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Quality and cost-effectiveness in long-term care and dependency prevention

IN-DEPTH STUDY: SWEDEN

Integration and freedom of choice in care for older people in Sweden – Compatible policy options?

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November 2019

European Commission

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1 Introduction

Sweden belongs to the Nordic welfare state family. Traditionally, the systems of welfare service delivery in the Nordic countries have been described as universalistic, publicly funded, (mainly) publicly provided and of high quality (e.g. Esping-Andersen, 1990). Another distinctive feature of the Swedish welfare system is a high degree of decentralisation to independent local and regional authorities with regards to financing and provision of health and social care. At the national level, the government and parliament set out policies and directives through legislation and economic incentives/steering measures. The state bears no responsibility for financing health and social care services.

Integrated care has been high on the health and social care agenda in Sweden for several years. Integrated care is an explicit national policy goal to avoid fragmentation and improve efficiency in care provision by introducing coherent and coordinated care services, both within the care systems and also between health and social care. A potential obstacle to achieving integrated care in the Swedish context, as well as in other countries, is the division of responsibility between health and social care. The responsibility is divided between different authorities and, with few exceptions, it is typically the case that the local level provisions of health and social care are organized separately, with separate governance systems, budgets and management.

Another development present in the Swedish health and social care is a strong marketization trend with policies aiming at privatization (i.e., privately provided but still publicly funded), increased competition, freedom of choice and diversity of care providers. During the early 1990s Sweden took the first steps towards freedom of choice and competition in health and social care, and in 1991 the new Local Government Act came into effect. The Act made it possible for local governments to set up purchaser-provider arrangements and to contract out the provision of care services to private actors. Better cost control was an important motive for introducing a purchaser-provider split and competition in health and social care. Outsourcing following competitive tendering was also expected to lead to improved quality and reduced costs, and the involvement of small companies and non-profit organizations was expected to stimulate the public sector (Meagher and Szebehely, 2013). In 1992, the Act on Public Procurement (LOU) came into effect, which was replaced by a new LOU in 2007. This act was complemented with the Act on System of Choice in the Public Sector in 2009, facilitating the introduction of customer choice models (a more thorough description of the Swedish development follows in Section 3). Similarly to policies on integration, choice and competition policies in health and social care aim at improving the efficiency of care provision, albeit through very different and possibly conflicting means.

The aim of this in-depth study is to address the question whether and how policy instruments on integration and marketization (e.g. freedom of choice and competition) are compatible or conflicting and can be implemented without unexpected outcomes contradicting the declared policy objectives. We start by analysing the theoretical basis of these two instruments; we define the concepts of integration and freedom of choice and ask whether these forms of organizing service provision can co-exist. After that we look at the existing empirical evidence and experiences that have been accumulated from applying these policy tools simultaneously in the provision of health and social care services for older people in Sweden. Our focus in this report is on services provided for older people.

The following analysis is based on both theoretical literature and empirical studies on integration. The conceptual analysis on integration and choice builds on articles analysing and defining the concept of integration (e.g. Leutz, 1999; Goddard and Mason, 2017; Kodner and Spreeuwenberg, 2002; Leichsenring et al., 2015). Empirical evidence on integration and choice comes mainly from the

Swedish literature on integration and choice in old-age care. The Norrtälje model in Stockholm, Sweden is one widely-studied example of the health and social care organization where integration and freedom of choice have been implemented simultaneously in practice (e.g. Rodriques et al., 2016; Le Bihan and Sopadzhiyan 2017). Our discussion on the performance of care systems for older people combining integration and freedom of choice is based on Swedish experiences.

The rest of this report is organized as follows. Section 2 will introduce concepts of integration and freedom of choice and analysis on the co-existence of integration and freedom of choice. Section 3 will set out the Swedish models on integration and freedom of choice in old-age care and discuss evaluations of the Norrtälje model to assess pros and cons of combining integration with free choice. Sections 4 and 5 will discuss our findings and draw conclusions.

2 Integrated care and choice

2.1 Integration

Integrated care is a multi-faceted concept. Leichsenring et al. (2015) define integrated care in the context of care for older people as a process in which units of health and long-term (or social care) care systems act in a coordinated manner to ensure cost-efficient and high-quality care for care recipients. Definitions on integrated care typically emphasize patient/client outcomes and efficiency. This appears in the above definition but also in the definitions of Goddard and Mason (2017) and Kodner and Spreeuwenberg (2002) who define integration as means of enhancing access, quality of care and quality of life, consumer satisfaction and system efficiency for patients/clients with complex needs cutting across multiple services, providers and sectors. Kodner and Spreeuwenberg (2002) further specify means of integration to include models of funding, administrative, organizational, service delivery and clinical levels creating connectivity, alignment and collaboration between care and cure sectors.

The depth of integration may vary. Leutz (1999) distinguishes linkages, coordination and full integration as different levels of integration. Linkages refer to the loosest form of integration where information about clients' needs is efficiently distributed and made available to the providers in different sectors of the care system. Provision of relevant information about patients' and clients' needs between the sectors and providers would be examples of linkages. Coordination takes a step further from linkages towards structural integration by coordinating benefits and use of services, sharing information in a planned manner, managing transitions between different sectors and assigning primary responsibility for care coordination. Different models of coordinated care with providers and units of care sharing information and coordinating the provision of care and benefits of patients/clients provide examples of coordinated care.

According to Leutz's (1999) classification, the final and deepest level of integration is full integration generating new units or programs by pooling resources from the existing ones. Full integration may materialize in different forms. Horizontal integration refers to full integration in which two, often competing, organizations or units merge into a single unit. An example of horizontal integration would be a merger of two (or more) competing residential care units. On the other hand, vertical integration refers to merging two (or more) units at different vertical levels of care provision as for example units of primary and secondary health care. In conglomerate merger (or integration) two (or more) units from different industries form a single operating unit.

Different functions of the care system may also be integrated as integration applies to funding, administrative or clinical functions of the health and

social care (Goddard and Mason, 2017; Kodner and Spreeuwenberg, 2002). Pooled funding and bundled payments are examples of fully integrated funding arrangements. Clinical level integration often refers to integrated care and service pathways, which aim at providing better outcomes to patients with complex needs, reducing duplication of effort and improving the efficiency of care and cure systems. Mergers of administrations of health and social care units may be expected to reduce the average costs of producing health and social care.

2.2 Freedom of choice

Freedom of choice in health and social care refers to the clients' or patients' opportunity or right to choose carers, services or providers according to their own preferences. Freedom of choice can be seen as a right of citizens but also as an instrument to organize the provision of health and social care. Personal budgets and vouchers are practical instruments used to promote freedom of choice in health and social care (Glendenning et al., 2009; Linnosmaa, 2012). Vouchers typically provide service users with an opportunity to make a choice between providers in the market but define those services on which the voucher can be spent. Personal budgets, on the other hand, allow more freedom to service users who can decide both about the services and service providers the money is spent on.

Freedom of choice and competition

Freedom of choice plays an important role in traditional economic models of market competition. Before analysing the interaction between freedom of choice and integration it is worthwhile to discuss briefly the role free consumer choice plays in competitive markets.

In traditional economic models on perfect or imperfect competition (e.g. Tirole, 1988) freedom of choice and competition are closely linked. Freedom of choice allows consumers to choose firms that meet their preferences in the best possible way. High-quality, low-cost and conveniently located firms are typically preferred to low-quality, expensive and distant firms. In a pure market economy, consumers' choices induce firms to compete for market shares by improving quality[1], lowering prices and choosing better locations. As average consumers value close locations, low prices and high quality, such market competition also enhances the welfare of consumers. More generally, perfectly competitive economies (Arrow and Debreu, 1954) have well-known features regarding the use of scarce resources. According to the First Welfare Theorem (e.g. Mas-Colell et al., 1995), allocative efficiency is maximized in a perfectly competitive economy.

It should be noted that consumer freedom of choice is not a necessary condition for competition between providers. Firms may also behave competitively in public procurements in which local authorities (or sponsors) invite bids from the providers in the market[2] and in which consumer choice plays a lesser role (Barros et al., 2017). In the most extreme case, the sponsor organizing the competitive bidding may create administrative rules to allocate service users to providers. In such settings, mechanisms developed to invite bids and choose providers to supply services become central to determine how efficient the market mechanism is in the provision of goods and services.

Freedom of choice and integration

While the central feature of competition is that providers behave independently, integrated organization of social and health care involve some degree of cooperation or coordination between the market providers. Whether integrated solutions also restrict consumers' opportunities to make choices between providers is the question that we will consider next.

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[1] There is a growing literature on the effects of competition on quality in health care (see Gaynor and Town, 2013). Contrary to the general view that competition is good for service quality, this literature suggests a much more refined picture about the implications of quality competition in health care markets.

[2] Housing services for old and disabled people are commissioned in this way in Finland.

Integrated care, and freedom of choice with competition and provider diversity are proposed as two means of coping with the challenges presented by an ageing population and deficiencies in the LTC system. At first glance, it seems that market-inspired models might not be compatible with the goals of integrated care, although both aim to reach similar objectives of user-responsiveness, improved efficiency, and reduced costs. Market-oriented instruments or models such as freedom of choice stimulate provider diversity and competition between many providers. On the other hand, integrated care promotes cooperation between as few providers as possible. Further, freedom of choice entails consumerist rhetoric while integrated care recognizes the notion of older people as frail. Thus, the ideas behind freedom of choice, diversity and competition are in several aspects in conflict with the characteristics in the concept of integrated care (see for example Øvretveit et al., 2010; Ahgren and Axelsson, 2011; Ham, 2012). Simultaneously pursuing official goals of integrated care, on the one hand, and freedom of choice on the other, seems to constitute a prime example of legislations with conflicting aims.

Are integrated care and freedom of choice and competition representing two different incompatible and conflicting (institutional) logics or can they co-exist? To answer this, we will focus on the organizational level of integration (Le Bihan and Sopadzhiyan, 2017) and consider a market with *n* health care providers and *m* social care providers, where $m \geq n \geq 1$ (more social than health care providers), and different levels of integration between these providers. Our interest is in integrated solutions between health and social care providers but we will not consider integration within the health or social care sectors. We start with the assumption that social and health care providers are integrated and that the level of integration may differ (Leutz, 1999). Each integrative solution may also be associated with different degrees of choice. Table 1 describes possible combinations of integration and choice when possibilities to choose exist (freedom of choice) or they are restricted. We also assume that consumers need both health and social care

Table 1: Integration and choice

	Integration		
	Full integration	Coordination	Linkages/networks
Freedom of choice	Several integrated social and health care providers each providing both health and social care services.	Several providers each specializing either in health ($n > 1$) or social ($m > 1$) care. Each provider of health (social) care services coordinates with at least one social (health) care provider.	Several providers each specializing either on health ($n > 1$) or social ($m > 1$) care. Each health (social) care provider shares information with at least one social (health) care provider.
	Consumers choose between integrated providers.	Consumers choose between coordinating providers.	Consumers choose between networks.
Choices are restricted	One large integrated health and social care provider.	One health care provider ($n=1$) and one social care provider ($m=1$) acting in a coordinated manner	One network available.
	Consumers decide whether or not to use services of the provider.	Consumers decide whether or not to use services of the coordinating providers.	Consumers decide whether or not to use services provided by the network.

services and that they are able to make choices. In this setting, we ask if there are integrated solutions that restrict the opportunities to choose. The case of old people who are not able to choose will be discussed and examined later.

Our descriptive model in Table 1 suggests that freedom of choice and integration can co-exist and this may occur in any one of the integrated solutions (full integration/coordination/linkages or networks). A market arrangement with full integration can provide free choice for consumers if they can choose between at least two fully integrated health and social care providers (full integration and freedom of choice). Similarly, if there are at least two networks/linkages, or coordinating pairs of health and social care providers, consumers can choose between integrated pairs of providers (linkages/networks and freedom of choice; or coordination and freedom of choice).

The second main implication of our descriptive model is that the number of providers in the market determines freedom of choice. This conclusion is similar to the conclusion typically reached when analysing consumers' choice possibilities in the context of competitive markets. In each integrated solution, choice is restricted because there is only one fully integrated service provider, coordinating pair or network/linkage in the market (Table 1, row 'Choices are restricted'). Even in such environments the opportunity to choose exists in theory and consumers can decide whether or not to use the services provided by the integrated provider. The case of one integrated provider however rules out the option to choose between service providers. The clearest example in this respect is full integration with one provider supplying both health and social care services.

Our descriptive analysis above (Table 1) has assumed that that various integrated solutions are exogenously given to consumers. Integrated solutions may be the result of firms' or regulator's decisions. It is also possible that some forms of integration between providers of health and social care may arise endogenously as the result of consumer choice. Linkages or possibly coordination between health and social care providers are induced by consumer choice, if a consumer first chooses health (social) care provider and after that decides which social (health) care provider to use. Note that the sequential consumer choice may be facilitated or arranged by a third party, such as a case manager. In the endogenous integration, the link between the first and second provider is created endogenously by consumers' choices. This observation does not effectively change our main conclusions that i) integration and freedom of choice can co-exist and ii) the degree of freedom of choice is affected by the number of providers in the market.

One of the underlying assumptions of the above descriptive model is that consumers are able and willing to make rational choices. Recent Swedish and Finnish policy measures on freedom of choice in old-age care have also been implemented on the presumption that older people can 'vote with their feet', i.e. leave one provider and choose another, and thereby act as a safeguard of quality. It has, however, been shown that many older people with considerable needs for health and social care have difficulties making well-informed choices, acting as well-informed customers, and navigating the health and social care system (Meinow et al, 2011; Erlandsson et al., 2013; Ulmanen and Szebehely, 2014). Free choice and the associated competition between the firms can be effective in incentivizing producers to invest in quality if consumers are well-informed and make rational choices on the basis of price and quality information (Gaynor and Town, 2013). However, competition can be a less-effective means in keeping up good quality if rational 'consumers' are not fully informed about the quality of services (Gravelle and Masiero, 2000) as might be the case with older people with complex health problems.

If the forms of management are based on ideas of New Public Management, where services are expected to improve and adapt to the needs of the user by having actors compete to be chosen as a provider (Molander, 2017), the providers are

presumed to be driven by incentives and the design of reimbursement systems. Achieving integrated care often requires networks to be formed, and is based on another logic: it builds on relations and mutuality rather than competition, from a bottom-up perspective (Hagman et al., 2014).

3 Experiences from Sweden

The Swedish welfare sector has been fundamentally reformed since the beginning of the 1990s. During the conservative bourgeois regime, between 1991 and 1993, a 'freedom choice revolution' was proclaimed, with privatization of public services (Burström, 2015). A range of reforms aiming to create more choice for citizens and break up the public monopoly in welfare service provision in order to increase private entrepreneurship and innovation were introduced. In the early years, private providers operated through contracts with the county councils[3] and the municipalities (procurement), but in recent years the system and the rhetoric have moved towards a consumer's/customer's choice model (e.g. Svallfors, 2018).

Privatization and freedom of choice in public welfare services have been enabled by legislation. A new Local Government Act came into effect in 1991, in order to make it possible for local governments to set up purchaser-provider arrangements and to contract out the provision of health and social care services to private actors. In 1992, the Act on Public Procurement (LOU) came into effect which regulates the purchase of procedures performed by public authorities (municipalities and county councils) when outsourcing tax- funded services to private companies and organisations. LOU was replaced by a 'new' LOU in 2007.

LOU was complemented with the Act on System of Choice in the Public Sector (LOV) in 2009, facilitating the introduction of customer choice models. For the municipalities it is optional whether they want to introduce a freedom of choice system in social services/eldercare or not. Since January 2010, it has been mandatory for the county councils/regions to have a freedom of choice system in primary health care according to LOV. This means that county councils/regions must give citizens the opportunity to choose their primary health care provider, and to allow authorized private providers to freely establish clinics wherever they want, and fund these services by taxes. Although private providers must be able to set up such clinics, they do not necessarily have to be established in all regions (Ekman and Wilkens, 2015). Essentially, private providers are given the opportunity to open a primary health care clinic wherever they choose, and have the region fund it. The regions have no say where the clinics should be located, for example in areas with the greatest needs (Erlandsson et al, 2013; Burström, 2015; Schön and Heap, 2018). While the Swedish health and social care sector is now highly deregulated it continues to be tax funded.

The changes have been profound: from a nearly total dominance of public provision, Sweden has experienced a rapid privatization of welfare provision (although still publicly funded). The entire increase of privately provided health- and social care is the result of the growth of for-profit, in contrast to non-profit, providers (Meagher and Szebehely, 2013; Svallfors, 2018).

Whether for-profit providers should be permitted to operate in the welfare sector has been the subject of lively debate in Sweden (e.g. Meagher and Szebehely, 2018; Schön, 2016). However, the question of whether the ideas of freedom of choice, competition and diversity are compatible with the notion of coordination and integration of care has been little discussed.

[3] Since 1 January 2019 all county councils in Sweden have become regions.

3.1 Ambitions and regulations

In Sweden, integrated care is an explicit policy goal, intended to avoid fragmentation and improve efficiency in care provision, both within the care systems and between health and social care. Collaboration in health and social care for older people is formally governed through regulation. The obligation on municipalities and county councils to cooperate is enshrined in legislation, regulations and agreements. According to the Social Services Act (SoL) and the Health and Medical Services Act (HSL), municipalities and county councils are obligated to cooperate on health and social care for older people. By an amendment in the law in 2010 (identical in both SoL and HSL) the requirement for collaboration at the individual level was further clarified. The law stipulates that an individual care plan (SIP) should be established when a person has needs of care and services from both municipal social services and the health sector within the county council.

3.2 Evaluations

Despite the comprehensive changes in the Swedish welfare, it was not until 2011, after twenty years of reforms, that the first broad analysis of the magnitude and consequences of privatization in general welfare (pre-school, school, individual and family care, labour market policy, health and medical care, and care of older and disabled people) was conducted in a research anthology edited by Hartman (2011). The researchers made an inventory of available research and statistics about the effects of competition in the production of welfare services. The researchers were very cautious in their interpretation of the results. One of the most important conclusions of the study was that there is a remarkable lack of knowledge and information regarding the effects of competition in the Swedish welfare sector. The study did not find any evidence that the reforms in the public sector have resulted in the large quality and efficiency gains that were expected.

This anthology has been followed by other studies and investigations, covering either the general welfare provision or different aspects of it (for further reading see, for example, Meagher and Szebehely, 2013; Burström, 2015; SOU 2016:78, 2016; Molander, 2017; Burström et al, 2017; Svallfors and Tyllström, 2018). The studies and evaluations on this topic have been subjected to much argument and criticism from different stakeholders and 'welfare market lobbyists'. None of the studies we found looks explicitly at the issue of integrated care versus freedom of choice.

A Swedish government investigation (SOU 2016:2, 2016), which was presented in 2017, concluded that the primary health care (PHC) choice reform has made integration and coordination around patients with complex needs more difficult and led to increased fragmentation. The investigation suggested that the PHC should be divided into two organizational sections, a general PHC and a targeted PHC. The general PHC should organizationally be the same as current PHC, among other things in regards to the regulation of the PHC. The targeted primary health care should be exempted from the mandatory PHC. The targeted PHC will have the commitment to provide PHC to older people with complex needs. In other words, the proposal is that the current mandatory PHC choice model should be substituted with new legislation that applies to older people with complex care needs and includes a choice among fully integrated care providers (the case identified in Table 1 as 'full integration and freedom of choice').

Accordingly, the targeted PHC and the municipal health and social care should be carried out jointly for older people with complex needs. This would be achieved by means of new legislation that obliges the county councils and the municipalities to carry out their services jointly for older people with complex needs so that the individual receives a coherent and integrated health and social care. The suggestion can be considered as a step towards creating a legal framework for services that must be linked together to form a horizontal link between the silos.

The report implies that the regulations for the PHC choice will change. If the county councils and the municipalities want to offer a freedom of choice system, they must agree on the terms regarding the division of responsibility and coordination. If so, the individual should be able to choose a provider who 'cares for the whole person' (Table 1: freedom of choice and full integration). The investigation suggested that the county councils and the municipalities should be required to establish a common plan, to include goals, guidelines and a joint resource plan for health and social care services.

In a scoping review of equity aspects of the PHC choice reform in Sweden, Burström and colleagues (2017) presented findings of the existing evidence on impacts of this reform. The review resulted in six scientific articles and nine reports or items of grey literature. Since 2010, more than 270 new private primary health care practices operating for profit have been established in Sweden. New establishments were mainly located in the largest cities and urban areas. The number of visits to primary health care has increased in the general population, especially among wealthier groups and those with lesser health care needs.

Regarding the impact of the PHC choice reform on integrated care in Sweden, the review found some potential and observed effects: the reform has had a negative impact on the provision of care for people with complex needs, i.e. coordination and integration of services for them have become more difficult. Short visits – less beneficial for those with complex needs – were incentivised (produced more income), leading to a tendency towards 'one visit, one problem'. However, integrated care packages were not incentivised. This resulted in less teamwork between doctors and nurses, less emphasis on health promotion and collaboration with other agencies, and reduced political influence on distribution of care according to need, and on resource allocation by need. The authors conclude that the evaluative evidence is sparse and incomplete (Burström et al, 2017).

3.3 The Norrtälje model

The only large-scale example of an integrated care model in Sweden, internationally known, is the Tiohundra organisation in Norrtälje (Schön et al, 2012; Øvretveit et al, 2010; Andersson Bäck and Calltorp, 2015). The starting point of the Norrtälje project was a threat of closing the town's hospital due to financial concerns. This led to a public appeal, which gathered broad political support, for saving the hospital. The Norrtälje model was initiated by Norrtälje municipality and Stockholm County Council in 2006 with the objective of improving efficiency, quality and coordination in care provision, while still controlling the costs. The project became permanent in 2016.

The Norrtälje model is a comprehensive integrated system with a high degree of structural and financial integration of health and social care for the population in Norrtälje. The integrated care organisation consists of a joint health and social care board with politicians from the Norrtälje municipality and Stockholm County Council. Originally, the main function of the joint board, which has its own administration, was to purchase services from a jointly owned stock company, Vårdbolaget Tiohundra. The model particularly focuses on different groups in special need of integrated care, for example older persons with complex needs, who might otherwise suffer from poor integration among providers (Schön et al, 2012; Andersson Bäck and Calltorp, 2015).

When the Norrtälje model was introduced in 2006, the purchasing and providing of health and social care was combined and managed by the 'Norrtälje administration'. The election in 2006 led to a new a centre-right political majority in Stockholm County Council, with changes in political ambitions towards freedom of choice, competition and diversity. This resulted in a purchaser-provider split, which was required in order to introduce freedom of choice systems in the health and social care (Schön et al., 2012). These changes were driven by the politicians in Stockholm County Council, but the local politicians and the Norrtälje management were not

in favour of the increased market orientation. However, Norrtälje were allowed to hold on to one of their original ideas – to integrate essential services provided in the care recipient's own home – and create an own choice model in home-based care, with a focus on integrated care. The idea was that providers of home-based care should be obliged to provide home-help services, home healthcare and home rehabilitation as a unit in order to facilitate integration of care. An important goal with integrated home care is that older people with complex needs should not have to coordinate and administer their health and social care on their own (Schön et al., 2012).

Different aspects of the Norrtälje model have been evaluated over the years. The Medical Management Centre (2011) found that the total costs for health and social care of older people were unchanged and developed in a similar way as comparable areas, but the rate of cost increase had been lower than in Stockholm county. The evaluation commented that the introduction of choice reforms (in 2009 for eldercare and 2010 for primary care) meant that the previous integrated care organization came to serve as one of several local actors on a health care market. Competition between actors reduced opportunities for integration.

Schön and colleagues (2012) have described the implementation process of the Norrtälje model. Some positive achievements were reported: simplified financing through the joint organisation had, to some extent, facilitated the coordination of care. Introduction of an innovative 'customer choice model' in home-based care improved cooperation and integrated care services (home-help services, home healthcare and home rehabilitation as a unit) which offered older people the opportunity to obtain all their home-based care from one provider, either the TioHundra owned provider or a private company (Table 1, 'full integration and freedom of choice'). According to the interviewed professionals, coordination of hospital discharges with following up care planning in the home was successful. The joint organization gave the opportunity to organize, prioritize and make follow-ups from a 'bottom-up' perspective, i.e. the older persons themselves. On the negative side, the introduction of freedom of choice and competition led to increasing numbers of providers, which complicated the integration process. This worked against the original idea of a 'fully integrated model', with a single organization purchasing and providing health and social care. In conclusion, the Norrtälje model has succeeded in achieving a high degree of horizontal and vertical care integration in a comprehensive health and social care organisation, which is unusual both in Sweden and internationally.

It must be emphasized that the evaluative evidence is scant, and the results should be interpreted with caution, as we discuss further below.

4 Discussion

Several Nordic countries strive to enhance freedom of choice and competition in their health and social care systems. This aim coexists with ambitions and demands to improve integrated care, in particular for service users with complex health care needs.

In this report we have discussed whether integration and freedom of choice are compatible policy options that can be implemented simultaneously in the provision of health and social care for older people with complex care needs. Our analysis is based on a descriptive model, which combines different levels of integration with different degrees of free choice among service users. We conclude that integration and freedom of choice can co-exist, but only if some assumptions are fulfilled, and that the extent of choice for service users depends on the number of providers in the market. It is noteworthy that the model presented does not take the welfare consequences of different combinations of integration and choice in the health and social care market into account, which in the practical

context of old-age care are likely to depend on the ability and willingness of elderly 'consumers' to make rational choices. Our plan was to assess the performance of the models to combine integration and choice using practical evaluations from Sweden.

We described the Norrtälje model, which is the most promising attempt in Sweden to develop an integrated 'one-stop shop' organization (Øvretveit et al., 2010; Schön et al., 2012). The Norrtälje model has attracted much interest and has become a showcase, both in Sweden and internationally, as a model that has managed to incorporate a freedom of choice model with a high level of integration. We cannot, however, stress enough that Norrtälje is an outlier. No similar model has been implemented elsewhere in Sweden, which illustrates the seriousness of the structural obstacles and conflicting interests between the authorities responsible for care. It is also essential to emphasize that the empirical evidence on the performance of the model is still weak.

There are substantial challenges in evaluating large scale interventions, 'natural experiments', such as that in Norrtälje. There have been few long-term follow-up studies and few scientific publications on the Norrtälje model. The existing evaluations mainly build on quantitative assessments, reviews of policy documents, and interviews with key persons at different organizational levels. Our conclusion is that the evidence available at the present is scarce and not sufficient to draw firm conclusions. There may be effects of the intervention in Norrtälje which have not yet been demonstrated, effects that have not been possible to capture with the methods and indicators used in the analyses. However, it is not clear which are the most appropriate methods and instruments to capture these possible effects. Which outcome measures are robust? Is it reasonable to look for effects for the general population 65+, or should particular groups, for example older people with complex health problems and severe needs be in focus of the analysis? Another question is whether it is reasonable or possible to identify any effects at the population level of an intervention like that in Norrtälje compared to other areas. There are indications that the health care in Norrtälje is more expensive compared to the rest of Stockholm region, which at first glance seems to be counterintuitive. The Norrtälje model may not lead to cost savings but even so it may have increased cost-effectiveness (Stockholm Gerontology Research Center, 2018).

The Norrtälje model has acted as an inspiration to investigations looking for new ways to reform health and social care for multi-morbid service users. The Swedish government investigation (SOU, 2016) has suggested that current choice model in primary health care should be abolished for older people with complex health care needs (a controversial and radical suggestion in the Swedish context). Instead, the investigation suggested another model for older people with complex health care needs, in which they would be given the opportunity to choose between different multi-professional 'LTC-teams', comprising all the relevant professions, from doctors to assistant nurses in homecare. This is similar to the Norrtälje model, which combines a (restricted) freedom of choice model for older people with integrated care. Hence, the investigation (SOU, 2016) aims at an integrated solution, which retains freedom of choice for old service users.

In any attempts to reform health and social care relying on freedom of choice, decision-makers should keep in mind that older people with complex needs may have difficulties in functioning as well-informed customers, reacting rationally to price and quality differences between the providers in the market – or they may not be willing to (Meinow et al, 2011; Ulmanen and Szebehely, 2014). Such unresponsiveness to price and quality information may lead to market outcomes that are not expected nor optimal (Gravelle and Masiero, 2000).

5 Conclusions

Our analysis indicates that various integrative solutions can be carried out together with freedom of choice for old service users, but the design of such models should be done carefully. Experiences from Sweden suggest that diversified competition induced by unrestricted freedom of choice models may challenge the successful coordination of care chains covering both health and social care services. However, restricted freedom of choice can be retained in market models where older people with complex needs choose between fully integrated service providers who can respond to the health and social care needs of service users comprehensively.

We have identified some recent local and regional initiatives that have emerged in Sweden: 'safe return' programmes including discharge teams and special care managers; ambulatory emergency geriatric teams; special out-patient clinics for older people; ambulant health care for different target groups; and some case management programmes. What these initiatives have in common is the aim to avoid where possible hospital in-patient care among older people and provide care in their own homes. Further, these initiatives target a particularly vulnerable group, older people with complex health problems and severe needs, who are dependent on coordinated health and social care. The focus for these initiatives is to provide person-centred and safe care for older people with complex health problems. A common success factor for these integrative initiatives, perhaps best illustrated by the Norrtälje model, seems to be an adaptation or reshaping of the national marketization policy to local conditions (see for example Schön et al., 2012; Le Bihan and Sopadzhiyan, 2017).

In a current governmental inquiry, new legislation guaranteeing 'all-inclusive integrated care provision' for older people with complex needs is under consideration; older people would be offered a choice of integrated care packages. If this legislation is enacted, it could be interpreted as an acknowledgement of the necessity to offer integrated care solutions for older people. The final report is expected to be presented in March 2020.

There is little scientific evidence supporting current policymaking regarding health and social care for older people with complex needs. We need more knowledge on the advantages and disadvantages of integrated care and freedom of choice for groups with complex health and social care needs. Such knowledge is crucial as current policymaking is to a great extent 'evidence-free' and driven more by political ideology and motives. Evidence to support decision-making is needed in Sweden, where new directions for long-term care for older people are under consideration, but also in other countries (such as Finland) where various health and social care models combining elements of integration and freedom of choice have been considered or are currently being debated.

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