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Choice of Primary Health Care

A Secondary Analysis of The Free Choice System in Stockholm and
Three County Councils

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Abstract

This master's thesis examines the outcomes of the new Free Choice policy with particular emphasis on whether giving residents the right to choose their providers of primary health care leads to a more equal distribution of primary health care accessibility. This study is based on the Secondary Analysis of assessment for *vårdval* (choice of health system) in Stockholm by Karolinska Institute (2010), socio-economic distribution in Stockholm and the Population Surveys in three county councils (Halland, Skåne and the Västra Götland Region) from 2009. By using the New Public Management (NPM) theory and the Public Value Creation this study tries to consider effectiveness and efficiency of service and understand the meaning of citizens' choice and participation in the free choice system. This study finds that the Swedish Primary health care system follows a line with the NPM theory, which more focuses on the outcomes and performance of service with high rates of patient satisfaction. In addition, individual choice of primary health care services will lead to stress citizens' voice to improve the quality of services and create public value. However, this choice system brings about also new gaps between the people who are active and not and are still difference between the different residence areas related to socioeconomic status. It needs further studies to consider the balance between the individual choice and the government responsibility of the value of social equality.

Key words

New Public Management, Free Choice System, Primary Health Care, the Third Way, Public sector, Private sector, Civil Sector, Citizens' Participation, Public Value Creation

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Abbreviations

CNI	Care Need Index
NHS	National Health Service
NPO	Non-Public Organizations
NPM	New Public Management
OECD	Organization for Economic Co-operation and Development
PPPs	Public Private Partnerships
SAMS	Small Area Market Statistics
SCB	Statiska centralbyrån

1. Introduction

1.1. New Public Management in the Health Care Sector

Over the last several decades, the ideology of neo-liberalism has become increasingly influential in public management across the Organization for Economic Co-operation and Development (OECD) countries, as governments attempt to reduce their budget deficits and overcome the current financial crisis (Whitfield, 2001; Jordan, 2006; Pierson, 2009; Simonet, 2008). Neo-liberalism as an ideology is based on the basic premise that the private sector, through the mechanism of market-based competition, can make more efficient use of resources than can governments. Other aspects of neo-liberalism relate to a perspective of market orientation and the rights of individuals against states (Scot–Marshall, 2005). In Sweden, in the context of the provision of public services, this idea drove welfare reforms aimed at encouraging individual responsibility in choosing service providers and promoted the privatization and deregulation of public services in different service areas such as education, health care and social services. Out of this series of reforms, of particular interest to this thesis is one entitled the New Public Management (NPM), which is a government–initiated management initiative aimed at using market forces to increase effectiveness and improve service quality by encouraging competition between social service providers.

Similarly to the operational mechanism of market competition, the NPM aimed to set up a competitive system that would select for improved performance of provider organizations, but at the same time the NPM would keep implementation under the state’s control in order to ensure that all service recipients have equal opportunity to access services (Simonet, 2008). In other words, the role of the state has shifted from administration to management, which outsources provision of services to private and non-public organizations (NPO), while regulating how the services are provided (ibid). These ideas also led to social services being delivered by organizations with several different corporate structures, such as Public and Private Partnerships (PPPs – partnerships between public and private organizations) or partnerships between public organizations and NPOs (Whitfield, 2010).

In this transition of the role of the state under the NPM, welfare reforms have been conducted in several public service sectors, including health care: the area of primary interest to this thesis. However, in comparison to other sectors targeted by these reforms, the health care reforms are more regulated by the state, due to concerns related to protection of equal access to health care services and preservation of service quality (Simonet, 2008). There has been a recent trend of similar health care reforms beginning employed not only across the OECD countries but also in developing countries, with the different implementations varying depending on the local contexts, social policies and backgrounds.

1.2. The principle of the Free Choice system in Sweden

In Sweden, equal access to health care services is one of the fundamental principles on which the universal health model is based, and has been promoted by the long-serving social democratic government (Anell, 2005). Different levels of government, such as the national government and county councils have traditionally been involved in providing health care services. However recent trends in public health policy have also increased the involvement of the private sector or citizen's organizations at a local level (Anell, 2005: the 2005 Public Health Policy Report, 2005). In line with this trend, the 'Free Choice System' ('Lag om Valfrihetssystem'), applicable to the areas of elderly care, disability care and other health services, was instituted in 2008.

The principle of Free Choice System is that an individual chooses which of a number of public and external service suppliers will provide them with services. The external service suppliers work under contract with the municipality or county council, and provide services to individuals for the same fixed price as the publically provided services. The county council is in charge of overall management and takes responsibility for setting the costs to individuals by entering into agreements with the external providers selected by the county council to provide the services. By January 2010 all county councils¹ introduced the Free Choice System in the primary health care sector (Anell, 2010). However, this thesis chose five county councils cases due to available data which were testified since 2007²: Halland, Stockholm, Region Skåne and the Västra Götaland Region. How the system is implemented is up to the individual county councils, and the implementation details differ slightly between them.

The general goal of the Free Choice System is on a basic level *“to move power from politicians to citizens and increase the choice and influence of users and to promote a*

diversity of providers” (<http://www.regeringen.se/sb/d/10057/a/99454>). The ‘Free Choice System’ aimed to meet this goal by shifting the service recipient’s role from being passive (such as that of a patient) to the more active role of a customer. Under the free choice legislation, citizens are able to choose any primary health care provider regardless of whether it resides in the public or private sectors, or whether the provider is locally or remotely located to the place of residence of the recipient. One phrase simply illustrates this transition.

Principen “patient följer pengarna” har i dessa landsting ersatts med principen “pengarna följer patient” (the Principle ‘Patient follow money’ in this county council replace with the principle of ‘Money follow Patient’) (Karolinska Institute, 2010:5)

Looking from another perspective at the Free Choice System, the free establishment of primary health care facilities represents a corporate structure located somewhere between the public and private sectors in the health care market. Free establishment of primary health care facilities is approved within the agreement with country councils (Karolinska Institute, 2010). In the cooperation between the public and private sector in the primary health care system, competition across providers has been taken into account in order to reduce waiting time, cost and match between health care services providers and users (Nordgren , 2009; Anell, 2010).

In this sense, the discourses of market-oriented incentives and the flexible social service providers are factors in the Swedish health care reform responding to the New Public Management. It is, however, a valid argument that the Swedish health care System has also slowly changed at a different level. This study focuses on the outcomes of the Free Choice System, in particular the perspective of the citizen’s participation in primary health care is considered. At the same time, the perspective of pluralistic structure of the public and private under this law will be taken into account as the change of the policy reform.

1. Sweden is divided into 290 municipalities, 18 county councils (the Swedish Institution, 2011)
2. ‘Free Choice System’ (‘Lag om Valfrihetssystem’) was instituted in 2008 and the law was implemented by January 2010. However, Halland testified to introduce by January 2007; Stockholm by January 2008; Region Skåne by January 2009; the Västra Götland Region January 2009(Anell, 2010)

2. Background

2.1.1 Research Question

In Sweden, operation of the primary health care system is the responsibility of the county councils, with consistency ensured through a system of regulation, subsidies, evaluations and guidelines (Anell, 2005). A major focus of government health policy is on providing equal opportunity for the entire population to access primary health care services and to minimize inequalities in health that exist amongst different sectors of the population (Lundgren, 2005).

This master's thesis will examine the outcomes of the new Free Choice policy with particular emphasis on whether giving residents the right to choose their providers of primary health care leads to a more equal distribution of primary health care accessibility. Not all individuals will be able to choose to their best advantage. In other words, the primary research question being asked is 'what are the outcomes of user participation in the primary health care system?' In order to answer this question the following two sub-questions will be considered:

- What is the results of the 'Free Choice system' ('Lag om Valfrihetssystem') for people choosing health care by themselves - in particular the people who are at risk of "social exclusion" caused by socioeconomic factors?
- What sectors of the population are advantaged/disadvantaged by the Free Choice System?

The reason why the question focuses on marginal groups within the population is that these are likely to be most impacted by such a social policy. As for the second question, this thesis will consider who in the population is advantaged or disadvantaged by this new system. These questions will be discussed from both theoretical and practical viewpoints. Finally, the conclusions of this study will be a combination of theoretical and empirical approaches.

2.1.2. Outline

In order to answer these research questions, both theoretical and empirical perspectives will be applied to a case study of the primary health care systems in Stockholm and three other county councils (Halland, Skåne and the Västra Götland Region). From a theoretical standpoint, this thesis will be divided into three sections. Firstly, it will illustrate the goals and ideas behind the NPM in primary health care at a policy level. The second part will examine the three actors under the NPM and how the idea of citizens' participation developed as a response to the increased popularity of the Third Way, using the examples of the UK and Sweden. Thirdly, this thesis will examine the perspective of choice in the health care sector.

In the methodology section, the technique of Secondary Analysis will be employed to perform an extended analysis of the first Free Choice System report in order to focus more closely on details of the reform and to clarify the effects of the social policy from different standpoints. The empirical analysis will focus on the outcome of the Free Choice policy from the perspectives of the numbers of patients visiting General Practitioners, registrations, the change of cost containments related to different social groups, and patient satisfactions in relation to utility and choice. In addition, socio-economic perspectives will be also considered in order to understand whether segregated living patterns also result in the choice of delivery of welfare services being affected in a negative way. Finally, the relation between the kinds of choices made and the introduction of the Free Choice system will be considered from population surveys in three county councils from 2009.

2.1.3. Possibility of This Study

A possibility of this thesis is to show a different approach to this new trend of the public management. Combining theoretical framework, sociological perspective and empirical data which are variable from different data resources will help to review on-going discussions on the Free Choice System in Sweden. There are still arguable and also considerable perspectives of the new system. In order to clarify both advantage and disadvantage of the Swedish Free choice system, using the example of the UK's case will be applied to and that will help to draw a clear picture of the Swedish case.

In addition, this thesis focuses on the outcome of the Freedom of Choice System using the Secondary Analysis which is able to focus on a certain perspective and complete by several existing datasets and contribute more detail of the reform and different perspectives from the primary analysis.

2.1.4. Limitation

The analysis of the Free Choice System has to confront limitation of the data source and analysis. One is limitation to collect data and access to metadata. Especially, the data of access to primary health at individual level was regulated by the municipality due to protection of privacy and those data at individual level would require special permission to be accessed. Therefore, this study employs the Secondary analysis in order to overcome the disadvantage of accessing to metadata using several dataset which is available data from Economic Department in Lund University the Karolinska Institution and Stockholms Stads Utrednings- och Statistikkontor AB.

This Case study based on the primary health care system in Stockholm area limited to generalize a whole Swedish primary health system, due to variety of the system in different county councils, where the Freedom of Choice System have been implemented. Moreover, the result from the population survey is only available in Halland, Skåne and the Västra Götland Region. Thus, it is also not enough to generalize opinions of users. However, the result will be relevant and considerable to discuss this Free Choice reform in detail. In addition, it is a limitation of time to argue with this reform due to new system, which was implemented in 2007. The analysis will be necessary to consider time period and take into account of a long span in order to understand the outcomes of the system.

2.2 Previous Studies

In this section the results of a number of studies looking at the current situation in the Swedish primary health care system will be discussed. First, several problems with the accessibility of health care services will be illustrated both from implementation and user perspectives. From the implementation perspective, costs and the limitation of resources will be described. From the user perspective, studies will illustrate discrimination of access to primary health care services. The second section of this chapter focuses on primary health care demand. The third part shows example of the Swedish universal primary health care system in order to distribute services equally among the different social groups.

2.2.1. Low Accessibility and Responsibilities to Primary Health Care Services

Given a choice of primary health care service providers, in general people will make a decision based on convenience of access and the expected service waiting times. Studies have frequently shown that health care is not extended equally to all parts of society (Dulin.F–Ludden.Tapp–Blackwell–Urquieta de Harnandez–Smith–Furuset,2009), for

example, it is often difficult to provide equal access to facilities in rural districts with small, spread out populations to densely populated urban districts.

Nordgren (2009) raises the point that the Swedish universal health care model, while ostensibly offering universal health insurance covering the entire population equally, can be criticized for low service productivity. Low public expectations regarding access to primary health care services are a major issue in the primary health care sector. It has been argued that Swedish primary health care services are not as effective as they could be given the resources allocated due to two issues: overhead costs and limited access to information for service recipients (Anell, 2005; Nordgen, 2009). High overhead costs, due to expenses such as the rental of facilities, purchase of equipment and consumables and salaries of healthcare workers reduce the efficiency of the health care service, resulting in increased waiting times and reduced overall health care service capacity. Another factor reducing efficiency is that service recipients often suffer from a lack of information regarding available resources and the capabilities of different councils to provide services (Anell, 2005; Nordgen, 2009).

2. 2.2. Discrimination in Primary Health Care Access

Accessibility of primary health care is not equal for all users. Typically, factors such as low conditions of social and economic status negatively affect the number of accesses of health services. People who are of lower social economic status may require more health services more than those people with relatively high socio-economic status. This was illustrated by the results from the National Public Health Survey (2006), which shows that individuals feeling socially or economically marginalized, for example as a result of being under financial strain contact health care services more relative to other social groups. In addition, the results also showed that individuals born outside Sweden on average required more medical services than other social economic groups.

In contrast, the results of a different study suggested that people who consider themselves as being discriminated against in fact accessed primary health care less frequently (Wamala–Merlo–Boström–Hogstedt, 2007). This study shows that factors of perceived discrimination and socioeconomic disadvantage are more strongly associated with less access to health care services than other independent factors such as age, long term illness, low education, and status of living alone in Sweden (Wamala–Merlo–Boström–Hogstedt, 2007). The study defined people with ‘perceived discrimination’ as those respondents that feel humiliated due to their ethnic background, religion, gender, sexual orientation, age or disability. The ‘socioeconomically

disadvantaged' was defined as being those recipients who were social welfare beneficiaries, unemployed, or in a state of financial impairment. According to their research, even in the absence of socioeconomic disadvantage, the ethnic background, age, gender and religion factors of perceived discrimination strongly negatively influence the determination to use medical care. In other words, those people who felt discrimination refrained from seeing doctors, even when they were in need of medical treatment. This may occur for example because of prior negative experiences of health care treatment or a lack of trust in the medical care system (ibid). In addition, Blomqvist (2004) points out that 'well-educated' groups likely to use a right to choose care providers than 'less well-educated' groups.

A National Public Health Survey (2006) showed that older individuals (pensioners or early retirees) generally had more contact with the medical care system than other age groups. This was especially marked in the case of well educated women, with the contact rate increasing with increasing age. In addition to this, the survey also pointed out that people who felt socioeconomically marginalized, such as those with low levels of education or suffering from long-term unemployment or chronic illnesses also accessed to medical care more than the working population in Sweden. Other observations from this study were that people in a situation of economic stress, with relatively low incomes accessed medical care services more than the average, and that those born outside Sweden accessed the medical care system more than those born in Sweden.

A different study reported opposite results to the National Public Health Survey: those people that perceived themselves as being discriminated against due to ethnic background, religion or gender refrained from accessing primary health care services relative to others, and those people that were who were unemployed or financially stressed actually had more contact with the health care system than those who were not. The difference in outcomes of these studies may be due to insufficient consideration of other factors, which may have influenced determination of whether a group has refrained from accessing primary health care services. For instance, women are more likely to feel discriminated against due to their gender than are men (Wamala–Merlo–Boström–Hogstedt, 2007). This study also did not explore the reasons why those that perceived themselves to be subject to discriminative factors such as ethnic background or gender refrained from seeking medical care (ibid). Regardless of these inconsistencies, the outcomes of these studies illustrate that even though the Swedish universal health care system is charged with providing equal care to the entire

population, there is still discrimination in access to health care treatment. The different results from these studies shows the complicated nature of the health care service access inequality, faced by universal welfare policy.

In addition, the study indicates that discrimination in the primary health care influences people’s decision regarding whether to seek medical treatment for their health problems, leading to treatment delays (Wamala–Merlo–Boström–Hogstedt, 2007). In other words, the primary health care utilization is different from the required treatment of primary health care and choice. In this sense, individual choice of health care treatment may be one important factor in order to consider the inequality to access to the primary health care due to the discrimination in the primary health care in Sweden.

2.2.3. Fixed payment System and Care Need Index

There are several policies to respond to the high demand across certain groups such as elderly group, the age group under 5 or potential need of health services (Anell, 2005). The central government has employed policies of fixed user charges and subsidies for primary health care facilities related to the rate of potential patient who are in need of health care(ibid).

A scheme of fixed user charges is used for different types of outpatient visits. Patients who are below 20 years old are exception of the payment system and the high cost protection for people who are above 64 years old in order to protect users from high cost and prevent an excessive use of the medical care. Table 1 illustrates the user charges in 2003 (Anell, 2005). The central government presents the protection for maximum user charges in particular for the targeted group who are in high demand for the health care. The new model implemented in 2007 and 2008 respectively, and the payment system varied in different county councils. The cost of payment for a visit a primary care services changed about 150 SEK in 2010. In Stockholm the percentage of fixed payment is above 40 percent which is different from other four county councils.

Table 1 User Charges and High Cost Protection Scheme for Health care in 2003

	Health Care
User Charges	<ul style="list-style-type: none"> ● Fixed user charges for different types of outpatients visits. ● Payment for a visit to a primary-care physician is 100 SEK (at the point in 2002) and 150 SEK (at the point in 2010), double amount of for a visit to hospital physician.

	<ul style="list-style-type: none"> ● Maximum user charge of 80 SEK per day in inpatient care(at the point in 2003)
Exceptions	Patients below 20 years old
High Cost Protection	Maximum 900 SEK in user charges for outpatient care in each 12 month period
Central/Local decision making	<ul style="list-style-type: none"> ● The central government determines the high-cost protection scheme for out-patient care and maximum user charges for inpatient care ● Country councils determines payment levels within the national framework

(Source: Anell, 2005, 2010)

Another is that the government applies to Care Need Index (CNI) which is an indicator to measure the expected risk related to the potential illness based on seven social economic factors in order to estimate the need of primary health care services. The Data of CNI is based on the so-called SAMS areas (Small Area Market Statistics) in Sweden from Statiska centralbyrån (SCB) and seven factors: 1.Unemployment between 16-64 years old, 2. Age under 4 years, 3.Foreign born outside EU (Southern and Eastern Europe, Asia, Africa and South America), 4.Single parent with children 17 or younger, 5.Person who have moved the area from the preceding year, 6.Low qualification between 25-64 years old and 7.Age over 65 years old and living alone. The index is used for assessments in practice, for instance the 20 % of all reimbursement to all primary care units is allocated by using the relative ratio of CNI for the single unit in RegionSkåne(http://www.skane.se/sv/Webbplatser/Valkommen_till_Vardgivarwebben/Utveckling_projekt/Halsoval-Skane/).

Previous studies show that low access to primary health care services in Sweden is major issue in health care sector which is identified by various factors. Not only limitations of cost and capacity of universal health care system, but also different social backgrounds and economic status influence to access to the primary health care services. Equal opportunity to access primary health care does not always mean that the equal outcomes to receive the primary health care services. In addition, those results show that dilemma between supply and demand in primary health care services. Although demand of health care is high among the certain groups such as elderly group or people who are outside socio-economic classification, the limitation of budget and capacity of primary health care services and the factors of perceived discrimination affect to produce less accessibility of primary health care services. Those issues are related to long waiting

time to see doctors and determination of refraining accessing medical treatment. Next chapter will consider several theories behind the primary health care system in order to cope with those issues.

3. Theoretical Framework

In this section the New Public Management (NPM) Theory will be outlined from different perspectives. In order to understand how the concept of the NPM theory relates to the ideology of neo-liberalism, several characteristics of the NPM theory will be discussed: it is not only from a market perspective, but also from the perspective of citizen participation responding individual choice of service. First, the concept of the NPM theory will be defined from taxonomy by Stoker (2006). Second, the NPM theory will be outlined from the standpoint of efficiency and effectiveness, service quality and Public and Private Partnerships (PPPs) from Whitfield (2010) and McQuaid and Scherrer (2010). Third, citizen participation and the decentralization of decision making will be outlined using the ideas of Pierson (2009). The concept of citizen participation will be related to the concept of the Third Way. From this perspective, the concept of public value will be explored to explain the co-production of value in social governance by Midttun (2005). Finally, this concept will apply several primary health care models in an international perspective. The Swedish Free choice case and the Big Society model in the UK will be employed as examples of the NPM in different contexts.

3.1. The New Public Management (NPM) Theory

As mentioned briefly in the introduction part, the New Public Management (NPM) is one of the public management forms, which aims to improve the performance of the public sector in order to enhance accountability through the measurement of outcomes (Pffner, 2004). Outsourcing public services to private companies or civil organizations (the so-called ‘civil’ sector or ‘third sector’) is a form of service provision called Public Private Partnerships (Simonet, 2008; Whitfield, 2001; Jordan, 2006). The competition among these service providers under the regulation and subsidization of the government is one characteristic of the NPM designed to increase effectiveness, efficiency and improve service quality under the state’s control.

The NPM gained attention as one of state’s possible management styles following the rise of the neoliberal movement in the UK and the United States after 1980 (Simonet, 2008:618). This management style had been applied as financial crisis solution in

Europe and Canada. Several studies have aimed to understand NPM as a dismantled management form of traditional public administration. For instance Stoker (2006) regards the traditional public administration as a ‘monopolistic form’ of providing social service by the government. The traditional public administration aimed to provide political inputs and create public order through bureaucratic supervision which is represented by forms such as political leadership, party and bureaucracy. Meanwhile, the NPM is regarded as manager and plays the role of coordinating the service provisions, rather than providing services.

Furthermore, Stoker (2006) clarifies the NPM by contrasting it with the traditional model and the network model (Public Value model). Stoker (2006) defines the NPM as being formed through a shift of performance management in the public sector with the government controlling input and procedure. However, the NPM focused on results measured by outputs and outcomes. The NPM gives rise to an idea which has coped with different social issues embraced by the government through a range of services and market-oriented providers. Stoker (2006) states that the aim of the NPM is

‘...to create an organizational home for the client or consumer voice within the system to challenge the power of producers. Consumers or their surrogate representatives, commissioners, would have the power to purchase the services they required and measure performance (Stoker, 2006:45).

As for the role of manager, the traditional public administration played the role of enforcer of the rules, while the NPM aggregates individual performances and supports the choice of customers in practice. The system of service delivery in traditional public administration is explained by Max Weber’s idea of the principles of bureaucracy: a system is controlled from top to down based on a rule and regulations (Pfiffner, 2004). By contrast, the NPM choose the service delivery through the business from the private sector which is called PPPs.

Table 1: Public Management Structures: The Tradition Public Administration and New Public Management (NPM)

	Traditional Public Administration	New Public Management
Key objectives	Politically provided inputs; services monitored through bureaucratic oversight	Managing inputs and outputs in a way that ensures economy and responsiveness to consumers
Role of manager	To ensure that rules and appropriate procedures are followed	Aggregation of individual preferences, in practice

		captured by senior politicians or managers and supported by evidence about customer choice
Preferred system for service delivery	Hierarchical department or self-regulating profession	Private sector (Public Private Partnerships)

(Source; Stoker, 2006: 44)

At the implementation level, the NPM has several features: a reliance on market forces, a strong demand for organizational performance, increased concerned about quality, a decentralization of decisions and greater citizen participation (Simonet, 2008:618; Connell–Fawcett–Meagher, 2009). In the next subsection, these features are considered to provide a clear picture of the NPM.

3.1.1 Efficiency and Effectiveness of Service using Market Forces

Efficiency in the NPM is intended to improve the performance of government management by outsourcing public services (Whitfield, 2001; 2010). The outsourcing of public services to the private sector has four characteristics: “partnership”, “value for money”, “risk transfer” and “additionality” (Whitfield, 2010; McQuaid–Scherrer, 2010). McQuaid and Scherrer (2010) understand partnerships between the public and private sectors from micro- and macro-economic perspectives. From the micro perspective, the model of PPPs emphasizes ‘efficiency’ and ‘effectiveness’ in order to improve and maintain the quality of public services through the use of the skills and knowledge of the private sector, while the government holds the general responsibility. It responds to the idea of “value for money” which means that the value of production is based on a minimum purchase price but at the same time the maximum efficiency and effectiveness of the good or service is required(ibid). Moreover, PPPs transfer potential risk from the government to the other providers, due to a sharing of financial risk (ibid). In other words, the policy of PPPs is not only an instrument to provide and finance public services, but also a provider to encourage an ideology of economic principles. From a macro-economic viewpoint, the policy of PPPs contributes to reducing the tax burden due to the encouraging of transactions off the balance sheet in the context of globalization and aging societies.

However, the policy of PPPs has potential problems with management. For instance,

several studies have shown that the PPPs model sometimes fails to improve based on past experience and knowledge, due to a lack of cooperation between the public sector and private sector and their different approach to coping with problems from each organization (McQuaid–Scherrer, 2010). These problems imply less effectiveness and less performance of outcomes through the outsourcing public services to the private sector. In addition, Hanque (2007) points out that if the NPM overemphasized efficiency and effectiveness, it would also lead to negative outcomes: it may exclude the entitlement of disadvantaged groups due to the stress of individual choice not rights to access to service equally (ibid).

3.1.2. Citizens’ Participation in the decision-making process: The Third Way Approach

The NPM also demands citizens’ participation in the decision-making process (Jorden, 2006, 2010; Seeleib-Kaiser, 2008). Citizens’ participation in the decision-making process is related to Giddes’ idea of the Third Way (Falkheimer, 2007). The Third Way is an approach which is based on a market mechanism orientation adding the element of civil society. The Third Way regards local voices as key element of the public management in order to improve the service quality from the citizens’ side. Connell, Fawcett and Meagher (2009) simply defined the Third Way as moving responsibility from the central to the local level. For instance, the government in Sweden divided the responsibilities of decision making: the central government decides the framework for high cost protection and user charge while the county councils determine service provision and contracting with private companies and civil organizations (Anell, 2010; Lundgren, 2005).

This decentralization from the central to the local level has been attentive to the individual responsibility and the role of associations and communities as alternative service providers of public services. (Jorden, 2006; Seeleib–Kaiser, 2008). From this perspective, Midttun (2005) explains that elements from the civil sector such as association or communities are one of the domains that form of processing the governing: the government, the civil sector (civil society) and the market comprise. The process of governing is explained as exchanges among these three actors: political exchange, commercial exchange and regulatory exchange. In political exchange between government and civil sector, the government provides social services and legitimates corrective actions in exchange for the contributions of income tax and votes from the civil sector. Commercial exchange makes the civil sector act as a workforce in the market, while at the same time supplying goods and services to civil sector. In other

words, the purpose of the civil sector is to serve as a channel connecting the user's perspective to the government. It is related to the Third Way, which emphasizes the voice of citizens and individualism. Pierson (2006) also explains the Third Way as follows:

The Third Way represented an attempt to give some coherence (and justification) to the general policy reorientation which informed the New Labor project. The Third Way lay between but more importantly 'beyond' two alternatives that were seen to have failed – not just the market led “neo-liberalism” of Margaret Thatcher but also the stated, producer-driven, paternalistic management of the old-style social democracy, including its commitment to a 'passive' welfare state (Pierson, 2006 :181).

In this sense, as Pierson (2006) indicates, the Third Way approach is a challenge to traditional monopolistic public administration through mixing elements of social democratic and market mechanism oriented approaches. Moreover, it has arguably built common perceptions of social equality and universal right to all citizens and empowerment of marginal groups (Esping-Andersen-Gallie-Hemerijck-Myle, 2002).

From this perspective, Benington (2009) explains that value is created by the three sectors (the public, private companies and civil organizations), not only the public sector. These three sectors are key to understanding such local governance in practice: the public sector (local government or county council), the private sector (private company) and civil sector (local communities or associations). Civil sector has been emphasized under the Third Way in order to support the voice of citizens. White (2006:45) simply defines the third sector as the voluntary, community sector, or non-governmental, non-profit, and voluntary or grassroots organizations. The Third Way approach focuses on their participation in the process of social policy in the form of citizen engagement such as the claim-making or consultation (ibid: 47-48). In the NPM civil sector is not only defined as a 'service provider' of the government, but also the representative actor from the citizen side. In other words, the relationship between the government and civil sector is different from those sectors used to regard as only a service provider of government.

Citizens' participation determines whether citizens (or users) come to participate in decision-making processes at all (Bochel.C-Bochel.H-Somerville-Worley, 2007). However, individuals do not involve directly into decision making process and the process of the governing. Bochel C- Bochel H- Somerville-Worley, (2007) explains different types of users, such as policy makers, activists or ordinal residents that have

different ways of participating in policy processes (ibid). Therefore, unequal power is often criticized among these different users when they participate in decision-making processes. For instance, ordinal residents does not represent any policy process, but is nonetheless directly influenced by these (ibid). Even though inclusive policy aims to encourage the individual to participate and contribute their voice, in reality most citizens are not policymakers or activists and are consequently categorized as ordinal residents who are not involved in the policy process. Therefore, experience shows that the intended inclusive policy fails to systematically influence public services programs, due the limitation of power of different users.

From this perspective, individual choice of services does not relate directly to the decision making process. Choice is based on individuals and it does not play role of representing the civil society such as the role of civil organization. Individual choice is more related to the idea of market competition mechanism. In the theory of perfect competition, the individual choice affects to force prices close to the marginal cost of production through competition among providers (Dixon–Robertson–Appleby–Burge–Devlin–Magee, 2010). This mechanism applies to improve quality of service. In the NPM the individual choice is one of the forms from citizens’ side to improve quality of service using market competition among providers. It will lead to create a value from user/ customer. However, the choice in health care is different from other markets due to the character of the health care production (ibid). Next, the meaning of choice will be considered from several perspectives at the context of the primary health care.

3.1.3. Public Value Creation: Choice in Primary Health Care

In Social Science choice is defined by several approaches from different disciplines. The concept of choice had been developed from several authors. Based on Weber’s idea of Rationality, the ‘Rational Choice Theory’ which is defined as ‘the assumption that complex social phenomena can be explained in terms of the elementary individual actions of which they are composed’ (Scott, 2000). In economic discourse choice is defined as rational decision, which consumers will make in order to pursue maximum utility (Dixon–Robertson–Appleby–Burge– Devlin–Magee, 2010:11). However, choice in the health care sector has features of uncertainty of power between providers and clients compared with other service sectors. For instance, studies reveal an asymmetry of information between consumers and providers in the health care, due to the fact that health care is a reputation good and it is difficult for the consumer to judge the quality of a service even after they receive the treatment(ibid,2010:12). The choice is affected by ‘how the choice is offered, how information is framed, and the context’ (ibid,

2010:11). On the other hand, patient choice is intended to lead to competition across different providers and improve their service quality and increase efficiency.

From sociological perspective, the 'Exchange theory' by Homans (1961) add sociological perspective to the 'Rational Choice Theory' within the area of behavior studies (Scott,2000). Homan explained that social behavior is exchange between two actors who acquire something from each other. Scott (2000) explains the Humans' exchange theory that individual choice is one of human behaviors related to the individual preferences and goals. However, the individual choice is not always directly related to their desired and the choice is also exercised under the given information and limited conditions. Therefore the individuals will exercise their choice in terms of the condition of the relationship between their preference and constraints (ibid).

In political discourse, the idea of choice from citizens is behind the idea of participation in policy process or co-production that creates value from both the customer and providers (Moore, 1995 Benington, 2009; Nordgren, 2009). Moore (1995) approached the process of the 'public value' through examples. First, Moore defined value as being 'rooted in the desires and perceptions of individual' (1995:52), but there are different types of the desires and public value follows the desires which are reflected by citizens expressed through representative government. Furthermore, Meynhard (2009:205) clearly defined the public as "an indispensable operational function of society" and the public value as "what impacts on values about the public". The public value creation can be explore from the concept of public value as

"Any impact of shared in relationships between the individual and society can be described as public value creation. Public value creation is situated in relationships between the individual and society, founded in individuals constituted by subjective evaluations against basic needs, activated by and realized in emotional –motivational states, and produced and reproduced in experience-intense practices " (Meynhardt, 2009:212)

From this perspective, Nordgren (2009) points out that the individual choice is one of the interactions between the customer and the provider. It is also a process of creating values from citizens' voice to improve service quality. In other words, the customer participates in a service process of exchange with service provider, is one solution to developing service production in health care services (ibid). The role of the customer is to drive health care providers to become characterized not only by financial value and reduced costs but also by increased service quality or reliability. The patients become more active

in the health care sector and become the role of customer, while they have to choose health care services by themselves and take an individual responsibility.

The discussion of process of governing is how to keep a balance between ‘public values’ such as social equality and universal rights, and individual choice within market orientation. In primary health care services, these ‘solidarity’ ideas mean that the state provides a proper and high quality of services for all citizens regardless of their ability to pay as arising from such factors as different socioeconomic status, cultural backgrounds, etc. Furthermore, these values stressing equal access to health care leads to the idea that resource will be directed to those in need. In other words, it is a redistribution of resources from persons with low risk or high incomes to those with high risk or low incomes.

3.2. Primary Health Care Model in the NPM from an International Perspective

When it comes to the NPM in primary health care, Anell (2010) uses two types of primary health care models from an international perspective defined by factors of effectiveness, productivity, continuity, access, equity of access, responsiveness and quality . These two models are based on the Taxonomy for Canadian primary health care model defined by Lamarche (2003) and Anell (2010) developed models to apply models at international level. There is a ‘community model’ and a ‘professional model’ and each model is divided into two sub-models. In the ‘professional model’, the two types are introduced as the ‘professional contact model’ and ‘professional co-ordination model’ respectively. The ‘community model’ is divided into the ‘integrated community model’ and the ‘non-integrated community model’ respectively (Lamarche, 2003; Anell, 2010:10). Table 3 shows the taxonomy of the primary health care model (ibid).

Table 3The Taxonomy of the Primary Health Care Model

Model	Professional model		Community model	
Type	Professional contact model	Professional co-ordination model	Integrated community model	Non-integrated community model
Example	The USA, Canada, Germany and Belgium	The UK, Netherland, Denmark and Norway	Sweden and Finland	

(Source: Lamarche, 2003; Anell, 2010)

The 'professional model' is defined by the following points:

- Design for delivering medical services to patients who seek these services (clients) or to people who choose to register with one of the parties responsible for primary healthcare to obtain these services (subscribers).
- Responsibility falls to physicians working alone or in groups who do not report to a regional or local healthcare entity.
- The public plays no role in the governance of these organizations.
- Funding is linked to compensation for physicians, primarily by a per capita formula (fixed payment) or a mixture of payment methods.

The 'community model' has the following four characteristics:

- Design for improvement of the health of populations living in a given geographic area
- Promotion of development of the communities served (its mission is to meet the healthcare needs of a population)
- Provision with all the medical health, social, and community services required
- The healthcare service centers are governed by public representatives.

(Lamanche, 2003: 9 ; Anell, 2010:10)

According to the classification of these models, the UK, the Netherlands, Denmark and Norway are examples of the 'professional co-ordination model', whose features include sharing information with different professionals to ensure coordination under the conditions of the 'professional model'. The 'professional co-ordination model' is funded by per capita payment and mixed payment, as opposed to the 'professional contact model', which is represented by the examples of the USA, Canada, Germany and Belgium. It is characterized by limited association and sharing of information with primary health care providers and a fee for service.

Sweden and Finland were representative of the 'integrated community model', which is designed for providing health care services to the general population and in which those services are related to geographical areas with various coordinated professional services before the Free Choice reform(ibid). Anell (2010) classifies the Swedish primary health care model after the Free Choice reform as combination

between the ‘integrated community model’ and the ‘professional co-ordination model’. That is because the Swedish model emphasizes comprehensive responsibility across different professional services, but at the same time, the model combined payment system based on the individual choice of General Practitioners with the payment to providers following the registrations of the General Practitioners.

However, Anell (2010) indicates that the case of Stockholm is more suitable for the ‘professional co-ordination model’ due to that the proportion of the payment to providers is different from other Swedish county councils. The Stockholm model focused more on the number of visits, not on the number of registrations on General Practitioners: Providers get payment from 60 percent per visit and 40 percent of fixed payment for registered individuals. The responsibility is divided into several professional services (General Practitioners, district nurse, social workers, physiotherapists, etc.) and they share information with each other (ibid).

3.2.1. The Privatization of Swedish Primary Health Care

As mentioned above, the Swedish primary health care system after the implementation of the Free Choice System is classified as a hybrid of the ‘integrated community model’ and the ‘professional co-ordination model’. It is characterized by its emphasis on the individual choice under the fixed payment system related to social indicators in the districts. This model has been influenced by several privatization reforms since the 1990s (Anell, 2005; Blomqvist, 2004).

The Swedish primary health care system has promoted privatization to a minor degree since the 1990s. Blomqvist (2004) points out that the privatization and decentralization from the central government to the county councils has been promoted since the 1990s in Sweden. In the primary health care sector, the reforms introduced privatization in 1993 and 2003. In 1993, the Primary Doctor Reform offered opportunities to private primary-care physicians to establish primary health care facilitated by establishing subsidies, as the same condition of the public primary-care physicians. At the same time, the patients also had the right to choose public or private health care. These choice systems were extended further when citizens could choose their own private or public doctors anywhere in the country. County councils purchased about 7 billion SEK from the private sector in 2007 (Swedish Statistics, 2011).

Nevertheless, the level of privatization in the public sector is different from that in

other countries. The Swedish social security system is still based on the values of social equality and universal rights which have influenced social policies by distributing benefits of ‘flat-rate payment’ and ‘income-related benefits’ by taxation (Blomqvist, 2004). In other words, the importance to Swedish society of social values has always influenced the provision of primary health care: all citizens are supposed to be provided with social services in their residence area by public social providers, regardless of income, social status or culture difference (Anell, 2005; Blomqvist, 2004).

The reform of the Free Choice System in 2007 in Sweden resembles the trend of primary health care reforms in other EU countries: not only by involving citizens by allowing them to choose their health care center but also by aiming to build new providers with public finances. Therefore, this law shows the turning point of Swedish universal care model. However, important discussion in the Swedish primary health care is how to reduce low productivity and improve the service quality in primary health care but at the same time keep the social value of the universal right for everyone to access to services equally. This balance is a key in the Swedish primary health reform and also NPM in the Swedish context to discuss individual choice and privatization. Therefore, the reform of the Free Choice System raised the public management question of how to keep balance between social equality, universal rights and market orientation to provide health care services due to more deregulation of the establishment and diversity of individual choices of primary health care facilities.

3.4.2. The ‘Big Society Model’ in the UK

The government of the UK has also implemented Free Choice reform in the National Health Service (NHS) since 2006. The UK’s free choice reform stresses also patient choice in order to improve service effectiveness and that encourage more varieties of service provision through collaboration between the public and private sectors. Following the taxonomy of the primary health care model outlined above, the primary health care model in the UK is the ‘professional co-ordination model’, which designs primary health care service provision based on individual choices with ‘fixed price reimbursement’, or payment by services (Lamanche, 2003; Anell, 2010; Dixon-Robertson-Appleby-Burge-Devlin-Magee, 2010: xiii). Moreover, sharing information with different professionals is one of the features of the UK’s primary health care. In these points, the choice reform in NHS is similar to Swedish Free Choice reform. One is different character from Swedish model is that the local networks began to play the important role of providing primary health care services which have been influenced by Third Way policies.

The UK has a long history of using the civil sector as a social service provider. After the 1990s the Third Way approach has been influential in the provision of public services. Civil organizations such as local organizations and non-profit organizations in local communities used to be just delivery organizations of public services supported by public funds that were not generally distinguished from public organizations in the UK (White, 2006). After the implementation of Third Way policies, civil sector was a component of the Third Way and recognized as a 'partner of the government' under the NPM (ibid). This new relationship between the state and the third sector suggests not only a new equal partnership, but also emphasizes a 'voice' of local people through which it promotes 'citizenship' to contribute to the public life and the development of their communities (ibid: 45-47). In other words, civil sector organizations changed their role after the spread of the idea of the Third Way in the UK.

After the policy changed from the Third way to the 'Big Society' in response to a new party coming to power, it is still the main principle of public service provision. The 'Big Society' focuses on the provision of public services policies in the UK have developed the ideology of civil society and service efficiency approaches of the Third Way under the welfare policy reforms. At the same time, this approach has struggled with the issues of how citizens are involved the policy process in reality and links to the idea of social citizenship for the people who are in social exclusion (Chapman, 2009; Whitfield, 2001; Esping-Andersen, 2002; Fawcett and Hanlon, 2009).

The idea of the 'Big Society' model influenced the reforms in the primary health care sector. It has empowered citizens through collaborative governance between the public sector and private sector or between the public sector and civil sector. The National Health Service (NHS) set up District Health Authorities and Hospital Trusts (Simonet, 2008). The District Health Authorities were in charge of a fixed budget based on population characteristics as well as medical planning for a designated geographic area. Those organizations took responsibility for the purchase of care from hospitals and other health-care providers at the community level. Moreover, the NHS in the UK has activated volunteer organizations to play a role as social support in the provision of primary health care services. The purpose of NHS choice is to build the 'Primary Care Trusts (PCTs)', which is collaboration between local authorities and other agencies that provide health and social care in order to ensure that local community's needs. For instance, volunteer organizations support them by giving them information or consulting with them. According to the NHS,

Local Involvement Networks (LINks) are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services.

(Source: <http://www.nhs.uk/NHSEngland/links/Pages/links-make-it-happen.aspx>)

In terms of the local involvement networks it plays the role of a bridge between citizens and public health care services. This network is a place to share individual opinions and experience with local services. Furthermore, it is in charge of supporting patient choice and the commissioning of local health care services that is able to help citizens by providing information about health care services. In fact, one study states that 69 percent of patients chose local provider in the UK, showing loyal to their local trust and considering the factor of travel for treatment (2010). Nevertheless, the study did not show any positive relation between individual choice and network services at a local level, but instead reveals more practical reasons for patient choice. The patients who choose non-local services may choose the available services outside their area because their area lacked needed specialists, or because they had had a bad experience at a local health care center.

The civil sector in the UK not only provides the ideology of activating citizenship but also grants actual social service providers the role of partner of the government. However, currently the British government cut expenditures for the 'Big Society' policy. This is sometimes just regarded as cutting social expenditures and the civil sector have to confront the challenge. Moreover, the result did not show the outcome of how civil sector or local network services were involved in citizens' decision making. The case of the British primary health care system shows that the Third Way approach is understood as a combination of the public, private companies and civil sectors. In particular, the partnership between the public sector and civil organizations has been anticipated as an alternative solution in which the government can reduce social expenditure by relying on the third sector with the ideology of social citizenship. In this sense, the privatization or activation of the citizen and the National Health Services (NHS) in the UK has activated the volunteer organization to play the role of social support in primary health care services.

4. Methodology

4.1. Purpose of Empirical Study

The purpose of this empirical study is to describe the outcomes of Swedish health care policy affected by the law of Free Choice System ('Lag om valfrihetssystem'). Above all, it will be examined whether the outcome of giving citizens the right to choose their providers of primary medical care shows that such ability to choose may increase the inequality of access to primary health care and outcome of health. The study is based on a case study of health care services in Stockholm and three other Swedish county councils (Halland, Skåne and Västra Götaland Region) through a secondary analysis approach.

At this stage in this empirical study, it will be assumed that the utility of the Free Choice System was influenced by socio-economic factor from the result of previous studies. For instance, low-income or unemployment status, non-Swedish background or low educational level may cause people to be less active in making choices about health care than those people who are highly educated, are employed and have a high income, and were born in Sweden. In other words, although the privatization of the health care system may increase the variety of individual choices, at the same time, the choice of health care centers may also increase inequality in access to health care across different social groups due to the disadvantage of knowledge, social networks and language barriers, etc. However, measuring individual choice in a numerical way is very difficult. Instead of measuring individual choice directly, the number of patients in the registration of the general practitioners lists and cost for its list will be considered as barometers of their ability to choose.

4.1.1. Triangulation in Social Science Research

The triangulation approach is a method in the social sciences in which data is collected using different kinds of methods such as qualitative or quantitative measurements in order to understand social issues from different perspectives and angles. Taking multiple approaches to social issues can, for instance, obtain statistical results from quantitative research and detail from qualitative methods. Marvasti (2003) describes

that triangulation does not serve to decrease the margin of error in data collection, but it is able to reduce misunderstandings about the data, due to the different approaches for a case. In other words, the triangulation approach combines the validity of qualitative research with minute detail from qualitative research in order to deepen understanding of the topic.

This thesis employs the triangulation approach for a case study based on Stockholm and analyzes this case using the secondary analysis. First, the definition of a case study will be outlined. Second, the secondary analysis will be explained from an approach to the outcomes of the Free Choice System. Third, the outcomes will be defined. Finally, the data and its validity and reliability will be outlined.

4.1.2. Case Study

The case study is one of the main social research methods in the social sciences, and it can be applied to a program, an event, an activity, a process or one or more individuals (Creswell, 2003:15). The data for the case consist of detailed information collected over a sustained period of time, lending the study validity (ibid: 15). The advantage of the case study is that a single example will aid in the understanding of the social unit in its own right and as a holistic entity (Payne 2004:34). First, the case study deals with the social unit as unique or significant ‘example’, not just one of the ‘samples’. Second, there is no study which can prove something but a single case is able to ‘disprove’ a general statement. Third, the case study can give a new understanding of the case and will be able to provide a framework for later research (ibid: 32-35).

This thesis will use the case of Stockholm as an example of Swedish primary health care. As already mentioned, the Stockholm case is a unique ‘example’ of the Swedish model and it cannot be treated as a generalized case. However, it will be a useful way to review changes in Swedish primary health care and has the potential to disprove certain general statements.

4.1.3. Secondary Analysis

Secondary analysis is the further analysis of a primary dataset, which focuses on more detailed, particular topics or is angled more towards particular social issues or political concerns than the first report. In social science research secondary analysis has been widely used as one of main methods to understand social issues from different perspectives from existing datasets or official government reports (Hakim 1982; Neuman, 2006).

Hakim (1982) pointed out that secondary analysis takes advantage of being able to compare different sources and results from several surveys of a topic. For instance, cross-national studies are commonly used as secondary analysis method to collect comparative data across different countries or time-periods. It is used not only for comparison studies of different countries and time periods, but also for the assessment of social policy such as the evaluation of official government documents or unofficial documents. In other words, secondary analysis can process a large volume of data by using several data sources and develop to summarize social indicators or indexes of a large number of data.

In addition, secondary analysis is able to facilitate interaction between the theoretical aims and empirical data of a study, bringing different existing datasets into current research paradigms and testing out developed theoretical frameworks (Hakim, 1982). It is able to treat broader issues with a large volume of data and comparison of time or countries through comparing the different datasets. Therefore, secondary analysis is able to contribute to a fresh or different perspective from the primary analysis and provide more focus on or extend certain perspectives of social issues which cannot be treated in primary analysis.

On the other hand, the difficulty of treating existing data is that researcher is lacking in substantial knowledge of, and is unable to control, the process of data collection (Neuman, 2006). Researchers employing secondary analysis are confronted by the task of integrating data which is sometimes inflexible and not easy to compare. The problem is that concepts embedded in the selection of which data were collected and coded in primary analysis, which do not always correspond with those employed in secondary analysis (Hakim, 1982; Neuman, 2006).

In addition, Neuman (2006) raises the point that there is a potential danger that secondary analysis gives a false impression by quoting statistics in primary analysis. In order to overcome these limitations in secondary analysis, two main operations are of setting data from the different existing data sources and using standardized definitions. The data and definitions derived from the existing datasets are considered as knowledge which may be affected by creators or organizers of datasets. Therefore it is necessary to take into account their choice such as coverage, sample size, time period, and data collection and the researcher needs to be cautious when treating existing data from the primary analysis.

4.2. Data

This secondary analysis will use several existing datasets as a resource: the assessment of *vårdval* (choice of health system) in Stockholm in the primary health service by Karolinska Institute in 2010 (“Uppföljning av husläkarsystemet inom Vårdval Stockholm – redovisning av de två första årens erfarenheter”). As for socio economic perspective, the data is used from the Stockholms Stads Utrednings- och Statistikkontor AB. In the section of patient satisfaction the data across Halland, Skåne and Västra Götaland Region comes from the population survey in 2009. Table 3 shows data resources in the Second Analysis.

Table 3 Data Resources in the Secondary Analysis

	Assessment of <i>Vårdval</i>	Socio-Economic Distribution	Population Survey
Data Resource	The Karolinska Institute	Stockholms Stads Utrednings- och Statistikkontor AB	Lund Economic Department
Period	2010	2011	2009
Area	Stockholm	Stockholm	Halland, Skåne and Västra Götaland Region

The Karolinska Institute (2010) is a national medical academic research center in Sweden, which conducted the assessment for the translation of the primary health care system in Stockholm in 2010. Stockholms Stads Utrednings- och Statistikkontor AB is a company which deals with statistics data of social indicators in Stockholm areas. The Population survey is employed by the Economic Department at Lund University.

4.2.1. The Outcomes of the Assessment by the Karolinska Institute

The assessment by the Karolinska Institute focuses on the outcomes of the Free Choice System Reform. Outcome means not only the state or condition of target groups with the factors expected by the program (Rossi Lipsey, Freeman, 2004). The outcome analysis focuses on three points: outcome level, outcome change and program effect (ibid). The outcome level is defined as the condition of outcome at some point in time. The outcome change is a variation between the different outcome levels in time. The Assessment by Karolinska Institute regards outcome level as the number of registration in the list of the primary health care system.

Table 4 The Outcomes of the Karolinska Institute’s Assessment of the Free Choice System in primary health care in Stockholm

Outcome Level	Outcome Change	Program effect
Variable	Period	Productivity
<ul style="list-style-type: none"> ● Number of visiting doctors ● Number of patients in the lists of General Practitioners ● Number of clinics (public, private) 	2007-2010	<ul style="list-style-type: none"> ● Cost containment ● Patient satisfaction ● Diversity of choice of both public and private clinics

Outcome change is time period (before and after the start of the Free Choice System). As for program effect, the cost containment and productivity in the Free Choice System are used as barometers to measure effectiveness. An outcome variable is a measurable characteristic or condition of a program’s target population that could be affected by the action of the program (Rossi- Lisey - Freeman, 2004: 206-207). In this study, the outcome variable is the need and utility of the primary health care services.

4.2.2. Validity and Reliability

When conducting social research regardless quantitative and qualitative methods, the important task is to discover “what it is “not “what ought to be”, which is traditional sociological stand point to look social issues in the society (G.Payne-J.Payne, 2004:54-56). It will lead reliability of the research. However, this stand point is criticized as a limitation of objectivity of the research and value free orientation, due to all researchers have own standpoints and more or less prejudice (ibid). In this point, the important thing in social research is reliable and valid, not distanced from its subjectivity.

Therefore, in order to meet validity and reliability which is to require of the level of research qualities, this secondary analysis follows four elements (Mogalakwe,2009). First, from the perspective of authenticity, the data source should be reliable and the evidence should be genuine.

- Authenticity (whether the evidence is genuine and from an implacable source)
- Credibility (whether the evidence is typical of its kind)
- Representativeness (whether the documents consulted are representative of the totality of the relevant documents)
- Meaning (whether the evidence is clear and comprehensible)

In the Secondary Analysis, the validity should match between the researcher's theoretical definition and the definition of the organization which investigated the primary analysis. Thus, the secondary analysis in this thesis should clearly state the definition of the result from existing statistics and the theoretical framework.

4.2.4 Ethics

Social Science research always needs to confront ethical issues due to that social science research treats humans and its society. This Secondary Analysis follows the four categories above and ethical rules (Swedish Research Council, 2011). The result of the research will more or less influence to society in a long run(ibid). Especially, This Secondary Analysis have to avoid misunderstanding one material written in Swedish (*“Uppföljning av hussystemet inom Vårdval Stockholm-redovising av de två första årens erfarenheter”*).

5. Analysis

5.1 The New Public Management (NPM) in the Swedish Primary Health Care System

In the theoretical framework, the NPM was discussed from various perspectives. By using a theoretical approach, this Secondary analysis discusses the effects of the change to a more market-based orientation and citizen's participation in the Swedish context. The Secondary Analysis is based on assessment of three sources: *Vårdval* (Karolinska Institute, 2010), Socio-Economic Distribution (Stockholms Stads Utrednings- och Statistikkontor AB 2010) and Population Survey (Anell– Beckman–Glenngård, 2009).

The NPM is often criticized as lacking effective communication between the public sector and private companies or civil organizations and also criticized because although one of the objectives of the NPM was to improve responsiveness to customer's needs, this has not necessarily been achieved. For instance, the Big Society Model in the UK is often held up as an example of a failed governmental model intended to reduce public expenditure by outsourcing public services to private companies or civil organizations. This led to issues between the public sector and the private companies / civil organizations due to their different management styles (McQuaid–Scherrer, 2010). In the UK civil organizations faced the problem of managing limited budgets once the government cut subsidies. From this perspective, Whitfield (2010) has a skeptical view of the NPM since it can overestimate the role of the civil sectors and the state's initiative management style. Several studies focus on the management issues, but there are not many studies that focus on the perspective of the citizens' participation and the role of individual choice in the NPM. This thesis attempts to focus on the meaning of individual choice in the NPM using the empirical model.

Theoretical framework and empirical studies suggest that the Swedish Free Choice reform responds to the NPM. Nevertheless, the Swedish context such as social policies based on universal value should be considered when applied to the NPM theory. As mentioned before, several previous studies point out the low productivity of primary health care services in Sweden. The studies argue that traditional management did not

sufficiently share information regarding available resources across health facilities, leading to unnecessarily long waiting lists (Nordgren, 2009; Anell, 2010). Furthermore, the studies showed that people who felt perceived discrimination had reduced access to primary health care services, while well-educated groups were more likely to choose their own care providers than 'less well-educated' groups (Blomqvist, 2004; Wamala, Merlo, Boström and Hogstedt, 2007). Access to primary health care amongst different social groups was uneven, leading to unequal health outcomes before the Free Choice System was implemented (ibid).

However, assessment of the new primary health care after the Free Choice System reform in 2007 finds a positive change brought about by the new system and generally were positive in their conclusions (Karolinska Institute, 2010). In addition, Anell (2010) wrote that this reform led to more flexible management, in which responsibility is shared amongst several professionals. A mixed payment system brought about new competition among the providers, where service providers received a fixed payment for registered patients combined additional payments depending on the number of doctor visits or other services (Anell, 2010). Those factors will make the Swedish universal health care system move from the 'community model' to the 'professional model' (ibid). In other words, primary health care provision shifts from 'district level' to that based on 'individual choice'. The Stockholm model, which is defined as the 'professional co-ordination model', focuses more on the number of doctor visits rather than the number of registrations of General Practitioners (ibid).

Do the changes show that the NPM in the Swedish primary care sector was successful in moving power from politicians to citizens? What are the outcomes of user participation in the Swedish primary health care system? This chapter will be divided into five sections. First, the result from Assessments of the Free Choice System will be outlined. Second, the effectiveness and efficiency of the system will be considered from the numerical data using the assessment by Karolinska Institute (2010). Third, the citizen's participation will be explained using the theory of Public Value Creation (Nordgren, 2009). Fourth, the socio-economic perspective will be considered. Finally, the correlation between the service provider choices made and the reasons for the choices will be outlined.

5.1. Assessments of the Free Choice System

According to an assessment by Karolinska Institute (2010), the number of doctor visits, the number of registrations of General Practitioners and the cost for the General

Practitioners' activities has increased since the reform was implemented in Stockholm in 2008. The primary health care system's costs have increased in response to the increase in the number of doctor visits. The costs related to high risk groups, such as those outside social classification or with potential illnesses based on social economic factors, have increased. In particular those belonging to certain age groups (0-14 and 65-75 years old) now use primary health care more than before. However, the cost per inhabitant has decreased after adjusting for the increase in the population (ibid).

Furthermore, the assessment of the Free Choice System by the Karolinska Institute (2010) showed that this system positively affects people who have socio-economic related disadvantage in accessing primary health care clinics. After the reform these people contacted primary health care more often compared with other social groups. The result shows that utilization of services shifted from people with high income to people with low income. However, allocation of resources is still higher in high-income groups relative to those with lower incomes. The survey from Stockholm Stads Utrednings - och Statistikkontor AB looked at the different socio-economic areas in Stockholm. The city is divided into three areas: the Inner city, the Western City and the Southern city. This division does not influence directly the Free Choice reform, but clinics situated in the West and South of the city (relatively lower income areas in 2010) have lower patient satisfaction scores. The Karolinska institute (2010) was not able to find any statistical correlation between geographical factors and patient's satisfaction.

According to the Population survey (2009), about 60 percent of the population in the three county councils (Halland, Skåne and Västra Götaland Region) made the decision to choose their primary health care clinics themselves. Individuals who have access to primary health care services are more likely to exercising their right to choose and elderly people are particularly active in choosing these services. In addition, the result of the survey shows that individuals who think that it is important to access specialists for special needs have an increased likelihood of making a choice of primary health care providers. Furthermore the people who answered that they have enough information to make a choice are more likely to make a choice.

5.1.2 Effectiveness and efficiency of the Primary Health Care Services

The NPM theory applied to the outcomes of the Free Choice System. As mentioned before, the NPM theory focuses on the outcome and performance of the management. The key of the NPM theory is "managing inputs and outputs in a way that ensures economy and responsiveness to consumers" (Stoker, 2006). The following four factors

are considered when assessing the effectiveness and efficiency of the service management in the primary health care:

- “partnership”
 - “value for money”
 - “risk transfer”
 - “additionality”
- (Whitfield, 2010; McQuaid and Scherrer, 2010)

There is no major difference between the public and private clinics when the individuals choose primary health care due to the fixed price system and contracts between the private providers and the county councils. In addition, the Karolinska Institute (2010) found that there is no major difference in productivity between the public and private providers. The partnerships that were in the form of private clinics under contract to the NPM led to diverse choices for individuals. In practice, from a customer point of view it is difficult to distinguish any difference between public and private clinics. The important thing becomes how to support individuals in selecting the best service provider for their circumstances.

In addition, the concepts of “value for money” and “risk transfer” cannot be applied with a straight-forward interpretation to the Swedish primary health care sector, due to the primary health care sector being a different structure with different restrictions to other market sectors (Dixon- Robertson- Appleby, Burge- Devlin- Magee, 2010). In contrast to the strong emphasis on minimum purchase price in markets in most industries, there is no price competition amongst providers in Swedish primary health care due to the fact that the county council sets the price of services. However, different indicators (numbers of doctor and nurse, the number of phone calls received or patient’s assessments) can be used to evaluate the effectiveness or efficiency of productivities of primary health care clinics. The Karolinska Institute (2010) used two of these indicators: the number of visits to doctors and patient satisfaction ratings. The number of doctor visits has increased after the reform and led to an increase of the cost containment. Table 5 shows that the number of visits to doctors per capita has increased in Stockholm in response to the Free Choice system reforms in 2008 (ibid). This result implies that citizens try to get involved in their own health care decision process and increases the positive changes in citizens’ participation in the Swedish primary health care system.

Table 5 Total Number of Doctor Visit or Nurse Service in 2006-2009

	2006	2007	2008	2009
Total number of doctor visits	2 374 251	2 477 048 (4, 3%)	2 844 476 (14,8%)	3 027 682 (6,4%)
Total number of nurse visits	883 243	896 249 (1,5%)	880 820 (-1,7%)	835 791 (-5,1%)

(Source: Karolinska Institute, 2010:30)

Besides the increase in the number of doctor visits, the system of payment to providers is considered to be one of the significant outcomes of the Free Choice System. As mentioned earlier, the Stockholm health care model stipulates that approximately 60 percent of provider's income derives from the number of patient visits, and 40 percent from fixed payments for registered individuals (Anell, 2010). This means that it is important for providers to increase in the number of patient visits in order to increase their income from the county council, hopefully leading to more competition across providers and increases in the quality of services. This perspective is one of the justifications used for implementing the NPM. The table 6 shows that the cost of General Practitioners has increased in response to the increase in doctor visits, while the number of visits to nurse or other services has decreased. Instead of patient assessment of the quality of services, the Karolinska Institute (2010) considers the correlation coefficient between the productivity and patient's satisfaction, which is combined with three different indicators.

Question 1: Did you feel that you were treated with respect and in a considerate way?

Question 2: Did you feel involved in decisions about your care and treatment, so much as you wanted?

Question 3: Did you get enough information about your condition?

Table 6 Cost for General Practitioner Activity and Cost per Inhabitant

	2006	2007	2008	2009
Cost for General Practitioner Activity	3,253,841	3,391,515 (4,2%)	3,522,093 (3,9%)	3,663,865 (4,0%)
Cost for Inhabitants	1923	1899 (-1.2%)	1883 (-0.8%)	1866 (-0.9%)

(Source: Karolinska Institute, 2010)

In 2008 there was no significant correlation between productivity and patient satisfaction, but in 2009 the Karolinska Institute finds a statistically significant correlation between these indicators. Primary health care clinics had a high productivity and at the same time they received a high reported level of patients' satisfaction of their services.

5.1.3. Citizens' Participation in Primary Health Care

As pointed out above, the number of doctor visits and user satisfaction surveys show positive outcomes. However, this part of secondary analysis focuses in detail on the results of what sectors of the population are advantaged/disadvantaged by the Free Choice System.

Table 7 Population and the Number of registrations of General Practitioners

	2006	2007	2008	2009
Population	1,854,299	1,885,471	1,911,667	1,963,255
The number registration of GPs	1,598,888 (86,2%)	1,717,443 (91,1%)	1,761,921 (92,2%)	1,805,774 (92%)

(Source: Karolinska Institute, 2010)

Table 7 shows the number of people registered with General Practitioners and the total population in Stockholm. The number of registration in General Practitioners means the number of the population who are registered within the Free Choice System. It means that after the reform the individuals who are registered the list of General Practitioners can choose any primary health care services regardless private and public services and outside districts they live in (Anell, 2010). In case of the registration system in Stockholm, individuals have to register of the General Practitioners by themselves. In other words, people have a choice to register or not. By contrast, Halland has a passive registration system, in which patients who do not register the General Practitioners is registered automatically by the county council.

It means that the number of registrations outside is the number of inhabitants who are not active in choosing the primary healthcare services. These unregistered people can also choose but only within the district they live in. The rate of registration on the General Practitioners has reached approximately 90 percent. Most of inhabitants register General Practitioners, but the rate has actually slightly decreased in 2008.

8 percent of the population is still unlisted of the General Practitioners registration and, they have less opportunity to access to primary health care services compared with those people who are registered. According to the choice system, if people are not able to choose the service by themselves or are passive to choose, they have a disadvantage in access to primary health care services. That shows inequality in access to primary health care services between people who participate in the choice process and people do not. At the policy level, the following principle of Free Choice System supports the choice and non-choice of the primary health care provider.

The individual user has to be supported by the authority in choosing a provider. The authority is responsible for assisting the individual and explaining what the freedom to choose entails and what providers are available [...] For people who are not capable of choosing by themselves, or who want help from someone else in making their choice, there are rules on deputies, representatives and legal assistance in ordinary cases when free choice systems have not been introduced. (<http://www.regeringen.se/sb/d/10057/a/99454>)

At policy level given a right to citizen to choose their providers of primary health care implies the value of citizens' participation in decision making process (Nordgren, 2009). The citizen's participation will create the idea of co-producing value from both sides of customer and providers. As Nordgren (2009) mentions in previous section, creating values from both side of the customer and the providers help not only to develop service production in health care services reduce costs but also increase reliability in health care sector. The Principle of the Free Choice assists people who need support to choose their primary health care facilities. However, in reality the system carries out the distinction between people who choose health care service by themselves and those who do not. It brings about inequality in access to health care services and leads to inference in health outcomes among the groups who are active to choose and those who are passive.

According to the Karolinska Institute (2010), the utilization of primary health care services such as visiting a doctors and the number of registration in the General Practitioners have increased since 2006. Nevertheless there is no relation between increase in utilization of primary health care services and the number of registration in choice system from their data. As a next step, the relation between socio-economic indicators and cost for the registration list is considered in order to examine if the Free Choice System has change of the structure of primary health care.

5.1.4 Socioeconomic perspective related to districts

The relation between the geographical area related to socioeconomic indicators and utilization of the primary health care also deserves consideration. Statistics (Stockholms Stads Utrednings- och Statistikkontor AB, 2010) shows uneven distribution of social backgrounds such as income, education level across three areas in Stockholm: South of the city, Inner city and West of the city. Socioeconomic factors of following five variables.

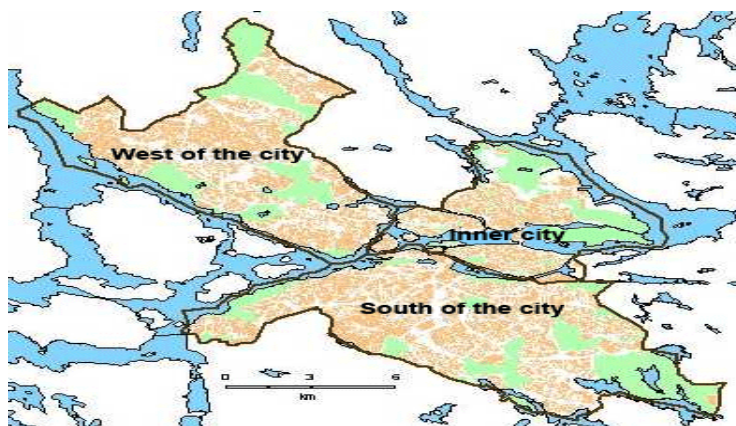
1. Age
2. Foreign background
3. Income
4. Employment status
5. Education status

According to Stockholms Stads Utrednings- och Statistikkontor AB (2010), three areas have a similar structure of age distribution. In 2010 population group consisted of those who are between 20 and 64 years old made up about 65 percent of the entire population. Inner city has a higher rate of people over 65 years : 15,4 percent compared with other two areas: South of the city with 13,6 percent and West of the city with 13 percent. In terms of people with foreign background in 2010, their percentage is quite high in West of the city. The percentage of foreign born in this area is 30,8 and of those who were born in Sweden with two foreign-born parent is 11,6. Thus total proportion of people with foreign background is 42, 4 percent compared with 18,1 percent in Inner city. In particular, the background of inhabitants in the West of the city is composed by 43,2 percent of Asia, 23,2 percent of Africa, 18 percent of the rest of Europe and 8,4 percent of Nordic countries except Sweden. In other words, the population from outside of the EU is concentrated in West of the city.

In terms of income³, the difference across the three areas is illustrated. In Inner city, the group with the annual household income over 360,000 SEK made up 34 percent of the population, while the same income groups in the South and West of the city made up only 19,6 percent and 21,3 percent of population respectively. The groups with the income between 120,000 and 240,000 in the South and West of the city are, on another hand, 26,5 percent and 23.9 percent respectively, compared with 20 percent in Inner city. As for the unemployed status between age 25 and 64 in 2010, the rate in west of the city is 4,7 percent, that of South of the city is 4,2 percent, while the proportion in inner-city is 2,3 percent. Inner city has 65 percent of the population with higher education compared with 46.2 percent in the South of the city and 44, 4 percent in the West of the

city in 2009.

Figure 1 Three Areas in Stockholm



(source: Stockholms Stads Utrednings- och Statistikkontor AB, 2010)

Karolinska Institute (2010) points out the health care utilization and resource distribution across different geographical areas in Stockholm. The calculations of the health care utilization are based on the consumption of residents in each area, regardless of where the visits take place. Resource is defined as production related to the cost of health care providers in a given geographical area. Karolinska Institute (2010) finds a shift of the primary health care utilization from the areas with higher income to the area with lower incomes. The areas with lower incomes had a greatest increase in doctor visits after the implementation of the Free Choice System, However, the allocation of resource to the health care is considered, the area with high income had increased the utilization of resources rather than the area with low income.

Furthermore, there are different levels of patient's satisfaction for different primary health care facilities in different geographical areas. For instance, the level of patient's satisfaction in the area of west of the town as Rinkeby-Kista, Upplands-Bro and Sundbyberg or the area of south of the town as Salem Botkyrka and Skärholmen is much lower than in other areas (less than 75 % satisfaction) (Karolinska Institute, 2010). As the survey shows the average income in West and South of the town are less than Inner city (Stockholms Stads Utrednings- och Statistikkontor AB, 2010), Though the Karolinska Institute concludes that it is difficult to explain relation between the patient's satisfaction and geographical areas due to the absence of correlation between living areas and patient assessment of the quality of services. However, it may be worth considering the relation between the geographical locations related to socio-economic indicators and the utilization of the primary health care.

When it comes to the relation between the cost for the listing and socioeconomic indicators and the Care Need Index (CNI) which is an indicator expected risk related to the potential illness based on seven social economic factors. Table 4 shows the relation between the costs based on the registration of General Practitioners and the CNI. The correlations between the cost per the lists and the CNI in 2007, 2008 and 2009 are all positive (Karolinska Institute, 2010). From the socioeconomic perspective, The Socioeconomic Index is calculated per municipality or district based on the income shared with social security recipient, living alone, low education and foreign born. The correlation between the cost and this index is also significant for year 2007 and 2009. In 2008, the correlation between these variables is not significant due to the difference in calculations. In particular, the Karolinska institute focuses on the elderly group and the population who are in need of care such as diagnosis groups. The age is correlated with the costs for the list in the year of the reform of the Free Choice 2008 and 2009 respectively. The Institution explained that the fact of removing the socioeconomic variables after 2007 affect the result. Meanwhile, there are not significant correlations among the different level of the diagnoses groups and the cost. Nevertheless, the cost for the list of diagnoses group had increased from 2008 and 2009.

Table 8 Correlation between Cost and Socio-economic Index and CNI Index

	Socioeconomic Index		CNI Index	
	Correlation	P-value	Correlation	P-value
Cost for the list in 2009	0,239	,004***	0,243	,003***
Cost for the list in 2008	0,112	.0174	0,252	,002***
Cost for the list in 2007	0,229	.005***	0,384	,000***
Change of the cost between 08-09	0,223	.007***	-0,023	,780
Change of the cost between 07-08	-0,195	,016	-0,250	,013**

(Source: Karolinska Institute, 2010)

Correlation coefficients⁴ between the costs and the Socioeconomic Index or CNI show that those people who are potentially in need of care uses primary health care more services after the choice system. It implies that the Free choice System does not affect to inequality across different social groups. Next, the outcome such as the cost for the registration list is considered in order to examine if the Free Choice System changed of the structure of primary health care.

5.1.5. The User Perspective

Population survey in the three Swedish counties (Halland, Skåne and Västra Götaland Region) in 2009 shows that there are several factors that determine to extent individuals exercised their rights to choose a provider. Table 9 shows that approximately 60 percent of the population in these three county counties made a choice of providers after the 'Free Choice System was implemented. In particular, the survey demonstrated that utilization of the free choice system associated with the number of primary health care visits per month. The data is based on the question 'Have you made a choice of primary health care unit in connection with, or after the introduction of Freedom of choice in your county?'(Anell–Beckman–Glenngård,2009). The result from shows that the choice is related to the access to the information about health care services, which is due to the regular contact with health care services. People who often use health care services or those who take care of family are likely to participate in health care decision making. Table 4 shows that people who visit a doctor 2-5 times and more than 5 times are more active to choose a doctor than other groups.

That result is a line with the result from previous studies of the choice system in the UK. The study about the choice of doctor in the UK shows the same result, which the more people access to primary health care services, the more people exercise a choice of doctors (Dixon–Robertson–Appleby–Burge–Devlin–Magee, 2010). In addition, the survey shows that the groups who are not working or studying choose the doctors than working groups. In particular the group of elderly people who are between 65 and 89 years old is more inclined to use the choice system (ibid). In addition, the result of the survey shows that there is statistic correlation between the determination of a choice and the individual opinion about the Free Choice System. The result of logistic analysis between two questions and there are coefficients of correlation between two variables.

3. People with a *low income* have an annual household income below SEK 159,756 for 2006 and those with a *high income* have an annual household income exceeding SEK 429,948 for 2006(the National Public Health care Survey, 23/03/2011). In this sense, an annual low income per person is about SEK 79,878 and a high income is above SEK 214, 974.

4. *** indicates that the correlation is significant at 1 percent level. ** indicates that the correlation is significant at 5 percent level and * indicates that the correlation is significant at 10 percent level.

Table 9 Relations between Primary Health Care Visits and occupations Age

Number of Primary Care Visits	0 visit	50
	1 visit	61
	2-5 visits	67
	More than 5 visits	62
Occupation	Working/Studying	58
	Other	65
Age	18-39	57
	40-64	61
	65-89	65
Total		61

(Source: Anell-Beckman- Glenngård, 2009)

Independent variables are

- Access to specialist for special my needs
- I have enough information to make a choice

Dependent variable is

‘Have you made a choice of primary health care unit in connection with, or after the introduction of Freedom of choice in your county?’

(Anell-Beckman-Glenngård, 2009)

Population Survey (2009)⁵ shows that establishments of new providers in connection with the reform and having enough information increased the likelihood of exercising a choice. By contrast, preferences for direct access to a specialist decreased the probability of making a choice. In other words, people intend to use free choice system due to the increase of the new options and enough information, not to preference for direct access to specialists. Furthermore, individuals were rather passive in their search for information and tended to choose providers that they previously had been in contact with (Anell-Beckman-Glenngård, 2009). On the other hands, socio-economic factors such as age and distance to hospital less than 5 km, occupation are not statistically correlated to exercising a choice (ibid).

5.The rate of respondents of the population survey is about 33 % (1449 samples) across three county councils. The survey divided several independent variables. The number of primary care visits (0 visits, 1 visit, 2-5 visits more than 5 visits). The category of occupations is working/studying or other. The three age groups were divided into: 18-39, 40-64 and 65-89(Population Survey, 2009).

The result from Population Survey implies that the individuals' choice is depended on their situation to access to information about the primary health care, not their socio-economic status or living areas (ibid).

5.2. Discussion

The secondary analysis discusses both sides of the market initiative and individual choice as well as the social values which is social equality and solidarity. Applying the NPM in Swedish Primary health care system brings about the question of how to keep a balance between the privatization and universal values for equality. As pointed out above, through the free choice reform, the outcome of the NPM in the Swedish primary health care encourages a greater diversity of primary health care providers and citizens to choose those facilities by themselves. Especially, the Free Choice Systems gives emphasis to the individual diverse choice outside their living areas in order to reduce waiting time and improve the quality of services through competition between the providers. At the same time, this Free Choice System stresses the citizens participation in the decision making process through exercising a choice by themselves. This is a line with the theories of the Third Way and the value creation between providers and customers in order to support customer's voice and improve the quality of services and reliability of primary health care.

From the Sociological theoretical frame work, both the results from Karolinska institute and the population survey should be discussed in depth. As it mentions above, within Homans' 'exchange theory', choice is regarded as social behavior which is motivated towards individual goals or aims (Scott, 2000). However, excising a choice is affected not only by individual motivation or goals, but also other social back ground, cultural aspects affect people to exercise a choice. Further study should consider those factors from sociological perspective.

Therefore, main research question, 'what are the outcomes of user participation in the Swedish primary health care system?' is discussed from four different perspectives. First, the uneven resource allocations across different areas are related to different socio-economic backgrounds. Even though the utilization of the primary health care moved from the higher household income areas to the lower household income areas, the allocation of resources is still higher in high household income areas. The result may not conclude that this Free Choice System reform redistributes the resources across the different socioeconomic groups. The Free Choice System encourages people to choose primary health care services but it does not directly lead to give an equal utilization of

the primary health care. Analyses of the results of the first report bring about two new questions: Why does uneven accessibility of the primary health care between higher income areas and lower income areas still exist, even though the system changed from the area-based provision to individual choice of the primary health care? Why does this Free Choice System bring the gaps among the people who more access/less have access to information? Furthermore, the Free Choice System reform creates the difference between people who register within the General Practitioners lists and those who do not. This argument is related to the result from the population survey (2009), in which the number of visits to primary health care center and the access to specialist for a special need are related to the use of Free Choice System. It becomes more gaps between the utilization of primary health care services across the different groups depending on the accessibility of information of care and the number of contact with doctors.

Then, what is the outcome of the 'Free Choice system' ('Lag om Valfrihetssystem') for people choosing health care by themselves - in particular the people who are at risk of "social exclusion" caused by socioeconomic factors? The answer from this thesis is that marginal groups who are at risk of "social exclusion" use more primary health care services. That is because the outcomes of cost for socio-economic index and CNI have increased since the Free Choice reform was implemented. This result does not match one of previous studies which showed those people had felt discrimination to access to the primary health care services. It shows the difference between the official results of the utilization of the primary health care services and the result of survey with what citizens think. These results imply further researches should approach more detail at individual levels as well as socio-economic groups. As another point, the new gap between groups who are active to exercise a choice and non-active groups should be discussed carefully. In addition, there are still uneven allocation of resources between the areas with high income and those with low income in Stockholm. The Free Choice System remains the gap between the different areas caused by socioeconomic backgrounds as well. Therefore, the further study should focus on utilization of primary health care services in different areas related to socio-economic indicators.

The Second question is what sectors of the population are advantaged/disadvantaged by the Free Choice System? It is difficult to answer the question from the Population Survey, 60 percent of population across the three county councils exercise a choice after the Free Choice System was implemented in 2007 as mentioned above. However, the more access to the information of the choice system people, more they are active in

exercising a choice. Therefore the outcome of the citizens' participation does not always equal utilization for all citizens. This question brings about the question of how to reduce the gap between advantage and disadvantage of accessing to the primary health care services.

These perspectives explore the question of how the government keeps the balance between the respect individual choice and the 'solidarity', the value of social equality in the society. In other words, how far the government takes responsibility to provide citizens with health services with an essential element of equal access to primary health care? How much does the government intend to use market- mechanism increase the service quality and effectiveness? The more diverse the providers are, the more it is necessary for the government to consider organization and coordination of the providers. 'Planning and co-ordination are more important to ensure fair distribution and management'. Emphasizing on the citizens' participation through exercising a choice is a process to create 'public value' from citizen's sides. The citizens' choice of primary health care is able to increase the service effectiveness and efficiency among the providers and promote the NPM. However, at the same time, it can lead to the contradiction of how much the free choice is useful for positive outcomes.

6. Conclusion

In this master thesis analyzes the new law of the Free Choice as an example of citizen's participation in policy process in primary health care sector. This thesis examines the outcomes of the new Free Choice policy with particular emphasis on whether giving residents the right to choose their providers of primary health care leads to a more equal distribution of primary health care accessibility. In theory part, the NPM theory behind the reform and change in primary health care sectors is explained which focus on not only the outcomes of management and performance but also citizens' participation. In empirical part, the outcomes of the system are examined by the method of the secondary analysis using a case study of the *vårdval* (choice of health system) in Stockholm by Karolinska Institution and socio-economic distribution by the population surveys in three county councils (Halland, Skåne and the Västra Götland Region) from 2009.

By using the New Public Management theory which is one of the government-initiative management and the process of the Public Value Creation this study considered to analyze effectiveness and efficiency of service and understand the meaning of citizen's choice and participation in the process of this policy. From this perspective, this study found that the Swedish Primary health care system more focuses on the outcomes and performance of health care services which lead to more efficiency of service quality with high rates of patient satisfactions. In addition, individual choice of primary health care services will lead to stress citizen's voice to improve the quality of services and create public value. However, besides the optimistic outcomes, this choice system brings also new gaps between the individuals who are active and those who are passive. Furthermore there is still difference between the different residence areas related to socioeconomic status. It will necessary to consider the balance between the responsibility of the government redistribution of the primary health care services and individual free choice in a long run.

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Executive Summary

Over the last several decades, the ideology of neo-liberalism has become increasingly influential in public management across the Organization for Economic Co-operation and Development (OECD) countries. In Sweden, in the context of the provision of public services, this idea drove welfare reforms aimed at encouraging individual responsibility in choosing service providers and promoted the privatization and deregulation of public services in different service areas such as education, health care and social services. Out of this series of reforms, of particular interest to this thesis is one entitled the New Public Management (NPM), which is a government-initiated management initiative aimed at using market forces to increase effectiveness and improve service quality by encouraging competition between social service providers.

This thesis will examine one of welfare policy reform, 'Free Choice System' ('Lag om Valfrihetssystem') in the primary health care with particular emphasis on whether giving residents the right to choose their providers of primary health care leads to a more equal distribution of primary health care accessibility. Not all individuals will be able to choose to their best advantage. In other words, the primary research question being asked is 'what are the outcomes of user participation in the primary health care system?' In order to answer this question the following two sub-questions will be considered. What is the outcome of the Free Choice System for people choosing health care by themselves - in particular the people who are at risk of "social exclusion" caused by socioeconomic factors? What sectors of the population are advantaged/disadvantaged by the Free Choice System?

In order to answer these research questions, both theoretical and empirical perspectives applies a case study of the primary health care systems in Stockholm and three other county councils (Halland, Skåne and the Västra Götland Region). From a theoretical standpoint, the NPM theory explains efficiency and effectiveness, service quality and Public and Private Partnerships (PPPs) from Whitfield (2010) and McQuaid and Scherrer (2010). The perspectives of citizen participation and the decentralization of decision making also consider analyzing the value within the NPM from citizens' voice using the ideas of Pierson (2009). The concept of citizen participation will be related to the concept of the Third Way. From this perspective, the concept of public value will be explored to explain the co-production of value in the process of governing by Midttun

(2005). This concept applies several primary health care models in an international perspective. By using these theoretical approaches, this Secondary analysis discusses choice in order to apply the features of market orientation and citizen's participation in the Swedish context: the Secondary Analysis is based on three resources, which is Assessment of *Vårdval* (2010), Socio-Economic Distribution (2010) and Population Survey (2009).

The secondary analysis discusses both sides of the market initiative and individual choice as well as the social values which is social equality and solidarity to answer the research question. Through the Free Choice reform, the outcome of the NPM in the Swedish primary health care encourages a greater diversity of primary health care providers and citizens to choose those facilities by themselves. Especially, the Free Choice Systems gives emphasis to the individual diverse choice outside their living areas in order to reduce waiting time and improve the quality of services through competition between the providers. At the same time, this Free Choice System stresses the citizens participation in the decision making process through exercising a choice by themselves. This is a line with the theories of the Third Way and the value creation between providers and customers in order to support customers' voice and improve the quality of services and reliability of primary health care.

From the result of the assessment for Free Choice System, marginal groups who are at risk of "social exclusion" use more primary health care services due to the outcomes of cost for socio-economic index and CNI have increased since the Free Choice reform was implemented. This result does not match one of previous studies which showed those people who felt perceived discrimination had reduced access to primary health care services, while well-educated groups were more likely to choose their own care providers than 'less well-educated' groups (Blomqvist, 2004; Wamala, Merlo, Boström and Hogstedt, 2007). It shows the difference between the official results of the utilization of the primary health care services and the result of survey with what citizens think. However, the Secondary Analysis finds that this choice system brings about also new gaps between the people who are active and not and are still difference between the different residence areas related to socioeconomic status. In addition, the more access to the information of the choice system people, more they are active in exercising a choice. Therefore the outcome of the citizens' participation does not always equal utilization for all citizens. This question brings about the question of how to reduce the gap between advantage and disadvantage of accessing to the primary health care services.

The more diverse the providers are, the more it is necessary for the government to consider organization and coordination of the providers. The citizens' choice of primary health care is able to increase the service effectiveness and efficiency among the providers and promote the NPM. However, at the same time, it brings about the question of how the government keeps the balance between the respect individual choice and the 'solidarity', in the society. In other words, how far the government takes responsibility to provide citizens with health services with an essential element of equal access to primary health care? How much does the government intend to use market-mechanism increase the service quality and effectiveness? It needs further studies to consider the balance between the individual choice and the government responsibility of the value of social equality.