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Purchaser provider split in principle and practice

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Purchaser provider split in principle and practice – experiences from Sweden

Abstract

In the public sector, market inspired organisation, control and accounting, along with business-like relationships between organisational units, usually goes under the name of New Public Management (NPM). One organisational form associated with NPM is the purchaser provider split. The model was first used in Sweden by county councils at the end of the 1980s. It was considered to be an effective and democratic method for controlling Swedish healthcare. Over the past few years researchers have begun doubting the model’s suitability and whether it has really been used in the way that was intended. However, the model is still popular in the Swedish healthcare sector. This article presents the effects found by the researchers in their studies of the purchaser provider split in Sweden. The effects are compared to the effects expected when the model was launched. The question is: does the purchaser provider split deserve its popularity?

Keywords

Purchaser provider split, New Public Management, Health care
Purchaser provider split in principle and practice – experiences from Sweden

Introduction

The market inspired organisation and control models along with the business-like relationships between organisational units that usually go under the name of New Public Management (NPM) are not as prominent as they once were in the public sector. Renewal and the search for efficiency have led to a change of direction in a number of countries. In certain areas the focus has switched to improving democracy (Pallot, 1999). However, this does not mean that there is no trace of NPM in the countries that began using quasi-market models first. On the contrary, many models remain in use and still have strong advocates. The difference now is that few (if any) consider the models to be the panacea for solving efficiency problems in the public sector.

NPM is a global phenomenon that has been seen at government and local levels of the public sector (see Pallot, 1999). However, it has differed between countries in form and the pace at which change has occurred, not least in the area of accounting (Guthrie et al. 1999). As this article indicates, also the same NPM model can differ between countries.

Generally NPM as a phenomenon is characterised by fragmentation, competition, raising value by managers, hands-on management and performance assessment (Hood, 1995). A great deal of inspiration has been gained from the private sector. However, NPM has not meant a complete transition from planned economy to market economy. Observers instead talk about managed markets (see Akehurst and Ferguson, 1993; Maynard, 1993; Walsh, 1995; Hughes et al., 1997; Propper and Bartlett, 1997; Barker et al., 1997; plus Flynn and Williams, 1997).

Criticism against NPM has come from many sides and will not be summarised here. We can however state that criticism has been both modest and fundamental. Examples of modest criticism are that NPM, through increased fragmentation, has created co-ordination problems (Pallot, 1999), implementation difficulties (Pettersen, 1999; Lapsley, 1999) – in particular if professionals have not recommended change (Groot, 1999) – and has not increased efficiency (Lapsley, 1999). Examples of fundamental criticism are that NPM has created inequality, inefficiency, increased costs and a dissatisfied general public (Evans, 1997). It is however difficult to determine which criticism is fairest, because there are not many empirical studies (Groot,
1999), and because evaluations of NPM in certain cases have not been supported by the people responsible (Broadbent and Laughlin, 1997).

One area affected by NPM is the healthcare sector. The intention has been to increase efficiency in different ways for service production (Pettersen, 1999). The purchaser provider split has been especially popular in this sector. The division between purchaser and provider would solve the efficiency problem at secondary care level (Fischbacher and Francis, 1998). The purchaser provider split, combined with contract management was initially seen as a basic restructuring of the welfare state (Flynn and Williams, 1997) and there was great hope that contract management would mean huge, favourable changes (Checkland, 1997). However, researchers have recently begun to doubt that the model is appropriate in public organisations. In the UK, market inspired models have become less common. New government initiatives have meant that competition and businesslike relationships have been played down. Instead the emphasis is on co-operation and trusting relationships (Giddens, 1999).

The purchaser provider split

International understanding of the effects of the purchaser provider split is hard to assess because the model shows significant differences between countries and even differences within countries (such as between England and Scotland [Lapsley et al., 1997]). Still, British research into the model shows interesting and fairly uniform results.

The aim of creating and retaining market relationships between purchasers and providers is considered to have rapidly fallen by the wayside. This is despite the purchasers in a number of cases being enthusiastic about the new role (Llewellyn and Grant, 1999). In practice the purchasers have paid limited attention to prices and other market signals (Ellwood, 1997). There are many circumstances that explain why. One is that it was common for the purchasers to have a monopsony and the providers to have a monopoly (Ellwood, 1996). In certain cases the purchasers (especially GP fundholders) felt that they were small and could not influence the providers (Fischbacher and Francis, 1998). In other cases the providers felt that they were in the hands of individual purchasers (Akehurst and Ferguson, 1993; Walsh, 1995).

Another circumstance was that the purchaser’s contract management of the providers did not become a strong instrument of control. Formal (hard) contracts were replaced by informal (soft) contracts that lacked detailed descriptions about which activity would be provided and clauses for penalties
if the contract was breached (Lapsley and Llewellyn, 1997; Flynn and Williams, 1997). The result was that conflicts between purchasers and providers could not be decided in courts of law (Flynn and Williams, 1997, Hughes et. al, 1997, Barker et. al, 1997), which was a disappointment for the people who wanted to strengthen the financial responsibility of public organisations through law.

A third circumstance explaining the lack of market relationships was the clear examples of hierarchical management and planned economy that the purchaser provider split came to work within (Propper and Bartlett, 1997).

Instead of market relationships, other forms of relationships arose between purchasers and providers. It was uncommon that purchasers altered providers (Fischbacher and Francis, 1998) and it became more common to look for co-operation and trusting relationships (Williams and Flynn, 1997, Flynn et. al, 1997). In this search for trust, contract processes could be hostile and harmful, but they could also get partners who lacked trusting relationships to begin trusting each other (Lapsey and Llewellyn, 1997). The purchaser provider split meant that purchasers and providers learned more about each other, developed partnerships, attempted to co-operate and work enthusiastically together in the shaping of services (Fischbacher and Francis, 1998).

In cases where competition between providers was achieved it has been noted that the costs for healthcare dropped to a certain degree (Propper and Bartlett, 1997). Fischbacher and Francis (1998) suggest that the purchaser provider split has brought about savings, but that the costs have meanwhile increased for management, and they suggest that it is unclear if any net gain can be seen.

The problems associated with the model are that patients of certain purchasers (GP fundholders) can receive shorter waiting times (Flynn and Williams, 1997). There are however differences between England and Scotland (Fischbacher and Francis, 1998). The Scottish model did not produce any such injustices. The market there is more subdued and the model’s main effects seem to be improved communication between primary healthcare and secondary healthcare (Llewellyn and Grant, 1999).

**Purchaser provider split in Sweden**

The above reasoning gives some insight into how the purchaser provider split has developed in the UK and the effects seen. The primary aim of this article is however to describe and explain the consequences that the split has had in the Swedish healthcare sector. The model was first used in Sweden in the late
1980s. At this time the public sector was being criticised for being ineffective and politicians were seen as being too involved in operational details. The purchaser provider split was launched as an instrument to introduce competition to the public sector and to change political control.

Many researchers and practitioners in Sweden are beginning to doubt the model’s suitability, but it has not affected the model’s prevalence in Swedish healthcare. In 13 of the county councils (which together comprise two thirds of Sweden’s population) a purchaser provider split is used to organise and govern activities (www.bestall.net). Here we map out – in light of the British experiences – how the model has worked in practice. Is the Swedish example a further indication that politicians make decisions without scientific evidence (Ham, 1995) or does the purchaser provider split deserve its popularity?

The remainder of the article is disposed as follows. First there is a description of the purchaser provider split’s main principles in Swedish healthcare. Then comes a description of how the split’s principles were put into practice. This section, which is the most comprehensive, is based on the research carried out for the purchaser provider split in Swedish healthcare. Finally the gap between the model’s working principles and practice is discussed and what this should mean for the people making decisions about Swedish healthcare.

**The principles of the purchaser provider model**

In Sweden, healthcare is the responsibility of county councils. There are in practice 21 county councils, but two of them are designated regions and one is a so-called county council-free municipality responsible for healthcare. The councils are governed by directly elected politicians who sit on the county council boards.

The purchaser provider split in Swedish healthcare includes three organisational units consisting of politicians and civil servants with different roles. These are financiers/owners, purchasers and providers (see figure 1).
The purchasers are made up of political committees, manned by politicians indirectly elected by the council members. The providers are made up of hospitals and healthcare centres, mostly owned by the council itself. Certain hospitals are governed by indirectly elected politicians. Financiers/owners in theory consist of directly elected politicians on the council, but in practice they consist of indirectly elected politicians on the council boards.

The purchasers have three important relationships. The first is with citizens (relation A in figure 1). The purchaser should represent citizens and make sure that they receive the healthcare they require – they became a sort of consumer representative. By being competent at mapping out the needs and requirements of the population the purchasers can gain competence lacking by the provider.

The second relationship is with the provider (relationship B in figure 1). Through contract management, the purchaser should make sure that the provider actually provides the service that citizens demand. Before orders are placed the purchaser should find out who the providers are, specify what they want to purchase and ask for a quote. They can then sign contracts with the providers that provide the best service for the money. When the financial year has drawn to a close they should follow up how well the activities have worked. Because purchasers remains further away from activities and daily problems they are better equipped to resist providers’ interests. Politicians in traditional structures were too representative and supportive of existing production (Bergman and Dahlbäck, 1995). Both relationship A and relationship B are very important. It is unimportant what politicians do if their decisions are not implemented or do not achieve the required effects (Lundquist, 1994).

The third relationship is between purchasers and the financiers who are responsible for the distribution of resources to the purchaser (relationship C in
The conditions that the purchasers have to work under are dependent to a great degree on the amount of resources the financiers have to divide and the way in which they divide these resources.

A fourth relationship in the purchaser provider split is between the provider and owner (relationship D in figure 1). Owners are responsible for ownership management of the internal providers.

The relationship between purchasers and citizens (A)

It is essential for democracy that our publicly elected politicians maintain good contact with all members of society. This is a prerequisite so that the decisions taken by the politicians actually reflect the decisions that the citizens want. The purchaser provider split in Sweden involves an increased emphasis on democracy. An important question is if the split has brought about increased contact with the general public.

A rather unexplored area

Research into democracy in county councils began late. When Montin and Olsson in 1993 started researching the political role of county councils, they found that they were treading virgin soil (Montin and Olsson, 1994, page 16). A decade later not a great deal has happened. The democratic effects of market reforms in healthcare are still rarely studied by researchers. Swedish researchers have been strangely uninterested in the political organisation within healthcare organisations. Not even the creation of healthcare parties has been met with any special interest among researchers (Amnå, 1999). The studies carried out cover far too wide a spectrum and lack focus on individual administrative reforms. There is also a lack of quality comparisons between purchasing councils and ordinary councils (Eriksson, 1999).

Studies that suggest an unchanged relationship

Of the studies that were carried out, a few show that not a great deal has happened in the relationship between politicians and citizens as a result of the purchaser provider split. One of the early studies suggested that there was no difference between county councils using the purchaser provider split and traditionally governed county councils in terms of the extent with which citizens had contacts with politicians (Montin and Olsson, 1994). Members of
the public actually taking contact with politicians are roughly at the same (low) level.

A number of studies also suggest that purchasers have not been particularly active in creating a relationship with citizens. Politicians’ tendency to make contact with citizens has not changed (Bergman and Dahlbäck, 1995) and the purchasing politicians consider it to be difficult to conduct a continuous dialogue with members of the public (Leffler, 1996). The purchasers do not appear to have involved the public so they feel involved in the issues affecting their health (Ljungberg, 1998) and they seem to have limited know-how of the needs of the general public (Eriksson, 1999). Bergman and Dahlbäck (2000) suggest that it is difficult to see a difference between county councils with a purchaser provider split and ones governed traditionally, from a citizen perspective.

The problems are highlighted in a case study carried out by Blomgren (2001). The study shows that in practice the purchaser, only to a fairly limited degree, gathered information about the general public’s health, their need of healthcare and their attitudes towards healthcare currently being provided. To the extent that information was collected it was difficult for the purchaser to interpret it. The purchasers therefore would rather use material that they received from the providers. The result is that the purchasers do not provide any new knowledge about the public’s needs and requirements.

**Studies suggesting that relationships have been affected**

There are however other observations that suggest that the relationship between the purchaser and the citizen have developed positively. This applies especially to studies where the purchasers judge their own work. Five examples are given below:

1. A survey of purchasing politicians in the middle of the 1990s shows that the purchasers are pleased with how well they succeed in completing tasks (in relation to the citizens) (Montin and Olsson, 1994).

2. A similar study around the same time showed that the purchasers consider that they have succeeded in carrying out requirements studies, following developments in society and understanding the needs, requirements and opinions of the general public (Bengtsson and Nilsson, 1995; Berglund, 1995).

3. Another study showed that purchaser politicians, more than traditionally organised council politicians, consider that contact with the citizens has increased (von Otter, 1995).
4. In a study of three councils with the purchaser provider split, the purchasers in two of the councils consider that contact between the purchasers and the citizens, primarily via patient associations, had improved (Bergman and Dahlbäck, 1995).

5. One case study suggests that the assessment of the politicians themselves is that their contact with the public has increased. This mainly concerns the majority politicians and in particular the politicians active in purchasing roles (Pettersson, 1998). The author of the report, however, stresses that it could be in the purchaser’s best interest to portray their relationship with the public as better developed and more positive than it actually is.

The difference between local and central purchasers

Certain councils in Sweden have chosen to work with a more centrally placed purchaser unit, while others have chosen to appoint a number of local purchasers, responsible for a geographic region within the council. The question is if central or local purchasers are more effective concerning establishing contacts with the public. This question is not studied particularly well in research, but a study from the middle of the 1990s gives a hint. The Montin and Olsson 1994 study compared one council with central purchasers and one council with local purchasers. The differences between these councils can be seen in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Central purchaser</th>
<th>Local purchaser</th>
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</thead>
<tbody>
<tr>
<td>Conducting studies of requirements</td>
<td>39 % satisfied</td>
<td>86 % satisfied</td>
</tr>
<tr>
<td>Mapping out the public’s needs, requirements and views about service</td>
<td>35 % satisfied</td>
<td>64 % satisfied</td>
</tr>
<tr>
<td>Providing information to make priorities</td>
<td>35 % satisfied</td>
<td>72 % satisfied</td>
</tr>
</tbody>
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Table 1. The difference between local and central purchasers (Montin and Olsson, 1994).

The table shows that there are significant differences between the councils. In the council with local purchasers the politicians are more pleased with the opportunities of conducting requirements studies, mapping out the general public’s needs, requirements and views about service, plus providing information to make priorities. These differences can partly be explained by the fact that the number that did not answer was considerably higher in the council with a central purchaser than in the council with local purchasers. A
closer look at the study shows however that if all politicians (in the council with central purchaser that did not answer) are included in the number that thought they did well, then they would reach a level on a par with councils with local purchasers.

It is far from certain, however, that politicians active in local purchasing committees have consistently succeeded better in creating relationships with the general public. A decentralised organisation is not a guarantee that contacts between politicians and the general public will increase (Eriksson, 1999).

The relationship between purchasers and providers (B)

The relationship between purchasers and providers is, formally speaking, built on contract management and follow-ups. The providers are managed through a contract that specifies the assignment and through follow-ups of how well the assignment has been carried out. From an efficiency point of view it is important that the choice of provider has been preceded by a competitive tendering phase. It is important from both a democratic and effective aspect that the provider really does perform the activity ordered and formalised in the contract.

Contract management is not a new phenomenon in Sweden. Purchasing of public services has taken place for hundreds of years, but for relatively less complex activities governed by contract. Transaction cost theorist Oliver Williamson stated that it was reasonable that complex activities were not contractually managed because contractual management of complex activities generates high transaction costs, which presumably meant that herarchic control was cheaper. But less complex activities can be hard to manage by contracts and Williamson has been criticised for his insistence that complex activities cannot be managed through a contract.

A common supposition is that the purpose of contractual management in healthcare is to increase competition. The purchaser signs a contract with the provider who supplies the best service at the lowest price. It is however not a question of increasing competition on the market, but of creating competition for the market. The holder of the contract, i.e. the provider, gains a local monopoly within a certain geographical area. The difference from before is that there is no need for a public provider to be responsible for production. Because competition does not increase after the activity has been negotiated, the most important factor is the actual purchase. Efficiency increases in healthcare when the purchasing process is exposed to competition. It should
be stressed that in councils where there are large towns and cities there is the opportunity to buy in healthcare (especially in primary healthcare) without creating a local monopoly.

**Successes and failures with contractual management in county councils**

Studies of councils that have used contractual management show both successes and failures. In practice it has been shown to be difficult for purchasers to get contractual management to work, as indicated by recurring financial deficits. The few successes reported concern the purchaser in a council being more pleased with the opportunity of management than the purchaser in a municipality (Nilsson, 1993) and that in one council there was a clear understanding that the purchaser provider split strengthened the opportunities of citizens to influence the range and formulation of health policies (Dahlström and Ramström, 1995).

The failures reported include the following: contractual management being reduced to the purchaser buying last year’s volume of care minus the savings required (Dahlström and Ramström, 1995; Ljungberg, 1998; Leffler, 2002); the contract being very generally formulated and lacking legal authority, reducing the manageable effect because sanctions do not exist (Rehnberg, 1995; Dahlström and Ramström, 1995); contractual management not facilitating structural change (Svensson and Nordling, 1995); producers with greater knowledge within healthcare becoming over-dominant (Leffler, 1996); and, purchasers and providers have not always agreed, which is why contracts have not been signed and permits have been awarded without contracts (Charpentier and Samuelson, 2000). Other problems noted are that the providers, at least initially were not interested in being contractually managed. Studies of a large council show that clinic directors were negative towards signing contracts in the beginning with the purchasers, but that with time they became more positive (ibid).

One circumstance that has affected the opportunity of contractual management is that providers have considered that purchasers have lacked the competence of negotiating healthcare well. This problem was identified at the beginning of the 1990s when there was talk of buying and selling healthcare (Anell, 1991), but the problem is still topical (Bergman and Dahlbäck, 2000; Charpentier and Samuelson, 2000). Shortfalls in the purchaser’s competence have been used as an explanation of why providers do not trust purchasers (Berglund, 1995). Providers allege that purchasers lack medical know-how (Bergman and Dahlbäck, 1995) and that it is difficult for the purchasers to specify what they want to order (Leffler, 1996; Charpentier
and Samuelson, 2000). Trust and competence problems have meant that many (not least consultants) have proposed that the purchasers’ competence should be strengthened, in order to reduce the purchaser’s disadvantage in relation to the providers (Dahlström and Ramström, 1995). It is recommended that medical specialists are brought into the purchasing departments (Dahlström and Ramström, 1995; Svalander, 2001; Olofsson, 2001) and that medical audits are performed (Dahlström and Ramström, 1995).

Another worry that has been established in relation between the purchaser and provider is that there has not always been a clear division of roles. The studies show that contractual management can lead to greater clarity in the division of assignments between politicians and civil servants (Dahlström and Ramström, 1995) but such clarity has not always arisen. It has instead come to light that purchasers take on more assignments than ordering healthcare (via purchasing agreements) and evaluating the result. They also want to affect how production is managed, for example via manning and training (Olofsson, 2001) and where service is provided (Leffler, 2002).

Less contractual management and more co-operation

From the middle of the 1990s the attitude of purchaser councils to contractual management changed. There was less talk of formal agreements and competition and a lot more about collaboration and co-ordination, and it was thought that larger hospitals were needed. A number of studies illuminates this:

1. In one council where the purchaser provider split was introduced at the beginning of the 1990s the ambition for a relationship between purchaser and provider being businesslike was replaces by the middle of the 1990s by the ambition that the purchaser and provider, through dialogue and consultation should set the conditions for future healthcare (Berglund, 1995).

2. Another study of the same council showed that none of the key politicians interviewed immediately linked the split with freedom of choice, variety and competition (Ljungberg, 1998).

3. In a study of eight councils the researchers noted that purchases began formally, with bidding procedures, negotiations and contracts, but that these time-consuming procedures were later replaced by coherent and well-arranged agreements (Bergman and Dahlbäck, 1995).

4. In both the above studies (Bergman and Dahlbäck, 1995; Ljungberg, 1998) it was also established that local purchasers were forced to join forces around
joint orders, where they were jointly responsible for possible deficits. Instead of each local purchaser negotiating with the provider the purchases were co-ordinated.

5. In a study of a large council it was established that a condition for the purchaser provider split should work was that the purchaser and provider co-operate to create long-term, trusting relationships (Dahlström and Ramström, 1995).

6. A later study of the same council established that competition and decentralisation of responsibility from the middle of the 1990s was becoming less important (Socialstyrelsen [the National Board of Health and Welfare], 2000a). Instead the focus was on co-operation, and the key solutions were about increased co-operation in paired hospitals and council run clinics (ibid).

7. A study of the economic management model in one council established that key civil servants and hospital directors did not see any connection between competition and the purchaser provider split (Siverbo and Falkman, 2001).

8. An internal study of the purchaser provider split in one council noted that the aim of developing buy/sell relationships had been reshaped into a quality dialogue between purchaser and provider (Gävleborg County Council, 2001).

By the middle of the 1990s it was noted that co-operation and trust are important qualities in a purchaser provider split. These are qualities that were not emphasised in the same way in early rhetoric about the purchaser provider split. One reason that contractual management in its original form has been abandoned in a number of councils can, according to Leffler (1996), be that the range of healthcare has not increased. There are few competing providers to choose among. Because the purchasers in practice do not have a choice when purchasing healthcare, they focus on making the existing healthcare work as smoothly as possible. That’s why thoughts of efficiency through co-ordination and collaboration replace thoughts of efficiency through competition. And if competition is not created then contractual management is considered unnecessarily formal.

Follow-up

An important task for the purchaser is to follow up that the providers really supply the healthcare required. Whether councils with the purchaser provider split have really succeeded with this follow-up is unclear because there is almost no research available.
However there is one report that follows up healthcare provision across the entire council sector (Socialstyrelsen [the National Board of Health and Welfare], 2000b). The report shows that in 2000 there was a lack of comprehensive follow-up in healthcare. Five problems were highlighted: (1) Low-quality basic information, with cost accounting especially unsatisfactory. (2) Follow-ups are not comprehensive. In certain activities, such as laboratories and x-rays, there is a total lack of follow-up. (3) The information requirements of all interested parties are not met. There is a bias towards providers’ clinic management. Information to patients, general public, purchasers and authorities is not provided adequately. (4) Activity follow-ups are sometimes considered unusable. Measurements and measuring methods are questioned and information is not trusted. (5) There is a lack of analysis, with no comments on areas such as equality and poor quality.

This report, as mentioned earlier, concerns the entire county council sector, but similar criticism is aimed from consultants towards individual purchasing councils. The criticism is that the purchasers cannot manage if they do not find out the results of their management (Olofsson, 2001).

One modern follow-up instrument is the balanced scorecard (BSC). BSC has begun being used in the county council sector and can help purchaser politicians to follow up activities. It should however be emphasised that BSC is used both in purchasing councils and traditionally organised councils. A study of BSC in purchasing councils shows that the instrument is seen as a practical tool for following up, but BSC is mainly used by providers themselves for their own control of activities (Aidemark, 2001). A study of BSC in three clinics shows that it can mean a partially new way of describing activities, giving a basis for discussions about activities and how they can be improved (Hallin and Kastberg, 2002). The study showed that BSC contributes to improving care, shortening waiting lists, redistributing resources internally and creating balanced finances.

**The relationship between financiers and purchasers (C)**

The purchaser provider split means that politicians receive new roles. The role of financier involved distributing resources to the purchasers, who in turn negotiate healthcare and sign agreements with providers. According to the principles of the purchaser provider split there is a clear division of roles between financier and purchaser, but in practice it has not worked quite so smoothly.
Unclear roles between financier and purchaser

As established earlier in the article, there are problems in councils using the purchaser provider split with the division of roles between purchaser and provider. This problem was however expected. More surprising was that the division of roles between politicians with different tasks is seen as equally problematic. The worries are about which tasks the purchaser and financier (the council and the council board) should have, and to what degree the financiers have the right to change the rules (Berglund, 1995; Dahlström and Ramström, 1995).

There has been uncertainty irrespective of whether the purchasing politicians have been active in local or central purchasing committees. The problem is that the rules that exist in the split are not always respected. Financiers have sometimes considered themselves forced to take responsibility for everything in the council and therefore made decisions that have not been in line with the stipulated rules (Leffler, 1996; Petersson, 1998). This might be the result of the difficulties the purchasers have found being public representatives and responsible for budgets while patients meanwhile have certain freedom to choose the healthcare provider (Bergman and Dahlbäck, 1995).

This is a problem that not only appeared at the beginning and middle of the 1990s. Later studies show recurring contrasts between purchasers and financiers (Charpentier and Samuelson, 2000). The purchasers consider that financiers intervene in the process too much, for example deciding how to compensate for production above and under agreed volumes and distributing extra resources straight to the providers (ibid). There seems to be a contradiction in combining decentralised responsibility and a market model with clear elements of central management.

Change in consumer patterns is not facilitated

One way of reducing costs within the healthcare sector is to move patients from the accident and emergency department to primary healthcare. A common understanding is that far too much healthcare is run from hospitals. The problem is that the public in many councils are used to visiting the accident and emergency department when they are sick. One challenge for the councils is therefore to alter the consumer pattern. There is talk within Swedish Healthcare of LEON “Lägsta Effektiva OmhändertagandeNivå” (lowest effective care level), which means that purchasers and providers should collaborate to provide patients with primary healthcare.
Early studies of purchasing councils established that the purchaser provider split did not succeed in facilitating the change of where healthcare was consumed (Brorström and Edlund, 1993). Later observations have confirmed this (Bergman and Dahlbäck, 1995). The purchaser’s aims of expanding primary healthcare were made difficult by central decisions that purchasers should purchase from existing hospitals so they reach full utilisation capacity. Orders that over the long-term would mean structural changes involving more healthcare being used in primary healthcare have been over-ruled by the financiers. This has been more common in councils with local purchasers. In councils where the purchasing unit is centrally located the purchasers have been given greater freedom to influence structural issues (Bergman and Dahlbäck, 1995).

**Financiers’ reimbursement to the purchaser**

One stage of the distribution of resources in the purchaser provider split is when resources are distributed from the financier to the purchaser. This stage can be considered as the first step of resource transformation and precedes the purchase of healthcare. Despite the fact that it is this reimbursement that is the basis of how much healthcare the purchaser can negotiate, this activity has not been well researched.

Reimbursement to hospitals has traditionally been based on political decisions that have lacked transparency. It has been difficult to know why a hospital has received certain funds and not a little more or a little less. In the middle of the 1980s discussions began of whether or not reimbursement could be based on structural parameters (Landstingsförbundet [the Federation of Swedish County Councils], 1987). This division of resources is called means tested. The effects of means-tested reimbursement in healthcare are not very well researched, but there are reports where different examples are given for what structural variables can be used. The report by the Federation of Swedish County Councils (ibid) concluded that age structure and number of inhabitants are common structural parameters. In a later report (the Swedish Association of Local Authorities, 1995) different social variables, used by county councils was identified. Examples of variables were unemployment, average income, living alone, level of education and poor health. Examples of variables used less often were estimated remaining lifespan and those variables that individual councils identify themselves using questionnaires.

The means-tested reimbursement aims to make the division of resources fairer (Anell and Svarvar, 1995). It should however be emphasised that means-tested reimbursement is not only feasible in councils with a purchaser provider split.
Such reimbursement is feasible in all councils divided into administrative geographic territories. In 2000, half of Sweden’s county councils had a population-related reimbursement model (Bergman and Dahlbäck, 2000).

The relationship between owner and provider (D)

So far this article has dealt with the purchasers’ relationships with citizens, financiers and providers. There is more and less comprehensive research into these relationships. No research has, however, been carried out concerning the last relationship to be dealt with in this article. The relationship between owner and provider has so far actually only been scrutinised by consultants.

Their reports emphasise the significance of owners being active in the control of the providers. In this case it is a question of the kind of management that lies beside that which purchasers do in their purchases. Consultants do not arrive at the same conclusions about how the ownership management should be organised. One report emphasises the importance of a strong and centralised owner who opposes sub-optimising (Svalander, 2001). The report points out that all (county council-owned) hospitals are planning to solve their financial problems by expanding, which is unreasonable considering that purchasers do not have the resources to order healthcare to such an extent. Another report states that ownership management should be decentralised at each individual hospital, because otherwise it will be difficult to create competition (Olofsson, 2001).

Other observations made about ownership management are as follows: there are few formal contacts between owner and hospital, but informal contacts do occur at top-managerial level (Olofsson, 2001); owners neglect their duties to make hospitals cost-efficient (Svalander, 2001); politicians who sit on the councils’ boards (as owners) are also members of healthcare committees (as purchasers), which means that the politicians might take care of their role as a purchaser ahead of their role as owner (Olofsson, 2001); and there is uncertainty surrounding which department has responsibility for structural issues (Mueller, 2001; Olofsson, 2001; Svalander, 2001).

Conclusions

When the purchaser provider split is used in Swedish healthcare it is important that the relationships work between purchaser and citizen, purchaser and provider, purchaser and financier, and owner and provider. It
is important to ask how the relationships work in practice and if there are gaps in know-how about the effects of the purchaser provider split.

Researchers are not sure how well purchasers have succeeded in establishing contact with the general public. Case studies based on the purchaser’s views show that the purchasers are generally pleased with the achievements. Meanwhile, other studies, where it is not the purchaser being asked, show that the purchasers often fail in providing information for making priorities and making contact with the citizens.

According to the principles of the purchaser provider split the relationship between the purchaser and provider must be organised according to contractual management and be preceded by competitive negotiations. The purchaser should follow-up activities to make rational decisions in the next negotiation. In practice it became something other than competition, contractual management and follow-ups, which is a reminder of the events in the UK.

It is difficult to base a control model on competition when there is a lack of alternative providers. Also, contractual management required more competence from the purchaser, which was lacking, and because the contracts were signed with the council’s own hospitals it was considered to be unnecessary to sign businesslike agreements and legally binding contracts. Instead, just like in the UK, a crossover to soft contracts was the final course of action.

Later on the ideas of competition were, to a large extent, replaced by ideas of collaboration and co-ordination, which require trusting relationships. Meanwhile it remains a worry that the providers perceive that the purchasers possess too little competence, do not want to make priorities and discuss the content of purchases. In addition, the purchasers concentrate too little on follow-ups. This applies to the entire council sector, but the problem is greater in councils with a purchaser provider split because the order process requires sound knowledge of how the providers manage their assignments.

The purchasers’ relationship with the financiers is in principle all about the resources the financier places at the disposal of the purchaser. Not much attention is paid to the distribution of resources from the financier to the purchaser. A transition to means-tested division of resources has occurred in a number of councils, but the effects have yet to be studied. However, in practice, the relationship between purchasers and financiers has concerned whether the financier respects the purchasers’ decentralised responsibility and how the purchasers take overall responsibility. The relationship between central and local efforts has been, and still is, a stumbling block for the
application of the purchaser provider split. In this context it is important to add that such problems are not just specific to councils using the purchaser provider split. The problem in the relationships between local and central players appears in all public organisations. It can however be established that the purchaser provider split has not made these problems diminish.

The relationship between owner and provider is also an area that lacks study. This is despite the conditions for ownership management being central concerning management of hospitals and in particular concerning structural issues, cost-efficiency and range of service. Consultants who have written about ownership management have however established that weak ownership management can cause expansion causing increased production capacity without the purchaser being given the opportunity to purchase all the healthcare available.

The aim of the present article has been to describe the consequences of the purchaser provider split in the Swedish healthcare sector. Despite a certain lack of studies it can be established that there is a division between the principles launched by the model and the practice that the researchers have found. The question is whether, based on existing reports, it can be stated that the popularity of the model is an indication that politicians make decisions without scientific evidence, or if the purchaser provider split actually deserves its popularity.

Of course it is easy to dismiss an administrative management tool if it proves not to give the desired effects and possibly even increases transaction costs. But a less rigid assessment leads to the conclusion that the content of this article does not provide enough evidence to justify abolition of the purchaser provider split. There are three reasons for this: The first is that more, better designed studies are required. The second is that it is uncertain whether the split is better or worse than other alternatives available. A model should not be discounted because it hasn’t achieved the set targets, but because there are other models available that are better. It is hardly fair to compare a model with an ideal because ideals by definition are unattainable (Williamson, 2000). The third reason is that the model should not be criticised because the users choose to abandon certain of its principles. On the other hand, if principles are abandoned because they are unrealistic then it is actually serious criticism against the model.

The purchaser provider split in Sweden is both an expression of NPM and of increased democratic aims. The split’s element of NPM – in the form of competition, negotiations, contractual management and follow-ups – has not been successful. There are no indications that the purchaser provider split has increased efficiency within healthcare. One explanation why the split remains
in use to a large extent in Swedish healthcare is the remaining hope for democratic improvements (compare Pallot 1999). The purchaser provider split remains in use to a large extent within Swedish healthcare, but its elements of NPM are limited.


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