

Experiences of Introducing a Quasi-Market in Swedish Primary Care: Fulfilment of Overall Objectives and Assessment of Provider Activities

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Abstract

The 2010 choice reform in Swedish primary care constitutes a major change in the way that primary care services are organised and resources are allocated, with implications for actors involved and objectives in primary care. The purpose of this paper is to describe the experiences of choice and competition in Swedish primary care with focus on fulfilment of objectives in primary care and access to information to assess provider activities upon, based on a review of studies published 2010-2014. It is not possible to draw any certain conclusion regarding the extent to which overall objectives in Swedish primary care are fulfilled. They are limited by what information is available in registers at the regional and local levels. While objectives related to accessibility have been met, there is more uncertainty about the distribution of services and results between various groups in the population. Problems of continuity appear to persist. Costs seem to be controlled but it is uncertain what impact the reform had on the productivity and effectiveness of primary care. Although there is some comparative information about providers available, individuals tend to assess provider activities based on what they can observe in their contacts with providers rather than through seeking information elsewhere.

Introduction

Health care systems are subject to continuous reforms as policy makers strive to improve their performance. Implementation of health care reforms is difficult as it involves balancing a large number of potentially conflicting objectives and the desires of many actors. Governments in their role as policymaker and payer of services, citizens in their role as patients and health care providers all have different expectations on health care systems and services provided (Smith et al 2012). There is no simple solution for how best to organise health care in order to meet some objectives without adverse consequences for other objectives (Bevan 2010).

As elsewhere, reforms of Swedish primary care have focused on introducing solutions to perceived problems. Primary care in Sweden has traditionally been based on large, publicly run, primary care units with a broad responsibility for patients based on geographical area (Anell 1996). Fixed payment to providers based on the size of the catchment population has usually been practiced. The traditional primary care model can best be described as an integrated community model. This model ideally performs well with respect to objectives related to productivity, continuity, equity and quality but often display problems related to accessibility and responsiveness (Lamarche et al 2003). Discussions in Swedish

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primary care during the mid 2000s reflected the fact that there had been a weak development in primary care historically, with specialists at hospitals providing a lot of outpatient services. There was a gap between both financial and physical resources and the services that primary care was supposed to deliver. There was also a problem of low trust in primary care in the population where individuals tended to seek care directly at hospitals. One reason for the gap was the structural changes that had taken place since the mid-1990s whereby services were to be shifted from the hospital setting towards primary care. Increased demands from the population due to new technologies and an increased proportion of elderly worsened this gap (Anell 2005). Reforms focusing on increased choice for citizens have been introduced in response to perceived problems of accessibility, trust and responsiveness towards patients in primary care. Whereas the first steps towards increased choice, in the early 1990s, were not combined with competition among providers, recent reforms have combined choice for citizens with competition among providers. Freedom of choice of primary care provider for the population combined with freedom of establishment for providers has been mandatory since January 1st 2010, following a change in the Health Care Act. Any provider accredited by the local county councils, with responsibility for the organisation and provision of health care in Sweden, may establish a primary care practice. Individuals may register with any public or private provider accredited by the local county council. Payment to providers should follow the choice of individuals (Anell 2011). The new governance model in Swedish primary care can best be described as a quasi-market (Le Grand and Bartlett 1993).

The intended outcome of expanded citizen choice and provider competition is that it should improve the efficiency and quality of services as well as the responsiveness of providers in relation to citizens' expectations through market mechanisms (Le Grand 2007; 2009). Quasi-markets are markets in the sense that they replace monopolistic state providers with competitive providers although they differ from conventional markets (Le Grand 1991). Competition is expected to deliver greater productivity, encouraging efficiency and raising quality (Propper 2012). One important difference between quasi-markets and conventional markets is that consumers do not express their purchasing power in monetary terms but with an earmarked budget (Le Grand and Bartlett 1993). Hence, providers cannot compete in terms of the price of services in a quasi-market. Instead, they have to compete by means of the type of services and/or the quality of services provided. Economic theory suggests that competition should have a positive impact on the quality of services provided in markets with regulated prices (Propper 2012). Choice in this respect is supposed to lead to increased responsiveness among providers towards individual demands as individuals may change provider if they are not satisfied. The idea originates from Hirschman's (1970) reasoning about exit, voice and loyalty. If citizens are not satisfied with the quality or services of an organisation, they may exit (withdraw from the relationship) or they may voice (attempt to improve the relationship through communication). Changing provider can thus be regarded as exit.

When introducing quasi-markets with freedom of choice for individuals, citizens are given the opportunity of holding providers of public services to account for their activities through mechanisms of corrective action related to choice. For this to work in practice it is necessary with alternative providers to choose from but also that individuals are both interested and informed enough to actually make a choice of provider. However, governments still have the overall responsibility to ensure the achievement of overall objectives of public services towards citizens. In their role as policy maker and payer of services, they should stipulate and follow-up requirements for providers to be able to practice and be eligible for public funding, and allocate resources (Le Grand and Bartlett 1993; Le Grand 2007). In quasi-markets, providers are therefore accountable for their activities towards both citizens and governments. When payment is separated from provision and private providers become involved in the delivery of public services, the accountability for delivering services towards citizens becomes shared between the provider and the government. Governments and providers are then involved in a horizontal accountability relationship whereby governments use contracts or agreements to provide resources and delegate power and responsibilities for collective objectives to providers (Edwards 2011). Mechanisms for corrective action between governments and providers are primarily contracts stipulating conditions for payment and accreditation/re-accreditation of providers. Along with setting priorities and monitoring performance, accountability is a key component in the process of governance in the context of health systems (Smith et al 2012). Setting priorities involves ensuring that a clear set of objectives for the health system is articulated. Monitoring performance is about promoting transparency in the health system through the compilation and reporting of information about providers or entire health systems. A primary purpose of the collection, analysis and dissemination information about provider performance is to promote transparency throughout the health system, and to enable various actors to assess the services of providers of public services (Smith et al 2012; Greiling and Spraul 2010). Hence, access to information is vital in enabling individuals and governments to hold providers to account for their activities.

Purpose of the study

The introduction of choice and competition in Swedish primary care constitutes a major change in the way that primary care services are organised and resources are allocated. New objectives related to responsiveness and accessibility have been introduced. The expected roles among actors involved in primary care have changed whereby access to information about providers activities for individuals and governments has become more important. Five years after the choice reform, a number of studies related to actors and objectives in the context of Swedish primary care have been conducted. The purpose of this paper is to summarise the results from such studies and describe the experiences of choice and competition in Swedish primary care with focus on fulfilment of objectives in primary care

and access to and use of information on which provider activities can be assessed.

Methods

The description and discussion of experiences of choice and competition in Swedish primary care in this paper are based on previously published work. Studies and reviews related to objectives and/or access to and use of information in Swedish primary care published 2010-2014 were reviewed. The aim of the review was to answer three questions:

1. What are the objectives in Swedish primary care after the choice reform?
2. To what extent are the objectives fulfilled?
3. What information is available and used for purpose of assessing provider activities?

Journal articles were found through searching in the database Pubmed and grey literature through searching in databases of Swedish governmental organisations. Terms used in the search were commonly described objectives in primary care, i.e. productivity, continuity, equity, quality, accessibility and responsiveness (see e.g. Lamarche et al 2003) and access to/use of information combined with terms limiting the search to Swedish primary care. Relevant studies were also found through the references in relevant articles (snowball principle). Hence, the paper is not based on a systematic literature review. It is rather a case study of experiences of choice and competition in Swedish primary care during the first five years following the reform, based on secondary data.

Results

What are the objectives in Swedish primary care after the choice reform?

Important political objectives behind the choice reform in Swedish primary care were to tackle problems related to accessibility and responsiveness, ideally without negative consequences for objectives related to equity (Anell 2011). Equity was not an objective with the choice reform in itself but rather an important traditional objective in the Swedish health care system (Fredriksson, Blomqvist, Winblad 2013). Swedish health care rests on a strong tradition of high quality health care for all. In the 1982 Health and Medical Services act not only equal access to good quality services on the basis of need but also a vision of equal health for all is emphasised.

The responsibility for organising and financing health care is decentralised to 21 county councils Sweden and primary care models vary across the country with respect to principles for payment and medical and financial responsibility for registered patients. However, there is a consensus among them as to what the overall role that primary care should fulfill. The National Board of Health and

Welfare (2010) summarised how the county councils define primary care and its overall objectives in connection with the introduction of the choice reform:

- Primary care should provide health promotion and disease prevention activities.
- Primary care should have good accessibility.
- Primary care should be responsive towards the needs of the inhabitants.
- Primary care should coordinate care efforts between various actors and contribute to a coherent care process for patients.
- The primary care provider where an individual is registered should constitute the natural point of entry to the health care system.

Are/ have the objectives been fulfilled?

Studies suggest that objectives related to accessibility are achieved (Swedish Agency for Health and Care Services Analysis 2014). Both the number of individuals who visit primary care and number of visits per individual on average has increased since the choice reform was introduced. There has been an increase in primary care providers by almost 20 percent throughout the country. The Swedish Competition Authority (2012) conclude that, throughout the country, some 80 percent of the citizens have less than a five-minute long car journey to an alternative provider to the one closest to their home. The establishment of new providers are closely tied to density in population. Therefore the accessibility varies across the country. A majority of the new providers have established in densely populated areas, suggesting that individuals who do not have access to alternative providers primarily live in less densely populated areas. Moreover, the increase in the number of primary care providers has not been accompanied by a corresponding increase in the number of physicians in primary care. There is still a shortage of physicians of about 30 percent according to a report by the Swedish Medical Association (2014).

Problems of continuity in contacts with patients, and of coordination with other caregivers seem to persist in Swedish primary care (Swedish Agency for Health and Care Services Analysis 2014). Less than 30 percent of the respondents in a recent survey think that their primary care provider is able to help coordinate their need of care with other caregivers. This proportion is much lower compared to other relevant countries. The results indicate that there have been no improvements with respect to coordination of care since the choice reform was introduced. The results regarding impact on continuity does not allow any certain conclusions. But the proportion of patients who report that they have an established contact with a family physician or similar is also lower than in other comparable countries.

Fulfilment of objectives related to responsiveness towards expectations among individuals seems to vary with respect to characteristics of patients. In a study based on a sample of slightly more than 400 primary care providers located in three Swedish county councils it was found that the most common factor associated with a lower satisfaction among patients was high social deprivation (as measured by care need index, CNI) among registered individuals with a provider (Glenngård 2012). Findings also indicate that there are differences in the ability to make a choice of provider with respect to socioeconomic conditions (Glenngård 2013a). Individuals who were registered with private providers two years after the introduction of the reform were on an overall level better off in terms of socioeconomic conditions compared to individuals who were registered with public providers. This may indicate that individuals with poor socioeconomic status have changed to recently established private providers to a lesser extent than individuals with better socioeconomic status. Public providers dominated the primary care market before the introduction of choice and competition. Individuals who are better informed hence seem to adapt to their new role faster and actually use their possibility of changing provider to a higher extent when given the opportunity.

Knowledge about objectives related to equity in the distribution and outcome of services in different groups of the population is limited. The studies that have been conducted so far about the distribution of services among different socioeconomic groups shows no conclusive results. This area needs to be studied further (Janlöv and Rehnberg 2011; Rehnberg 2014; Fredriksson 2012; Ekström et al 2013, Beckman and Anell 2013a; 2013b; Swedish National Audit Office 2014; Andersson et al 2014). Studies are limited by the availability of data, primarily the lack of information about the content and distribution of visits (Swedish Agency for Health and Care Services Analysis 2014; Anell 2013). The lack of such information makes analysis of how resources are allocated and what benefits they bring to patients in different groups a challenge.

Knowledge of the consequences for the quality of medical care based on studies in the Swedish context is also limited (Winblad, Isaksson and Bergman 2012; Swedish Agency for Health and Care Services Analysis 2014; Glenngård 2013a; Kastberg 2014). This is partly due to limited comparative information on the performance and outcomes among primary care providers. One recurring conclusion in studies of Swedish primary care is that information describing what providers do and what values their activities lead to among patients is largely lacking. This makes analysis of the quality of medical care difficult.

There are some studies that suggest an increase in productivity after the introduction of the choice reform. In a review from 2012, Winblad, Isaksson and Bergman conclude that costs have been under control when implementing the reform but further evaluations of the impact on effectiveness and productivity are needed. In a report from the Swedish Medical Association (2014) it is found that in Sweden, as a whole, primary care's share of total health care expenditures has not changed in the last decade. Primary care's share of the county council's total costs is fairly stable at around 18 percent. While primary care's share of

health care expenditures has remained constant, primary care percentage of doctor visits have increased. This could be interpreted as an increase in productivity in Swedish primary care. There are differences between county councils however. In some cases the share of resources allocated to primary care has increased since the introduction of the choice reform.

There are also several studies of productivity in primary care based on data from individual county councils using Data Envelopment Analysis (DEA), where the number of health care contacts is related to costs in primary care (The Swedish Agency for Health and Care Services Analysis 2014; Janlöv och Rehnberg 2011; Glenngård 2013b; Glenngård and Anell 2012). The method is, in practice, a way to measure technical efficiency. The ability for a primary care provider to produce a maximum amount of output (such as visits or percentage of satisfied patients) given a certain amount of input or resources (eg. money) is calculated. The results show that productivity varies between county councils both before and after the introduction of the choice reform. In summary, it is not possible to explain changes in productivity with the introduction of the choice reform. The fact that it is mainly analyses of technical efficiency that has been carried out is associated with the availability of data. Generally one shortcoming in studies of the effectiveness and productivity in primary care (as well as in other health care) is that data describing what providers do and how they perform is lacking. To a large extent, such studies are limited to measuring the number of health care contacts in relation to costs.

What information is available and used for purpose of assessing provider activities?

The introduction of choice and competition in Swedish primary care has highlighted the need to compile other information about primary care than what is traditionally available through registers at national and local levels more generally. As increased possibilities for individuals to choose provider has been introduced in Swedish primary care, the gathering and compilation of comparative information about primary care providers have been improved and made publicly available. The National Patient Survey is a recurrent patient survey administered to all health care providers in primary care since 2009. It is coordinated by the Swedish Association of Local Authorities and Regions (SALAR), which is the organisation representing all county councils in Sweden. When the results of the National Patient Survey in primary care are presented to the public, they are summarised into eight broad categories regarding the perceived quality of the provider. The categories are overall impression, respectful and considerate attendance, participation in decisions, information about medical condition, accessibility, confidence, need adequately taken care of and if they would recommend the provider to others (Institute for Quality Indicators 2014; SALAR 2014a). Questions regarding the first seven categories are formulated to capture perceptions regarding the specific visit, whereas the question about recommending the provider to others is formulated to capture more general perceptions about the provider. Since 2009, accessibility in primary care is also measured annually for

all providers in Sweden through a national waiting time survey and published online. Accessibility here is defined as the proportion of patients contacting a primary care practice that got an appointment with a general practitioner within seven days (SALAR 2014b). There is also information about the geographical location, opening times and the categories of staff working at various clinics available through practices own websites and through regional and national websites to varying extent.

Comparative information about quality of providers besides what is collected through the national patient survey and the waiting time survey is limited. In general there is a lack of information about medical quality and ability to coordinate the care among different caregivers for patients. Such aspects may be important for individuals. For example, 90 percent of respondents in the study by Glenngård, Anell and Beckman (2011) stated that an important factor when making a choice of provider was the providers ability to coordinate their needs with other caregivers. Other studies also show that individuals are interested in information regarding aspect related to coordination and continuity of care (Swedish Agency for Health and Care Services Analysis 2013; Nordgren and Ågren 2010; Winblad and Andersson 2011).

Although there is some comparative information about providers publicly available, this information is rarely used by individuals when choosing a provider. Individuals think that they have enough information to make a choice of provider but are rather passive in their search for information. The most common source of information to base their choice of provider upon in Swedish primary care tend to be the chosen provider and friends or relatives (Glenngård, Anell, Beckman 2011; The Swedish Agency for Health and Care Services Analysis 2013). The results indicate that individuals base their choice on parameters that they themselves may observe to a great extent rather than facts or comparative information about providers (Kastberg 2014).

While individuals assess providers activities primarily based on what they can observe, county councils primarily use comparative information about providers for this purpose. County councils mainly use contracts stipulating conditions and requirements for payment and accreditation/re-accreditation of providers to control providers. Assessment of providers activities against set requirements is largely based on information from local and national registers. Examples of national registers include the national waiting time survey and patient surveys. At the local level many county councils collect information about goal achievement on selected quality indicators. Such information is often used to allocate resources to providers within pay-for-performance schemes (Anell, Nylinder, Glenngård 2012; Lindgren 2014). In a majority of the county councils there are also different models for clinical audits and feedback to providers in place to hold providers to account for their activities (Hagbjer 2014). Also for this purpose information available in different registers is used to obtain information about provider performance (SALAR 2013).

Discussion

Studies of Swedish primary care after the choice reform support theoretical arguments that accountability relationships between providers and governments (county councils in the context of Swedish health care) need to be maintained for purpose of fulfilling objectives related to high quality of services, also in a situation with choice for individuals. The picture that individuals base their choice on parameters that they themselves may observe to a great extent is in line with economic theory about the behaviour of individuals in health care, i.e. that they base their assessment on such parameters they can observe in their actual contacts with providers (Scheaff 2002). It is also in line with previous empirical research in the area (Kastberg 2014). Empirical beliefs as opposed to facts or comparative information guide individuals choices of provider. Such information is unlikely to be enough for individual choices to lead to fulfilment of many aspects of a high quality of services. Quality refers to the total quality of care as perceived by patients or professionals, technical quality including compliance with guidelines, and appropriateness, which reflects the suitability, of services provided (Lamarche et al 2003). The dependency on empirical beliefs causes information asymmetries between citizens (on their role as patient) and other actors (Scheaff et al 2002). To what extent providers offer services that are of high technical quality, including compliance with guidelines, and appropriateness, which reflects the suitability of services provided, is not visible to individuals in their contacts with providers. Providers know more about diagnoses and treatments than most patients. Providers and governments also know more about the need and availability of treatments for different groups in a population than most individual patients do. Therefore individuals possess less information about what services would benefit them as patients, both individually and relative to other patients, than health care providers do. Such knowledge is also used by governments and incorporated in clinical guidelines and conditions for payments of providers. What is perceived as high quality from the individual perspective might be the opposite from a population perspective. For example the prescription of antibiotics for uncomplicated infections may seem rational from an individual perspective. From a population perspective, it is important to be restrictive however since a generous prescription of antibiotics might lead to antibiotic resistance. Then, patients with severe or complicated infections will be more difficult to treat.

On the other hand, empirical beliefs might be appropriate with respect to fulfilling objectives related to accessibility, providers being responsive to its users and to quality of care as perceived by patients. Responsiveness here refers to consideration of and respect for the expectations and preferences of service users and providers (Lamarche 2003). Personal experiences, reputation and recommendations from friends and relatives might be good enough or even better than comparative information about providers to guide individuals choice with respect to objectives related to responsiveness, including accessibility. The extent to which providers offer services that is fulfilling such objectives is visible to individuals in their contacts with providers. Hence, individuals may, based on

their own or friends and relatives experiences, choose a provider they consider being responsive to their desires.

Accountability mechanisms between providers and county councils needs to be maintained also for purpose of achieving objectives related to equity in Swedish primary care. Governments need to compensate for differences in the ability to make informed choices in different groups of the population to ensure that accessibility and responsiveness towards some groups is not improved at the expense of worse accessibility and responsiveness in other groups in the population. Similar to the findings on specialist care in Norway (Iversen and Kopperud 2005), individuals who were registered with private providers shortly after the introduction of the reform were on an overall level better off in terms of socioeconomic conditions compared to individuals who were registered with public providers in Swedish primary care. This might suggest that individuals who are well-educated and more articulated find it easier to adapt to changes in the health care system and take advantages of increased possibility to choose provider. Individuals with poor socioeconomic status also tend to be less satisfied with services in Swedish primary care (Glenngård 2012). The results are consistent with previous findings from Sweden and other countries. A poor socioeconomic status is commonly associated with lesser ability to make an informed choice and to travel to a non-local provider according to previous research (Fotaki et al 2008; Barr et al 2008; Dixon 2006; Hibbard and Peters 2003; Blomqvist and Rothstein 2000). Knowledge of the fulfilment of objectives related to equity in the distribution and outcome of services in different groups of the population based on studies in the Swedish setting is limited, however.

The introduction of choice and competition in Swedish primary care has highlighted the lack of information available for purpose of assessing provider activities in general. Other information about primary care than what is traditionally available through registers is needed in order to hold providers to account for overall objectives in primary care. Information about content, distribution and outcome of services produced is limited in existing registers at the national and local levels. Such information is necessary for county councils to assess objectives related to equity, effectiveness and quality of services. It is an important challenge for Swedish county councils to gather and compile this kind of information. In their role as guardian of the market of independent actors, governments have an important task to reduce information gaps. This is important for their possibilities to assess provider activities. Compiling and making comparative information available to the public is also important for citizens possibilities to assess providers and make informed choices. To improve the availability of information about providers and enhance the use of such information is important from the perspective that individuals ideally should have the possibility to choose a provider that corresponds to their preferences.

As noted by Bevan et al (2010) there is no simple solution on how to best organise health care services to better meet some objectives without adverse consequences for other objectives. There is always a risk that reforms continue to call for new reforms if they focus on a few new objectives singlehandedly and

disregards traditional objectives (Brunsson 1992; Anell 1996). Health care reforms, as other public sector reforms, therefore commonly follow an action-reaction pattern where the solutions to one set of problems then turn in to a problem in itself, which requires new solutions (Bouckaert et al 2010). The starting point is an initial situation, which is perceived as a problem. If the solution to a particular problem is a reform, which focuses on a few new objectives single-handedly and disregards traditional objectives, inevitably new problems will arise. Reforms often result from previous reform and the outcome of reform is often new reforms (Brunsson 1992; Anell 1996). Structures where providers are accountable only to governments are probably not the best for achieving objectives related to accessibility and responsiveness of providers towards citizens' individual preferences. To better fulfil such objectives can be regarded as the rationale for introducing expanded citizen choice. On the other hand, citizens cannot be expected to hold provider to account for traditional objectives of public services. Mechanisms for holding providers to account for their activities between governments and providers need to be maintained and continuously improved in quasi-markets. Merely introducing expanded citizens choice will likely not lead to increased responsiveness and accessibility without adverse consequences for equity.

Mechanisms for holding providers to account for governments are primarily contracts stipulating conditions for payment and accreditation/re-accreditation of providers. Such mechanisms provide limited possibilities for providers to improve their performance in accordance with expectations from citizens and governments. Hirschmans (1970) reasoning about exit and voice refers to individuals being able to hold organisations to account in case they are dissatisfied with its activities. In the context of quasi-markets, the organisation refers to a provider of public services. However, exit and voice as mechanisms for corrective action may also be used to describe the accountability relationship between providers and governments. The range of consequences that governments can pose on providers can be related to both exit and voice. Providers who do not comply with what is stipulated in contracts with governments may ultimately be forced to stop practicing (exit). In similar fashion to the mechanisms for corrective action between citizens and providers, exit might give power to voice also for governments. As providers know that they might be forced to exit the market if they do not comply with requirements imposed on them by governments, they will have incentives to act upon complaints raised through voice from governments as well. Hence, voice can be a powerful mechanism for corrective action between providers and governments. As Hirschman (1970) argues, voice is not only confrontational; it is also more informative than exit. If providers are aware of gaps between and the services they provide they may adjust their services to better meet the expectations of individuals and governments. Voice would in this respect be better than exit in terms of fulfilling overall objectives. This points at a need for governments to continuously improve their accountability relationships with providers in order to improve the performance of health systems. Simply setting up the quasi-market and stipulating conditions for accreditation,

re-accreditation and payment for providers and follow up of stipulated conditions based on information in registers is not enough.

Summary and conclusion

The purpose of this paper has been to describe the experiences of choice and competition in Swedish primary care with focus on fulfilment of overall objectives and access to and use of information to assess provider activities upon. The introduction of the choice reform constitutes a major change in the way that primary care services are organised and resources are allocated. Economic theory in general and on quasi-markets in particular suggest that the introduction of the choice reform has changed the roles of actors involved in primary care and shifted the focus from traditional objectives related to equity towards new objectives related to responsiveness and accessibility of care (Le Grand 1991; 2007; 2009; Propper 2012). To tackle problems of accessibility, responsiveness and trust in primary care were also important drivers behind the choice reform. As the Swedish health care system rests on a strong tradition of high quality health care for all, these new objectives should ideally be reached without negative consequences for objectives related to equity.

Studies related to actors and objectives in the context of Swedish primary care after the choice reform does not permit drawing any certain conclusion regarding to what extent overall objectives in Swedish primary care are fulfilled. They are limited by what information is available in registers at the regional and local levels. While objectives related to accessibility have been met, there is more uncertainty about the distribution between various groups in the population. Problems related to continuity appear to persist. Costs seem to be controlled but it is uncertain what impact the reform has had on the productivity and effectiveness of primary care. Although there is some comparative information about providers publicly available, this information is rarely used by individuals when choosing a provider. Individuals rather base their choice of provider on factors that they themselves can observe in their contact with a provider, i.e. empirical beliefs, which is in line with economic theory about the behaviour of individuals in health care (Scheaff et al 2002). Empirical beliefs might be appropriate with respect to fulfilling objectives related to accessibility, providers being responsive to its users and to quality of care as perceived by patients. However, objectives related to productivity, effectiveness, equity and many aspects of quality of public services are aspects which individuals cannot be expected to assess and hold providers to account for irrespective of how much effort they put into searching for information and how interested in choice they are. Assuming that these objectives will continue to be important in Swedish primary care, mechanisms for corrective action between providers and governments need to be maintained and developed even in a situation with increased individual choice. The general conclusion from this is that markets in public services in this respect always will be quasi-markets, as opposed to conventional markets. This conclusion is in line with findings in previous studies in the Swedish context (e.g.

Hartman 2011) as well as in the UK (Dixon and Le Grand 2006). New accountability relationships between providers and citizens might be appropriate for achieving objectives related to quality and responsiveness of services towards individuals. But traditional accountability relationships between providers and governments have to be maintained and continuously improved to achieve objectives related to other aspects of quality, efficient use of resources and equitable distribution of services

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