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The purchaser-provider split in principle and practice

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The 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 managing Swedish health care. Over the past few years, researchers in many countries 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 health care sector. This article presents the effects of the purchaser-provider split found in Swedish studies. These effects are compared to the anticipated effects when the model was launched, and the effects of the purchaser-provider split in Britain. The aim of this article is to explore the effects of the purchaser-provider split in practice.

Keywords

Purchaser-provider split, New Public Management, Health care, Managed market

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 pursuit of efficiency have led to a change in 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 now 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 from country to country in form and in the pace at which change has occurred, not least in the area of accounting (Guthrie et al. 1999). As this article indicates, the same NPM model can also differ between countries.

Generally, NPM as a phenomenon is characterised by fragmentation, competition, hands-on management and performance appraisal (Hood, 1995). A great deal of inspiration has been gained from the private sector. However, NPM has not meant a complete transition from a planned economy to a 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 of 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 dissatisfied the general public (Evans, 1997). It is difficult, however, 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; Maddox, 1999).

One area affected by NPM is the health care sector. The intention was to increase efficiency in different ways for service production (Pettersen, 1999). The purchaser-provider split has been particularly popular in this sector. Consequently, this article focuses specifically on the purchaser-provider split and the health care sector. It aims to summarise the effects of NPM by presenting experiences of the introduction of the purchaser-provider split in the Swedish health care sector and comparing them to corresponding experiences in Britain.

The next section outlines the principles and practical experiences of the purchaser-provider split in Britain. The section after that describes the model's popularity, principles and relationships in Sweden. This is followed by four sections in which the model's principles are compared with its results in practice. The reports are based, as they should be, on the available research results. However, because of a lack of research in certain areas, self-appraisals and consultants' reports have also been used as reference material. In light of this, some of the reported effects should be interpreted with caution. The final section compares Swedish and British experiences, and discusses the problems encountered with NPM in the health care sector.

The purchaser-provider split in Britain

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, and these are highly relevant for a comparison with the Swedish results.

In Britain, the purchaser-provider split was introduced in the health care sector as part of the Conservative Government's programme to create an internal market. The previous hierarchical structure based on directly governed hospitals and community services was replaced by a market-inspired structure in which the purchasers (Health Authorities and GP fundholders) bought health care services from providers (trusts). The plan was to create market incentives and thereby increase efficiency (Locock 2000).

The GP fundholders were to act as patient representatives; to be well-informed buyers of specialised care and financially responsible, which required them to

take finances into consideration and to be price-sensitive and responsive to other market signals (Ellwood 1997). The health authorities were to represent the local population rather than the local providers, as under the previous structure. This meant that it was necessary for the health authorities to demonstrate a democratic decision-making process, challenge the prevailing patterns of resource distribution between primary and secondary health care and clearly specify what was expected of the providers (Locock 2000). Power was to be transferred from the providers to the public representatives, i.e., the purchasers (Maddox 1999). Neither the GP fundholders nor the health authorities included locally elected politicians (Walsh et. al, 1997).

The idea was that the division between purchaser and provider would solve the efficiency problem at the 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 were great hopes that contract management would mean huge, beneficial changes (Checkland, 1997).

However, the studies carried out show that the reform was difficult to implement in practice. The aim of creating and retaining market relationships between purchasers and providers is considered to have rapidly fallen by the wayside. This was despite the purchasers being enthusiastic about their new role in a number of cases (Llewellyn and Grant, 1999; Maddox 1999).

In a comprehensive study of GP fundholders, it was recognised that in practice the purchasers have paid limited attention to prices and other market signals. Waiting times, the providers' geographical location and the quality of service have been given priority over prices. Another contributing factor is the purchasers' reluctance to refer patients to unknown providers. However, the purchasers' limited regard for prices may be due in part to the lack of financial pressure (Ellwood, 1997).

Another extensive study shows that even the health authorities had difficulty changing their providers. A main reason for this is that local 'political' players took action to keep the providers local (Walsh et. al, 1997).

The contracts that were to specify the terms between purchasers and providers turned out to have a subordinate role. Their effect as instruments of control has been limited, and the important decisions were made in other contexts (Flynn and Williams 1997; Locock 2000). Formal (hard) contracts were replaced by informal (soft) contracts that lacked detailed descriptions about the activity to 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 use the law to increase the financial accountability of public organisations. The contracts also made it difficult for the purchasers to set priorities, by showing too clearly what was being taken away. Explicit priorities would expose purchasers to far-reaching criticism from the media and the public. To some extent, the contracts may nevertheless have resulted in the health authorities setting more explicit priorities, but the main reason was that they were subject to financial pressure (Locock 2000).

Instead of market relationships, other forms of relationships arose between purchasers and providers. It was uncommon that purchasers changed providers (Fischbacher and Francis, 1998) and it became more common to look for co-operation and relationships based on trust (Flynn and Williams, 1997; Flynn et. al, 1997). In this pursuit of trust, contract procedures could be hostile and harmful (Locock 2000), but they could also get partners who lacked such a relationship with each other 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 worked enthusiastically together in the shaping of services (Fischbacher and Francis, 1998).

One explanation as to why real competition was seldom achieved 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 explaining the lack of market relationships was the clear examples of hierarchical management and planned economy that the purchaser-provider split came to operate within (Propper and Bartlett, 1997).

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

One problem associated with the model is that patients of certain purchasers (GP fundholders) could get shorter waiting times (Flynn and Williams, 1997; Walsh et. al, 1997). However there are differences between England and Scotland (Fischbacher and Francis, 1998). The Scottish model did not produce any such inequities. The market there is not as volatile and the model's main

effects seem to have been improved communication between primary health care and secondary health care (Llewellyn and Grant, 1999). However, a study based on interviews with representatives of GP fundholders showed no inequities between patients of GP fundholders and other patients (Maddox 1999).

To sum up, the creation of an internal market in the British health care sector did not generate the desired effects, but it did not have any dramatically adverse effects either. The reform officially ended in 1997 when New Labour was elected to government and published its white paper entitled *The New NHS* (Maddox 1999). It is probably fair to conclude that the New NHS ended the experiments with market-inspired organisation and control in the health care sector. The division into purchasing and providing units remained, but the word 'purchasing' was replaced by 'commissioning', and the contracts were replaced by long-term service agreements. The GP fundholders and health authorities were replaced by significantly larger 'primary care groups' (PCGs). The providers (trusts) were now required to collaborate rather than compete. Nowadays, the emphasis is on co-operation and trusting relationships (Giddens, 1999; Locock 2000).

The purchaser-provider split in Sweden: prevalence, principles and relationships

In Sweden, health care is largely the responsibility of county councils. In practice there are 21 county councils, but two of them are regions and one is a so-called 'county council-free' municipality responsible for health care. The councils are governed by directly elected politicians who sit on the county council boards. The Swedish constitution states that these organisations are autonomous, which means that the politicians (and managers) are able to make decisions about taxes, organisation, and management control systems. But the county councils are not entirely independent of the state. The government controls some of their finances and the National Board of Health and Welfare some of their operations.

The purchaser-provider split was first used in Sweden in the late 1980s. At this time the public sector was being criticised for being inefficient 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 shift political control.

The purchaser-provider split in Swedish health care includes three organisational units consisting of politicians and civil servants with different roles. These are financiers/owners, purchasers and providers (see Figure 1).

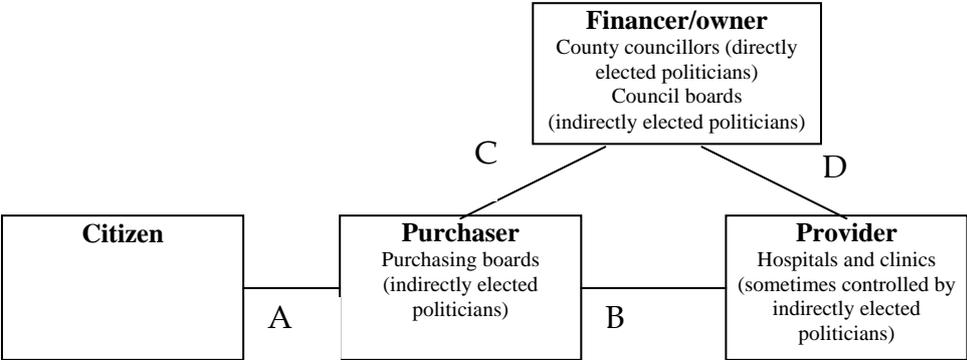


Figure 1. Purchaser-provider split

The purchasers are made up of political committees, manned by politicians elected by the county councillors. The providers are made up of hospitals and health care centres, mostly owned by the county council itself. Certain hospitals are governed by indirectly elected politicians. Financiers/owners comprise directly elected politicians on the council, and the indirectly elected politicians on the county council boards.

The purchasers have three important relationships. The first is with the public (Relationship A in Figure 1). The purchaser should represent the public and make sure that they receive the health care they require. By becoming competent at mapping the wants and needs of the population, purchasers can possess a competence that the provider lacks. In principle, the purchaser should handle the relationship with the public, and it is only when the citizen becomes a patient that contact is initiated with the provider. However, this relationship is beyond the scope of this article.

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 the public demand. Before orders are placed, the purchaser should find out who the competing providers are, specify what they want to purchase and ask for a quote. They can then sign contracts with the providers who provide the best service for the money. When the financial year draws to a close, they should evaluate how well things have worked (see for example Lindkvist, 1996). Because purchasers remain more distant from activities and day-to-day problems, they are better equipped to stand up to the interests of providers. Politicians in traditional structures were too representative and supportive of existing production

(Bergman and Dahlbäck, 1995; Lindkvist, 1996). Both Relationship A and Relationship B are very important. It is not important what politicians do if their decisions are not implemented or do not achieve the desired 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 Figure 1). The conditions that the purchasers have to work under are dependent to a large degree on whether the financiers respect the purchasers' decentralised responsibility (Leffler, 1996; Petersson, 1998).

A fourth relationship in the purchaser-provider split is between the provider and owner (Relationship D in Figure 1). Owners are responsible for owner management of their own internal providers. However, this owner role can be exercised in various ways, and the scope of owner management varies among the individual county councils. Often, the role is limited to HR policies and decisions of investments. Very rarely do owners impose demands on the providers in terms of return on investment.

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 health care. In 13 of the county councils (which together cover 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 experience – how the model has worked in practice. Is the Swedish example a further indication that politicians make decisions without scientific evidence (Ham, 1995)?

The relationship between purchasers and the public (A)

It is essential for democracy that our publicly elected politicians maintain good contact with all members of society. This is a prerequisite for the decisions made by politicians to actually reflect what the public 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 somewhat unexplored area

Research into democracy in county councils began late. When Montin and Olsson started researching the political role of county councils in 1993, they

found that they were treading virgin soil (Montin and Olsson, 1994). A decade later not a great deal has happened. The democratic effects of market reforms in health care are still rarely studied by researchers. Swedish researchers have been strangely uninterested in the political organisation within health care organisations. Not even the creation of health care political 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 of purchasing county councils with non-purchasing county 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 the public 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 to which the public had contact with politicians (Montin and Olsson, 1994). Members of the public actually contacting politicians is roughly at the same (low) level.

A number of studies also suggest that purchasers have not been particularly active in creating a relationship with the public. The propensity of politicians to make contact with the public has not changed (Bergman and Dahlbäck, 1995) and the purchasing politicians consider it to be difficult to maintain a continuous dialogue with members of the public (Leffler, 1996). The purchasers do not appear to have involved the public so that they feel empowered in issues affecting their health (Ljungberg, 1998) and they seem to have limited knowledge 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's point of view.

The problems are highlighted in a case study carried out by Blomgren (2001). The study shows that in practice the purchaser gathered information about the general public's health, their needs in relation to health care and their attitudes towards the health care currently being provided only to a fairly limited degree. In so far as that information has been gathered, it is difficult for the purchaser to interpret it. The purchasers therefore prefer to use material that they receive from the providers. The result is that the purchasers do not provide any new knowledge about the public's wants and needs.

Studies suggesting that relationships have been affected

There are, however, other observations that suggest that the relationship between the purchaser and the citizen has developed positively. This applies especially to studies in which the purchasers have appraised 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 satisfied with how well they have succeeded in completing their tasks (in relation to the public) (Montin and Olsson, 1994).
2. A similar study around the same time showed that the purchasers considered that they had succeeded in carrying out needs analyses, following trends in society and understanding the wants, needs and opinions of the general public (Bengtsson and Nilsson, 1995; Berglund, 1995).
3. Another study showed that purchaser politicians, more than politicians in county councils organised along more traditional lines, consider that their contact with the public has increased (von Otter, 1995).
4. In a study of three councils with the purchaser-provider split, the purchasers in two of the councils considered that contact between themselves and the public, primarily through patient associations, had improved (Bergman and Dahlbäck, 1995).
5. One case study suggests that, by the politicians' own assessment, their contact with the public has increased. This mainly concerns the politicians who belong to the majority and in particular those politicians active in purchasing functions (Pettersson, 1998). However the author of the report stresses that it could be in the purchaser's best interests to portray their relationship with the public as better developed and more positive than it actually is.

The differences between local and central purchasers

Certain county councils in Sweden have chosen to use a more centrally placed purchasing unit or function, while others have chosen to appoint a number of local purchasers responsible for a geographical region within the county council. The question is if central or local purchasers are more effective in establishing contact with the public. This question has not been studied particularly well in the available research, but a study from the middle of the 1990s gives a hint. The Montin and Olsson 1994 study compared a county

council with central purchasing with a county council with local purchasers. The differences between these two can be seen in Table 1.

	Central purchaser	Local purchaser
Conducting needs analyses	39 % satisfied	86 % satisfied
Mapping of the public's needs, wants and opinions about the service	35 % satisfied	64 % satisfied
Gathering data on which to base setting priorities	35 % satisfied	72 % satisfied

Table 1. The differences between local and central purchasing (Montin and Olsson, 1994).

The table shows that there are significant differences between the two county councils. In the county council with local purchasers, the politicians are more satisfied with their abilities to conduct needs analyses, map the general public's needs, wants and opinions about the service, and gather data on which to base the setting of priorities.

It is far from certain, however, that politicians active in local purchasing functions have consistently succeeded better at 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 evaluation. The providers are managed through a contract that specifies the assignment and through evaluations 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 efficiency point of view that the provider really does perform the activity ordered and formalised in the contract.

A common supposition is that the purpose of contractual management in health care is to increase competition. The purchaser signs a contract with the provider who supplies the best service at the lowest price. However, it is not a question of increasing competition in the market, but of *creating* competition in the market. The holder of the contract, i.e., the provider, gets 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 procured, the most important factor is the actual procurement or purchasing process. Efficiency increases in health care when the purchasing process is exposed to competition. It should be stressed that in county councils where there are large towns and cities, there is the opportunity to buy in health care (especially primary health care) without creating a local monopoly.

Successes and disappointments of contractual management in county councils

Studies of county councils that have used contractual management show both successes and failures. In practice it has been proved difficult for purchasers to get contractual management to work, as evidenced by recurring financial deficits. The few successes reported concern the purchasers in a county council being more satisfied with their possibilities to exercise control than were the purchasers in a municipality (Nilsson, 1993); and that in one county council there was a clear understanding that the purchaser-provider split increased the opportunities of the public to influence the scope and shape of health care (Dahlström and Ramström, 1995).

The disappointments 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 (Lindkvist, 1996) and lacking legal enforceability, reducing the control effect because sanctions are lacking (Rehnberg, 1995; Dahlström and Ramström, 1995); contractual management not facilitating structural change (Svensson and Nordling, 1995); that producers, with their superior knowledge of health care, have been dominant (Leffler, 1996); and, that purchasers and providers have not always agreed, resulting in contracts not being signed and permits being issued without contracts (Charpentier and Samuelson, 2000). Other problems noted are that the providers, at least initially, were not interested in being managed by contract. Studies of a large county council show that in the beginning clinic directors were negative towards signing contracts with the purchasers, but that with time they became more positive (ibid).

One circumstance that has affected the possibilities of management by contract is that providers have considered that purchasers have lacked the proper competence to procure health care in a good way. This problem was identified at the beginning of the 1990s when there was talk of buying and selling health care (Anell, 1991), but the issue is still topical (Bergman and Dahlbäck, 2000; Charpentier and Samuelson, 2000). The lack of competence of purchasers has been used as an explanation as to why providers do not trust purchasers

(Berglund, 1995). Providers allege that purchasers lack the medical knowledge necessary (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 issues have meant that many (not least consultants) have proposed that the purchasers' competence should be increased, in order to thereby reduce the purchasers' disadvantage in relation to the providers (Dahlström and Ramström, 1995). It was recommended that medical specialists be brought into the purchasing departments (Dahlström and Ramström, 1995; Svalander, 2001; Olofsson, 2001) and that medical audits be performed (Dahlström and Ramström, 1995).

Another problem in the relationship 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 tasks between politicians and civil servants (Dahlström and Ramström, 1995) but such clarity has not always emerged. It has instead come to light that purchasers take on more tasks than ordering health care (via purchasing agreements) and following up on the result. They also want to affect how production is managed, for example, through manning and training (Olofsson, 2001) and where the service is provided (Leffler, 2002).

Less contractual management and more cooperation

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

1. In one county council where the purchaser-provider split was introduced at the beginning of the 1990s, the goal of the relationship between purchaser and provider becoming more businesslike was replaced by the middle of the 1990s by the goal that the purchaser and provider, through dialogue and consultation, would shape the foundation of health care for the future (Berglund, 1995).
2. Another study of the same county council showed that none of the key politicians interviewed immediately linked the split with freedom of choice, multiplicity of choice, and competition (Ljungberg, 1998).
3. In a study of eight county councils, the researchers noted that purchases began formally, with bidding phases, negotiations and the signing of contracts, but that these time-consuming procedures were later replaced by

clear, lucid agreements characterised by a sense of solidarity (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 behind 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 county council, it was established that a condition for the purchaser-provider split to work was that the purchaser and provider cooperated to create long-term trusting relationships (Dahlström and Ramström, 1995).

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

7. A study in one county 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 county council noted that the aim of developing buying/selling relationships had been reshaped into a quality dialogue between purchaser and provider (Landstinget Gävleborg [Gävleborg County Council], 2001).

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

Evaluation

An important task for the purchaser is to determine through evaluations if the providers really are supplying the health care ordered. Whether county councils with the purchaser-provider split have really succeeded in this evaluation is unclear because there is almost no research available.

However, there is one report that describes evaluation of health care provision operations across the entire county council sector (Socialstyrelsen [the National Board of Health and Welfare], 2000b). The report shows that in 2000, a comprehensive evaluation of health care was lacking. Five problems in the evaluation of operations were highlighted: (1) It is based on data of low quality, with cost accounting being particularly unsatisfactory. (2) The evaluations are not comprehensive. In certain activities, such as laboratories and x-rays, there is a total lack of evaluation. (3) The information requirements of only some of the interested parties, not all, are being met. There is a bias towards the managements of clinics on the providers' side. Information to patients, the general public, purchasers and authorities is not provided adequately. (4) Evaluation of operations that *is* done is sometimes deemed to be unusable. Measurements and measuring methods are questioned and deficiencies in the information's credibility has resulted in it not being accepted. (5) There is a lack of analysis, with no comments on areas such as equity and deficiencies.

This report, as mentioned earlier, concerns the entire county council sector, but similar criticism is levelled by consultants at individual purchaser county councils. The criticism is that the purchasers can hardly manage if they do not know what the results of that management are (Olofsson, 2001).

The relationship between financiers and purchasers (C)

The purchaser-provider split means that politicians have new roles. The role of financier involves distributing resources to the purchasers, who in turn negotiate health care 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.

Lack of clarity concerning the financier and the purchaser roles

As established earlier in this article, there have been problems concerning the division of roles between purchaser and provider in county councils using the purchaser-provider split. This problem was anticipated, however. More surprising was that the division of roles between politicians with different tasks was seen as equally problematic. The worries are about which tasks the purchaser and financier (the county council and the county 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 functions. 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 county 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 experienced in being public representatives and responsible for budgets while patients meanwhile have some freedom to choose their health care provider (Bergman and Dahlbäck, 1995).

This is a problem that was not only apparent in the early and mid 1990s. Later studies show similar contrasts between purchasers and financiers (Charpentier and Samuelson, 2000). The purchasers felt that financiers intervened in the process too much, for example, deciding how to compensate for production over and under agreed volumes and distributing extra resources straight to the providers (ibid). There appears to be a contradiction in combining decentralised responsibility and a market model with clear elements of centralised management.

Change in consumer patterns is not facilitated

One way of reducing costs within the health care sector is to move patients from casualty or the emergency room to primary health care. A commonly held understanding is that far too much health care is run from hospitals. The problem is that, in many county council areas, the public are accustomed to visiting the casualty or the emergency room when they are sick. One challenge for the county councils is therefore to alter the consumer pattern. There is talk within Swedish Health Care of LEON 'Lägsta Effektiva Omhändertagande Nivå' (lowest effective care level), which means that purchasers and providers should co-operate to provide patients with primary health care.

Early studies of purchasing county councils established that the purchaser-provider split did not succeed in facilitating a change in where health care was consumed (Brorström and Edlund, 1993). Later observations have confirmed this (Bergman and Dahlbäck, 1995). The purchaser's aims of expanding primary health care were made difficult by central decisions that purchasers should purchase from existing hospitals so they could reach full utilisation capacity. Orders over the long-term that would mean structural changes involving more health care being consumed in primary health care have been over-ruled by the financiers. This has been more common in county councils with local purchasers. In county councils where the purchasing function is centrally located, the purchasers have been given greater freedom to influence structural issues (Bergman and Dahlbäck, 1995).

The relationship between owner and provider (D)

So far this article has dealt with the purchasers' relationships with the public, financiers and providers. There is more and less comprehensive research concerning these relationships. However no research has 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 actively managing providers. In this case it is a question of the kind of management that is supplementary to what purchasers do in making their purchases. Consultants do not arrive at the same conclusions about how the owner 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 health care to such an extent. Another report states that owner management should be decentralised to each individual hospital, because otherwise it will be difficult to create competition (Olofsson, 2001).

Other observations made about owner management are as follows: that there are few formal contacts between owner and hospital, but informal contacts do occur at top-level management (Olofsson, 2001); that owners have neglected their task of making hospitals more cost-effective (Svalander, 2001); that politicians who sit on the county council boards (as owners) are also members of health care committees (as purchasers), which means that the politicians might put their interests associated with their role as purchaser ahead of those

associated with their role as owner (Olofsson, 2001); and that there is uncertainty surrounding which department is responsible for structural issues (Mueller, 2001; Olofsson, 2001; Svalander, 2001).

Discussion

The purchaser-provider split appears to have been introduced with high expectations in both Britain and Sweden. The rhetoric surrounding the model in both countries suggests similar expectations of the results of market-inspired organisation and control. However, the reform was initiated at different levels. In Britain, it was introduced as the result of a government initiative, while in Sweden, the decision was made by the individual county councils who use the model. While the impact of this difference is hard to assess, both countries appear to have found it difficult to make use of the market mechanism.

When the purchaser-provider split is used in Swedish health care, 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 knowledge about the effects of the purchaser-provider split. This article has discussed the problems associated with the various relationships, and a comparison with experiences in Britain shows that several of the problems found in Sweden are not unique.

Researchers are not sure how well Swedish purchasers have succeeded in establishing contact with the general public. Case studies based on the purchasers' views show that the purchasers are generally satisfied with their achievements. Meanwhile other studies, where it is not the purchaser who is being asked, show that purchasers often fail to provide information for setting priorities and making contact with the public. Britain appears to have focused less on this relationship, perhaps because the NHS does not include locally elected politicians.

According to the principles of the purchaser-provider split, the relationship between the purchaser and provider must be organised in the form of contractual management and be preceded by a competitive purchasing process. The purchaser should evaluate activities to make rational decisions in the next purchasing process. In practice, the split became something different from competition, contractual management and evaluation. In both countries, it was unusual for the contracts to be efficient instruments of control, for providers to compete with each other, and for purchasers to change their

providers. Later on and to a large extent in both Britain and Sweden, the idea of competition was replaced by ideas of co-operation and co-ordination, which require relationships based on trust. In Sweden, this happened spontaneously, while in Britain, it first happened spontaneously, at least to some extent, and was subsequently formalised under the New NHS.

It remains a problem in Sweden that the providers perceive that the purchasers have insufficient competence, do not want to set priorities and avoid discussing the content of purchases. In addition, the purchasers have concentrated too little on evaluation. This applies to the entire county council sector, but the problem is greater in county councils using the purchaser-provider split because the order process requires a sound knowledge of how the providers manage their tasks.

It is difficult to base a control model on competition when there is a lack of alternative providers. This becomes even more difficult when large sections of the health care sector are structured in a way that restricts exposure to competition (Lindkvist, 1996; Walsh et. al, 1997). It becomes more difficult still when both major and minor purchasers are reluctant to change their providers. These are observations from both counties. In Sweden, because the contracts were signed with the county council's own hospitals, it was considered to be unnecessary to sign commercial-type agreements and legally binding contracts. Instead, just like in Britain, a crossover to soft contracts and limited competition was the final course of action.

The relationship between purchasers and financiers, which is especially interesting in the Swedish case, has concerned whether the financier respects the purchasers' decentralised responsibility and how the purchasers take responsibility. The relationship between central and local instances has been, and still is, a stumbling block to the application of the purchaser-provider split. In this context, it is important to add that such problems are not just specific to county councils using the purchaser-provider split. The problem in the relationships between local and central players is evident in all public organisations. However, it can be established that the purchaser-provider split has not diminished these problems.

The relationship between owner and provider is also an area in which studies are lacking in Sweden. This is in spite of the conditions for owner management of hospitals, in particular where this concerns structural issues, cost-efficiency and range of service, having been centralised. However consultants who have written about owner management have established that weak owner management can lead to expansion, causing increased production capacity without the purchaser being given the opportunity to purchase all the health care available.

Conclusions

The aim of this present article has been to illustrate the impact of NPM by describing the consequences of the purchaser-provider split in the Swedish health care sector, and by comparing these consequences with those in the British health care sector. Despite a certain lack of studies, it can be established that there is a clear difference between the principles launched by the model and the practice that the researchers have found.

Of course it is easy to dismiss an administrative management tool if it proves not to generate 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, at least in the Swedish case, provide enough evidence to justify the abolition of the purchaser-provider split. There are three reasons for this. The first is that more, better-designed studies are needed. 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 has not achieved the set goals, 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. The third reason is that the model should not be criticised because the users choose to abandon some of its principles. On the other hand, if principles are abandoned because they are unrealistic then it constitutes serious criticism of the model.

The purchaser-provider split in Sweden is both an expression of NPM and of aims of increasing democracy. The split's elements of NPM – in the form of competition, a purchasing process, contractual management and evaluation – have not been successful. There are no indications that the purchaser-provider split has increased efficiency within health care. One explanation of why the split remains in use to a large extent in Swedish health care may be that the politicians in the purchaser county councils – despite the researchers' doubts – consider the split being a democratic improvement. The purchaser-provider split remains in use to a large extent within Swedish health care, but its elements of NPM are limited.

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