform are run by private operators. The share of private health centres has increased in 17 of the 21 läns, remains unchanged in two läns and dropped in two läns (Kalmar and Värmland).

With more health centres, it might be expected that the number of consultations would increase because of greater accessibility for patients. However, there is no immediate indication of this happening. The number of consultations increased by 1 percent annually from 2005 to 2010, and then slowed down, see Figure 3. Furthermore, the development in the cost per consultation follows the overall wage development in Sweden throughout the 2005-2010 period, see figure 4. The terms of patients' self-payment for treatment in the practice sector has not been affected by the reform.

The analysis of the Swedish experience does not find any major changes in the patients' experienced quality in the years around the reform. Some sources estimate that there has been no change, while others point to a slight quality improvement. For example, a survey conducted by the Swedish Association of Local Authorities and Regions (SKL) shows that the patient-perceived quality remained largely unchanged in the period from 2009 to 2013.<sup>9</sup> It should also be mentioned that the quality, cost and number of consultations is obviously also influenced by factors other than the reform in that period.

**Figure 4**  
Cost per consultation within the practice sector in Sweden.  
Index 2005 = 100.



**Source:** The Swedish Association of Local Authorities and Regions (SKL) 2005-2015 (cost and number of consultations in primary care) and Statistics Sweden (general wage level).

**Note:** The "general wage level" curve shows the evolution of the average monthly wage for a full-time employee, incl. increments and bonuses for the entire Swedish economy.

### Relevance to Denmark

The Swedish experience of the reform of the practice sector is also relevant to Denmark. This should be seen in the light of regulation in Denmark being reminiscent of that in Sweden before the reform.

Today, who is allowed to treat in the practice sectors is a regional decision in Denmark, just as the number of practices, the capacity of the practices and the geographical location of the practices is regulated. Among other things, this is done via the so-called provider numbering system and practice schemes determined on the basis of agreements between the Regions' Wages and Tariffs Board (RTLN) and the respective professional organisations.<sup>10</sup>

On the basis of health regulation, the agreements also establish that only practitioners who sign up to the collective agreement may own clinics personally and have a controlling influence in companies (ownership rules). Finally, it follows from the Health Care Act that patients in Denmark can only receive subsidies for treatment, if the practitioner practices within the practices sector.

The Swedish experiences indicate that the relaxation of i.e. ownership restrictions may improve the accessibility of treatment etc. in the practice sector, without adversely affecting other general health considerations.

The Competition and Consumer Authority's November 2013 analysis of the markets for physical therapy and chiropractic,<sup>11</sup> which are part of the practice sector in Denmark, also points to existing Danish regulation excluding effective competition between providers. Regulation of the number of therapists and their geographical location in Denmark through provider numbers also creates a risk of local monopolies.

The 2013 analysis indicated that the regulation creates unequal conditions of competition between providers with and without provider numbers, despite all therapists being authorised by the Danish Health Authority. Patients thus only receive subsidies for therapists with a provider number. This creates unequal conditions for therapists, who do not have a provider number.

The regulation of chiropractors and physiotherapists limits the incentive of practitioners to improve productivity and their opportunity to run the clinics effectively. Furthermore, the possibility that the more productive and efficient clinics can grow and replace less productive and efficient clinics is reduced. Overall, this is hampering productivity growth in the industries and could result in losses for Danish consumers.

### Box 2.

#### Main conclusions of the report on the deregulation of the practice sector in Sweden

In outline, the experiences following the 2010 reform are as follows:

- There are more health centres in 19 of the 21 Swedish regions.
- Travel time to health centres for most Swedes remains unchanged or has been shortened, even in sparsely populated regions.
- There has been close to zero growth in the number of consultations in general practice.
- There has been an evolution in the cost per consultation which follows the general wage development in Sweden
- The patients' self-payment terms have not changed.
- There have been no significant changes in waiting times or perceived quality.

**Source:** Incentive, *Deregulation of the practice sector – experiences from Sweden*, 2016.

**Note:** The report is based on a literature review of existing studies of the effect of the Vårdval reform, supplemented by interviews with the Swedish Competition Authority, the Public Health Agency of Sweden, the Swedish Association of Local Authorities and Regions (SKL) and the Swedish Association of Physiotherapists.

- 
1. The article has prepared for the Competition Council by the Competition and Consumer Authority.
  2. Rehnberg C et al. Follow-up on the family doctor system in Vårdval Stockholm – Reporting of the experiences of the two first years, Karolinska Institutets Folkhälsoakademi report, 2010: 12.
  3. European Observatory, Sweden Health System Review, 2012.
  4. Anell, A, Choice and privatization in Swedish primary care, Health Economics, Policy and Law, 2011, 6: 549-569.
  5. Newly established medical practitioners operate under the terms of accreditation. However, there are still doctors who have established themselves before the Vårdval reform, and who practice under the previous regime of national tariff.
  6. European Observatory, Sweden Health System Review, 2012.
  7. Anell, A, Choice and privatization in Swedish primary care, Health Economics, Policy and Law, 2011, 6: 549-569.
  8. Incentive, Deregulation of the practice sector – experiences from Sweden, 2016.
  - (9) The Swedish National Audit Office, Administration of primary care – as needed or as retired, 2014, page 39
  10. [www.rtl.n.dk](http://www.rtl.n.dk).
  11. The Competition and Consumer Authority, markets for private chiropractors and physiotherapists, 2013.
- 

## Competition Council

---

Competition Council has overall responsibility for the Competition and Consumer Authority's administration of the Danish Competition Act and the regulations issued pursuant thereto. The Competition Council makes decisions in test cases and major cases. The Competition Council and The Competition and Consumer Authority are independent from the Minister of Business and Industry in all tasks related to the Competition Act.

The Competition Council consists of seven members, including a chairman and a deputy chairman. The members are appointed by the Minister of Business and Industry on the basis of their personal and professional qualifications.

---