cutting through complexity

The Swedish market for Home-based care

Desktop analysis of the case for expanding Buurtzorg's operations in Sweden

Final version

2013-11-11

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Private and confidential

11th of November 2013

Buurtzorg Nederland
Att: Jos de Blok
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Dear Sir

KPMG is pleased to be engaged as your adviser in regards perform a desktop analysis of the Swedish home care market to serve as an basis for expansion strategy for Buurtzorg's home care concept via the newly established organization Grannvård.

This report has been based on a limited scope and contains high level limited analysis based solely on documents available in the public domain without full disclosure or access to information. The mere part of information sources used have been available in Swedish only. No official translation into English has been made, but translation is solely performed by KPMG professionals.

The scope of work set out in our Engagement Letter is attached as Appendix 1 to the report. This details the agreed scope of our enquiries, directed at those issues which you determined to be critical to your investment. You should note that our findings do not constitute recommendations to you as to whether or not you should proceed with the proposed transaction. The Important Notice on this page should be read in conjunction with this letter.

Anders Röstin

Partner
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Glossary of terms

GP	General practitioner
DN	District nurse
LOU	Public Procurement Act
LOV	Act on System of Choice in the Public Sector
HCC	Health Care Centre
BHV	Child Health Services
MHV	Reproductive Health Services

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Executive summary

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Executive summary

Our understanding of Buurtzorg and their objectives for entering the Swedish market	■ Historically, home-help and home-care have been delivered separately both in Sweden and in the Netherlands, resulting in poor patient focus ■ Buurtzorg has introduced reverse task shifting which have empowered nurses, reduced hours of care, improved quality and raised work satisfaction ■ In 2011, a Swedish subsidiary called Grannvård was established in Bålsta, north of Stockholm, with the purpose applying the business model throughout Sweden ■ Buurtzorg's professionals strive to make the patient self-sufficient, rather than maximizing the number of tasks preformed ■ Buurtzorg's teams, of maximally twelve nurses per team are independent and self-steering, supported by a centralized service organization* ■ Patient satisfaction scores are 30 percent above the national average ■ Buurtzorg's high productivity level could potentially free up almost 7 000 full time employees nationwide (in the Netherlands)
The structure and market for Home-based care in Sweden	■ Both County Councils and Municipalities has responsibilities for home based care and with large degrees of freedom for municipalities regarding how to procure and compensate for the services results in fragmented market ■ The current market do not favour integrated solutions, but there is a trend moving towards a structure that will make it possible to offer a truly integrated solution including Health Care Centres, Home Care and Home Help ■ Already, there are a number of markets, municipalities, with a structure in place making it possible to offer a truly integrated solution with for all three required services
The Business Case for Buurtzorg/Grannvård in Sweden	Several factors are indicating a strong growth and a strong case for increased demand for home based care in Sweden, among them: ■ Lack of patient beds are increasing the need for home based care ■ Lack of funding results in more usage of cost efficient care, e.g. home based care ■ Increased will to stay at home for elderly ■ Increased demand for integrated solution from both care takers and their relatives – the care takers wishes for one counterparty, not one for each services delivered. ■ By including Health Care Centres in its offering in a number of carefully selected markets, Buurtzorg can offer a truly integrated solution and can participate in driving the market for integrated home based care solutions.

** Figures based on actual numbers 2011*

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Our understanding of Buurtzorg and their objectives for entering the Swedish market

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Historically, home-help and home-care have been delivered separately both in Sweden and in the Netherlands, resulting in poor patient focus

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In 2011, a Swedish subsidiary called Grannvård was established in Bålsta, north of Stockholm with the purpose applying the business model throughout Sweden

Sweden has a history of home-help and home-care being delivered and financed in a fragmented way resulting in a uncoordinated sub par delivery of the services elderly and sick people need in order to be able to continue living at home. more often than not, the needed services are executed by different professionals and as a result, patient care tends to lack coordination, making it difficult for the care providers to respond appropriately to changing patient conditions, which in turn leads to compromised continuity of care and low patient satisfaction.

Initial steps has been taken to address the problems, among them has several municipalities to varying degrees taken over the county councils role for providing home-care.

The Netherlands has the same fragmented market for delivery of home based services and in response to these challenges, the home-care organisation Buurtzorg (meaning neighborhood care) was created to focus on patient value by putting professionals in the lead through reverse task shifting. Essentially, the program empowers nurses (rather than nursing assistants or cleaners) to deliver all the care that patients need.

And while this has meant higher costs per hour, the result has been fewer hours in total. Indeed, by changing the model of care, Buurtzorg has accomplished a 50 percent reduction in hours of care, improved quality of care and raised work satisfaction for their employees..

Since 2011, under the Freedom of choice model in the municipality of Bålsta (just north of Stockholm in Uppsala County), a spin off from Buurtzorg called Grannvård, has established its operation s focusing on providing integrated home-help and home-care.

Buurtzorg is now looking into the possibilities to expand the operations in Sweden and doing so by also including primary care center services in its offering, in order to provide a more complete delivery of services tailored to elderly population.

On behalf of Buurtzorg in the Netherlands this report should focus on the possibilities and strategies for doing so by:

- **Describing the different models for procuring (tender processes, free choice models) contracting and paying (compensations models) for home care, home health care and primary care centers in Sweden.**
- **Describe consequences of the different combinations of the alternative models (for procurement contracting and payments) for the home care market, home health care market as well as for the market for primary care centers .**
- **Describe pros and cons of different combinations (procurement, contracting and payment) for the establishment of Grannvårds operations regarding risk, investments cost potential etc to serve as a basis for identifying preferred conditions for establishing Grannvård.**
- **Analysis of how to include a primary care centers offerings/operations in the Grannvård operation, either by starting own primary care center as part of establishing Grannvårds operation or by buying or cooperating with established primary care centers where Grannvård would like to establish its operation.**

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Our understanding of Buurtzorg and their objectives for entering the Swedish market

Buurtzorg's professionals strive to make the patient self-sufficient, rather than maximising the number of tasks preformed

Buurtzorg's teams are independent and self-steering, supported by a centralised service organisation

Patient satisfaction scores are 30 percent above the national average

Buurtzorg's high productivity level could potentially free up almost 7,000 full time employees nationwide

One of the keys to the program's success is that Buurtzorg's home care nurses organize their work themselves. Moreover, rather than executing fixed tasks and leaving, they use their professional expertise to solve the patient's problem by making the most of their clients' existing capabilities, resources and environment to help the patient become more self-sufficient. Simply put, Buurtzorg professionals' aim is to make themselves superfluous as soon as possible, versus other providers who tend to execute the subtasks without truly focusing on the patient's overall situation.

Buurtzorg uses small self-steering teams (with a maximum of 12 nurses) who attend to an area of approximately 15,000 inhabitants and work together to ensure continuity of care. As a result, the professionals build durable relationships with their community, which further strengthens their ability to find local solutions for patients' problems. Although the teams are independent and self-steering, they are supported by a centralised service organisation which provides management information to both the team and the organizations' leadership in order to minimize local overhead and maximize the professional's face-to-face time with patients.

By 2013 Buurtzorg employed approximately 7 000 nurses and nurse assistants working in over about 600 autonomous teams. Preliminary results show that Buurtzorg's patients consume just 40 percent of the care that they are entitled to and half of the patients receive care for less than three months. As a result, patient satisfaction scores are 30 percent above the national average and the number of costly episodes requiring unplanned interventions has dropped. The company's financial revenue has also dramatically increased over the years since the establishment of the operation.

The Buurtzorg approach to healthcare delivery has also led to higher workforce productivity and reduced rates of absence through illness. Indeed, the total Buurtzorg organisation requires overhead of just eight percent, compared to more than 12 percent within the regular home care services sector in the Netherlands. In 2010, the company achieved a 58 percent time actually spent with patients, versus a national average of only 51 percent. Given that 45 million hours of home care were provided in the Netherlands in 2010, the higher productivity level represented by Buurtzorg could potentially free up almost 7 000 full time employees nationwide.

In order to repeat its success from the Netherlands in Sweden, Buurtzorg should focus its initial expansion in areas with the highest possibilities to repeat its success. The purpose of this report is to identify critical success factors and areas where the success factors are present.

The hypothesis is that by including health care centres (HCCs) in its offering the likelihood for success will increase since that will be a requirement for offering a complete and integrated care delivery model.

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The structure and market for Home-based care in Sweden

Chapter summary

	Home help ("Hemtjänst")	Home Care ("Hemsjukvård")	Health Care Centres ("Vårdcentral")
	Service tasks including cleaning and laundry, help with shopping, post office and bank errands and preparation of meals with the extent subject to an assessment of need.	All health care interventions in the individual's home, i.e.. both in ordinary and special accommodation. It may include help with medicine, wounds, pain management, rehabilitation, injections, and extra nutrition in the form of drip or probe.	General practitioners and district nurses with responsibility for both preventive and medical/nursing care for all age groups.
Range of services	■ On assessment of need basis	■ Performed by licensed staff or ■ Performed by home-help staff with delegation	■ All primary care services or ■ Primary care services except reproductive health services and/or child health services
Contracting authority	■ Always municipalities	■ A transfer of responsibility from county councils to municipalities is underway	■ Always county councils
Procurement scheme	■ Competitive tendering (LOU) or ■ Free choice system (LOV)	■ Competitive tendering (LOU) or ■ Free choice system (LOV)	■ Competitive tendering (LOU) – No new contracts but old contracts still in force or ■ Free choice system (LOV)
Payment mechanism	■ Rendered hours* or ■ Granted hours*	■ Rendered hours* or ■ Granted hours*	■ A blend of Capitation and Fee-for service

* = Hourly rate set individually in each municipality)

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The market for Home-based care in Sweden

Home-based care have been developed for a long time as a result of an increase in both costs and demand

A strong political agenda have facilitated private offerings and consumer freedom, in some cases with negative effects

Roughly 20% of the Swedish population are over 65. Around 5% are over 80.

The elderly are generally in good health, partly as a result of home-based care

Historical development

In Sweden, home-based care (home-help and home-care) has a long tradition and was developed many years ago with the support of the authorities to replace institutional care. In 1988, advanced home-care was considered the most rapidly growing medical technology in health care. The two main causes were the need to reduce costs in the public sector at the end of the 1980s and greater demand for this type of care. The cost containment trend was due mainly to the higher proportion of people over 80 years in the Swedish population. Publicly financed and publicly provided services have been both affordable for the poor and attractive enough to be preferred by the middle class.

The trend towards mercerization has been more clearly intended by national policy-makers. Legislative changes have opened up tax-funded services to private provision, and a customer-choice model (LOV) and a tax deduction for household- and care services have been introduced. As a result of declining tax-funded home-care services, older persons with lower education increasingly receive family care, while those with higher education are more likely to buy private services. The number of private companies in the social-service sector increased fivefold between 1995 and 2005. Recent media investigations have unearthed alarming shortfalls among several private care companies. In subsequent criticism, the companies were accused of letting profit have a negative impact on the standard of care.

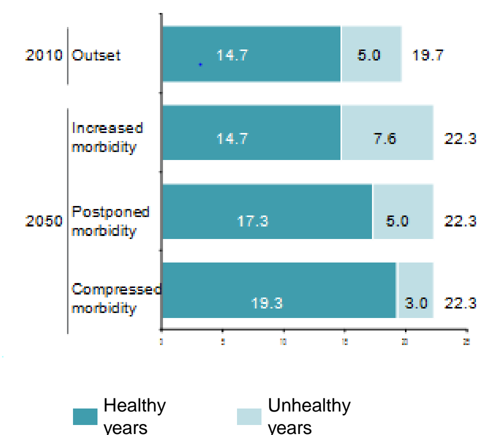
Demography

Health and social care for the elderly constitutes an important part of Swedish welfare policy. Of Sweden's 9.6 million inhabitants, 20 % are pensioners (65 and above). This number is projected to rise to 23 % by 2025, partly because of a baby boom in the 1940s. Since more and more citizens in this age group are in good health, their care requirements have declined since the 1980s. Most elderly care is funded by municipal taxes and government grants. Healthcare costs paid by the elderly themselves are subsidised.

Life expectancy in Sweden continues to rise. In 2010, it was 79,1 years for men and 83.2 years for women. More than 5 % of the Swedish population are aged 80 or over, which is a large proportion compared to rest of the EU member states. This can be partly attributed to falling mortality risks for both heart attacks and strokes. However, the number of children born in Sweden has been increasing steadily since the end of the 1990s, a shift that will reduce the relative proportion of elderly residents. Many elderly in Sweden are in good health and lead active lives. Most live in their own homes by choice, and can do so thanks to public support in the form of home meal delivery, help with cleaning and shopping, transportation and healthcare when needed. Should their health deteriorate with age, there is special housing with around-the-clock care.

The Senior Market in Sweden		
Total Population: 9 616 429 (August 2013)		
	Number of Seniors 65+	Percentage of population
2012	1,834,000	20.27%
2025	2,158,000	23.16%
2050	2,337,000	25.72%
GDP Per Capita: $41,700 (2012 est.) Number of existing franchise outlets: 18,000		

Lifespan after 65 years of age in 2010 and 2050



Source: KPMG Sweden, Swedish Institute, Health & Social Care in the Community (2012), Home Instead Senior Care, Perroca MG, Ek A-C. Swedish advanced home care: organizational structure and implications of adopting this care model in Brazilian health care system (2004)

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Legal and institutional framework

The state, through the Ministry of Health and Social Affairs, is responsible for overall health care policy. There are eight government agencies directly involved in the area of health care and public health (see Appendix 1). The responsibility for performing cross-sectoral follow-up and evaluation of the national public health policy lies with the National Institute of Public Health (Folkhälsoinstitutet).

The Health and Medical Services Act of 1982 specifies that the responsibility for ensuring that everyone living in Sweden has access to good health care lies with the county councils/regions and municipalities. The Act is designed to give county councils and municipalities considerable freedom with regard to the organization of their health services.

Sweden is divided into 290 municipalities, 16 county councils and 4 regions (Gotland, Halland, Skåne and Västra Götaland). Regions are based on county councils or municipalities that have assumed responsibility for regional development from the state. Counties are grouped into 6 medical care regions to facilitate cooperation regarding tertiary medical care

Each county council/region covers a geographical area where several municipalities are situated. The number of municipalities in each county council varies between 5 and 49. The number of inhabitants in the county council areas varies between 128 000 and 2 100 000. Traditionally, Swedish county councils have been responsible for health and medical services, while social services have been the responsibility of municipalities at the local level.There is no hierarchical relation between municipalities, county councils and regions. Around 90 % of the work of Swedish county councils concerns health care, but they also deal with other areas such as culture and infrastructure.

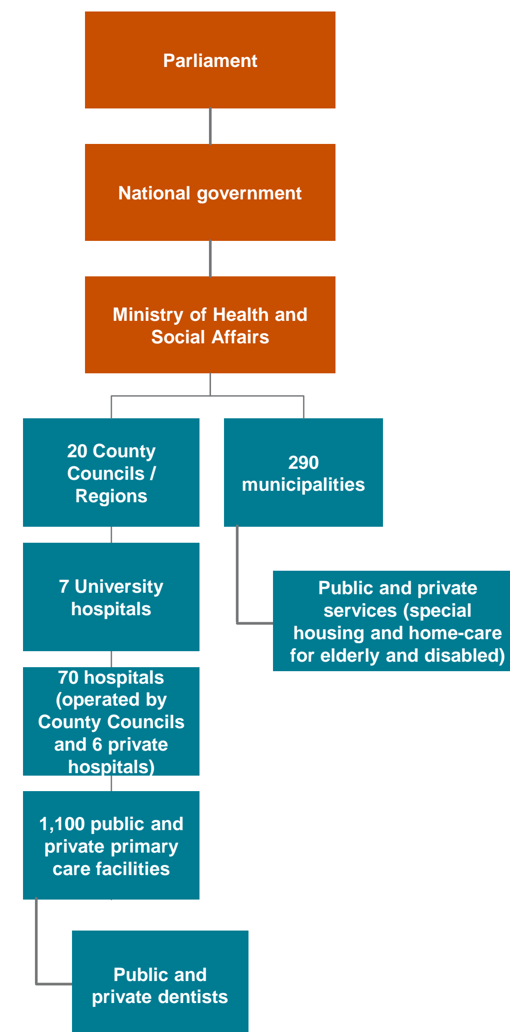
Local self-government has a very long tradition in Sweden. The regional and local authorities are represented by the SALAR. Decentralization of responsibilities within the Swedish health care system refers not only to relations between central and local government, but also to decentralization within each county council. During the latter part of the 1990s and the 2000s there have been efforts towards strengthening national influence again, partly driven by the need to better coordinate care and to reduce regional differences. Today the roles are divided between municipalities, county councils as follows:

County councils are responsible for:

- Hospitals (acute care)
- Primary care in Health Care Centers (general practitioners)
- Primary home-care in ordinary housing (in 50 percent of the counties)
- All doctors

Municipalities are responsible for:

- Care of older people as well as support and service to those whose medical treatment has been completed and who have been discharged from hospital care.
- Housing, employment and support of people with psychiatric disabilities.
- Care in special housing (nursing homes)
- Primary home-care in ordinary housing (in 50 percent of the counties)
- Support from personnel in social care



Source: KPMG Sweden, WHO: Sweden: Health system review. Health Systems in Transition, (2012), EU Commission: The Interlinks Project

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Health Care Centres, Home Help and Home Care

Primary care

Health Care Centres ("Vårdcentral")

- Primary health care is largely organised in HCC ("Vårdcentral") or family doctor's surgery ("Husläkarmottagning"), which is merely an alternative name primarily used in the Stockholm region.
- In the majority of counties, child health services are included in HCC:s obligation, in Stockholm, Uppsala and Skåne it is organised in a separate choice of care. Reproductive health services is the HCC:s obligation in 8 out of 20 counties.
- The HCCs treat adults and children for non-urgent or life-threatening illnesses and complaints, e.g. sore throats, a high temperature in children, urinary infections, allergies, dizziness, backache and chronic illnesses such as diabetes.
- Both general practitioners and district nurses have responsibility for both preventive and medical/nursing care for all age groups.
- Ownership of private HCCs can broadly be categorised as follows:
  - Large corporate owners (Attendo, Aleris, Capio etc) often private equity-owned
  - Local franchises of 2-10 units
  - Staff-owned
- If the general practitioner ("husläkaren") at the HCC conclude that the patient need specialist care ("specialistvård"), they will be referred to a specialist clinic ("specialistmottagning").

Home-based care

Home Care ("Hemvård/Hemsjukvård")

- Home-care refers to all health care interventions in the individual's home, i.e.. both in ordinary and special accommodation. It may include help with medicine, wounds, pain management, rehabilitation, injections, and extra nutrition in the form of drip or probe.
- Home-care is performed by licensed staff, not doctors, and other staff with delegation; nurses, DNs, occupational therapists and physiotherapists. More than 30 percent of home care patients have tasks performed using delegation of other staff, mostly home-help-staff. It is mainly help with medicine that is delegated.
- There is no universal definition of "home-care" due to the fact that it implies different activities depending on what county or municipality that is studied.
  - Home-care implying medical care in the home is often combined with home-help.
  - The purely medical services performed may be more or less advanced.
  - Even in the governing documents there is a significant ambiguity, which becomes evident when municipalisation is mentioned although municipalities already have a responsibility for comparable services.
- In Stockholm County, there is the Hospital-Based home-care program ("Avancerad sjukvård i hemmet", ASiH), that offers patients in need of specialized medical care and technical nursing procedures who wish to remain at home, the possibility to receive palliative and acute care and rehabilitation from a multidisciplinary working team., including doctors
  - Caretakers can receive 24-hour support for home visits (planned or in emergency situations) and advice within 30 minutes after a phone call. For the patient in need of more extensive medical treatment there is the possibility of using hospital facilities at any time.

Home Help ("Hemtjänst")

- When an elderly person is no longer able to cope with the demands of everyday life, he or she can apply for assistance from municipally funded home-help services.
- Service tasks include cleaning and laundry, help with shopping, post office and bank errands and preparation of meals. Personal care also includes assistance with eating and drinking, getting dressed, personal hygiene and moving around.
- The extent of home-help is subject to an assessment of need. It is the assistance officer in the municipality that assesses what services a caretaker is eligible for.
- Elderly people with disabilities can receive assistance around the clock, which means that many are able to remain at home throughout their lives. The severely ill can also be provided with health and social care in their own homes.
- In October 2012, home-help staff assisted 250 500 individuals aged 65 or over of which to 163 600 in ordinary housing.
- Each municipality decides its own rates for home-help. The cost depends on such factors as the level or type of help provided and the person's income. A maximum charge for home-help, daytime activities and certain other kinds of care has been set since January 1, 2011, at SEK 1,760 per month.
- Private operators often offer additional services. For example, if a caretaker does not get cleaning granted, it can be purchased as a household service under favourable tax deduction rules for household- and care services. There are also suppliers with different specialties, such as the linguistic, religious or cultural competence.

Source: KPMG Sweden, WHO: Sweden: Health system review. Health Systems in Transition, (2012), The Health Care Guide ("Vårdguiden"), BMC Family Practice (2007), Perroca MG, Ek A-C. Swedish advanced home-care: organizational structure and implications of adopting this care model in Brazilian health care system (2004), The National Board of Health and Welfare

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Contract models in the Public Sector Health Care market

Procured activities

LOU – Competitive tendering

Procurement under the Public Procurement Act ("LOU")

A number of providers compete for time-limited contracts, often 3-year agreements, for running a special-housing unit or for providing home-help services in a specific area by sending in tenders. The tender that, according to municipal criteria, offers the agreed services to the lowest cost is awarded the contract. The incentive of this tender procedure has primarily been to lower costs.

Presently, slightly more than 10% of the consumers of elderly care in Sweden receive help from a private provider procured under LOU. However, this form of elderly care procurement is showing signs of stagnation, mainly due to risks of impairing the quality of care as a result of cost cuts.

LOV – Free choice system

Procurement under the Act on System of Choice in the Public Sector ("LOV")

The system implies that caretakers may (within reasonable geographical boundaries) choose between private suppliers with whom the contracting authority (county councils or municipalities) has concluded a contract in the system of choice, or service providers within the contracting authority´s own organisation.

Organisations/companies to register as primary care providers, given some basic criteria – requirements on competencies, range of services, financial conditions. The level of payment given to the suppliers is set by the contracting authority and stated in the contract documents, and is depending on the amount of users choosing the supplier as their service provider (a capitation formula - basic + specific visit payments) . Some County Councils have more elaborate models that pick up quality measures, linking to population goals, access and low number of hospital ambulatory visits

Public and private home-care and home-help providers render the same fees to the end-user. All home-care providers receive compensation pre-determined by the county council/municipality. This means the providers cannot compete to have the lowest price.

Observed developments

- One explanation for the comparatively strong position of for-profit actors in Swedish eldercare is that until recently, the outsourcing to private providers took place after a process of competitive tendering (LOU).
- Especially during the recession of the 1990s, the competition was about price rather than quality .
- The traditional LOU procurements has favoured larger companies as they have greater capacity to meet the paperwork related to the bidding procedure than small companies or not-for profit organisations, and they can also submit an underbid if needed to enter the market. As a result, the private sector is highly concentrated: only two corporations make up half of the private elderly care market.
- Encouraged by the introduction in 2009 of the Act on Free Choice Systems (LOV) implemented by the centre-right government that has been in power since 2006, this kind of competitive tendering has become less common.
- LOV, in contrast to LOU, does not generate price competition
- Even in municipalities that have adopted LOV, there are certain kinds of home-care that is procured using LOU (e.g. home-care during evenings and nights in Stockholm)

Source: Bengtsson (red.): Population ageing – a threat to the welfare state?: the case of Sweden (2010), The Swedish Competition Authority, Nuffield Trust European Health Summit (2013)

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Payment mechanisms – Health Care Centres

There are two principal models for compensating primary care providers in Sweden, both containing one fixed and one variable part

One model is used in Stockholm and the other in the rest of the country

Health Care Centers

Generally, there are two principal models for compensating primary care providers in Sweden. Both are based on a blend of per registered patient payments (capitation), fee-for-service, and performance-based payment, and apply equally to public and private providers within a county council.

Stockholm county council bases approximately 40% of primary care compensation on capitation with more than 55% based on visits by both registered and non-registered patients. Another 3% of the payment is performance based for meeting targets (such as patient satisfaction rates, compliance with governmental treatment recommendations, etc.).

In other county councils, payment is predominated by capitation funding (80-98%) with the remainder consisting of payments for visits primarily for non-registered patients and a small performance-based payment for meeting targets.

Payment mechanism in Stockholm county council

- Fixed payment – capitation, fixed prospective payment (~40%)
- Variable payment based on visits (~55-57%)
- Performance-based payment based on fulfilment of specific goals (~3%)

A slight variation of payment mechanism in all other county councils

- Fixed payment – capitation, fixed prospective payment (80-90%)
- Variable payment based on visits (5-10%)
- Performance-based payment based on fulfilment of specific goals (2-3%)

More than half of the county councils are using age to adjust compensation per listed person. Eight county adjusts the fixed compensation based on the caretaker's possible diagnoses (according to ACG, Adjusted Clinical Groups). Five of these eight also takes into account the age when setting the fixed compensation.

A majority, 16 county councils, change the fixed compensation based on socio-economic conditions (usually with the help of CNI, Care Need Index). In Östergötland County compensation is adjusted with the average income in the area where the listed person lives. In Sörmland County primary care in disadvantaged socio-economic areas, receive extra compensation.

A research project performed by the University of Uppsala recently investigated the mechanisms behind privatization as well as the resulting effects on care quality:

- In the elderly care sector the share of private providers has increased from 1% in 1990 to 14 % in 2008
- The number of employees per resident is significantly smaller (-10%) among private regimes.
- In favor of private contractors are:
  - participation (+7%)
  - share of elderly with a reasonable length of nightly fast (+15%)
  - number of food alternatives (+26%)
- The conclusion is that private care providers emphasize service aspects rather than structural prerequisites for good care.

Source: KPMG Sweden, WHO: Sweden: Health system review. Health Systems in Transition, (2012), Uppsala University: Department of Public Health and Caring Sciences (IFV)

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Payment mechanisms – Home Help and Home Care

For both home-help and home-care, most municipalities recompense for either granted or rendered hours

There are a number of differentiations of the compensation that differs from one municipality to the other

Home Help

- The caretaker's right to home-help is granted in accordance with the Social Services Act
- The majority of municipalities have chosen to recompense for either:
  - Granted home-help hours
  - Rendered home-help hours
    Electronically measuring the time or by the supplier reporting the time
- Some municipalities recompense in unit prices for specific services
- Compensation is often differentiated between service activities (cleaning , shopping, laundry) and nursing care
- Compensation is also differentiated by the amount of the municipality's own home-care (proprietary) and alternative (private) providers
- Some municipalities differentiate compensation, depending on where the patient lives (in urban or rural areas)
- The caretaker's fee is calculated individually based on income, rent and a so-called reserve amount. There is a statutory maximum fee for what the municipality may levy from the caretaker.

Since compensation to providers is often based either on an hourly rate or a cost per item of assistance, it is argued that performance-based remuneration systems may lead to higher costs. Depending on how decisions to grant assistance are formulated, there may be opportunity for providers and users to specify the content of assistance in greater detail. There may also be room for providers and users to influence the extent of the assistance. Performance-based remuneration creates an incentive for providers to maximise the number of hours they spend on providing assistance. Services that are not included in the grant decision can often be ordered directly from the provider. Caretakers pay only half the cost of labor, the rest is collected as direct tax deductions.

Home Care

- Home-care services are compensated for rendered hours or a fixed pre-determined compensation.
- Home-care operations are normally recompensed for either delegated tasks or for the entire nursing assignment. The latter includes nurses and paramedical staff in the system of choice. Delegated tasks refers to what district nurses and others delegate to auxiliary nurses to perform.
- Some municipalities have chosen to differentiate compensation based on when in time the service is executed, often on a inconvenient working hours reimbursement basis with a breakdown in day, evening and weekend compensation. Sometimes there are also night compensation and major holiday compensation

A survey performed by The Swedish Agency for Public Management indicates that there is a large differential in the remuneration rates for home-help services.

- There are 2 varieties of remuneration models and charging structures.
- 2/3 of the 92 municipalities in the survey compensate providers for the time they spend on each user
- 1/4 of municipalities compensate for the time granted to each user.
- Just over half of the local authorities distinguish between remuneration rates for urban and rural areas.
- Nearly half of the municipalities pay a higher rate for care than for other services
- 1/4 of the municipalities have chosen to pay the same rate for all categories of assistance.
- The rate paid for care services in urban areas averages at SEK 338 per hour
- The rate for non-care services averages at SEK 303 per hour.
  These amounts apply to external providers, while the average level of compensation paid to in-house providers is somewhat lower.
- The rates for services performed in rural areas are generally higher than in urban areas.
- Remuneration rates differ greatly between municipalities. This applies, for instance, to rates for care services performed by external providers, which range from SEK 253 per hour to SEK 437 per hour.

Source: KPMG Sweden, The Swedish Agency for Public Management

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Current structure – basis for Business Case

County Councils / Regions

20 county councils and 4 regions

- Hospitals (acute care)
- Primary care in Health Care Centres (general practitioners)
- Primary home-care in ordinary housing (in 50 percent of the counties)

Municipalities

290 municipalities

- Care of elderly and service to those whose medical treatment has been completed and who have been discharged from hospital care.
- Housing, employment and support of people with psychiatric disabilities.
- Care in special housing (nursing homes)
- Primary home-care in ordinary housing (in 50 percent of the counties)
- Support from personnel in social care

Health Care Centres

Over 1 100 units named ”Vårdcentral” or ”Husläkarmottagning”

- General practitioners and district nurses with responsibility for both preventive and medical/nursing care for all age groups.
- There is mix of publicly and privately owned HCC but they are publicly funded. 1/3 of the HCC are privately owned.

Home Help

Provided to 250 500 individuals (163 600 in ordinary housing) aged 65 or over

- Service tasks including cleaning and laundry, help with shopping, post office and bank errands and preparation of meals with the extent subject to an assessment of need.
- Almost 20% of home-help services are provided by private suppliers.

Home Care

- All health care interventions in the individual's home, ie. both in ordinary and special accommodation. It may include help with medicine, wounds, pain management, rehabilitation, injections, and extra nutrition in the form of drip or probe.
- Home-care is performed by licensed staff, not doctors, and home-help staff with delegation; nurses, district nurses, occupational therapists and physiotherapists.

LOV – Free choice system

- The system implies that caretakers may choose between different public and private suppliers.
- All providers receive compensation pre-determined by the county council/ municipality.

LOU – Competitive tendering

- A number of providers compete for time-limited contracts, for running a special-housing unit or for providing home-help services by sending in tenders.
- Since the introduction of LOV in 2009, competitive tendering has become less common.

Capitation

- Compensation based on the number of listed caretakers at the Health Care Centre

Fee-for service / Performance based

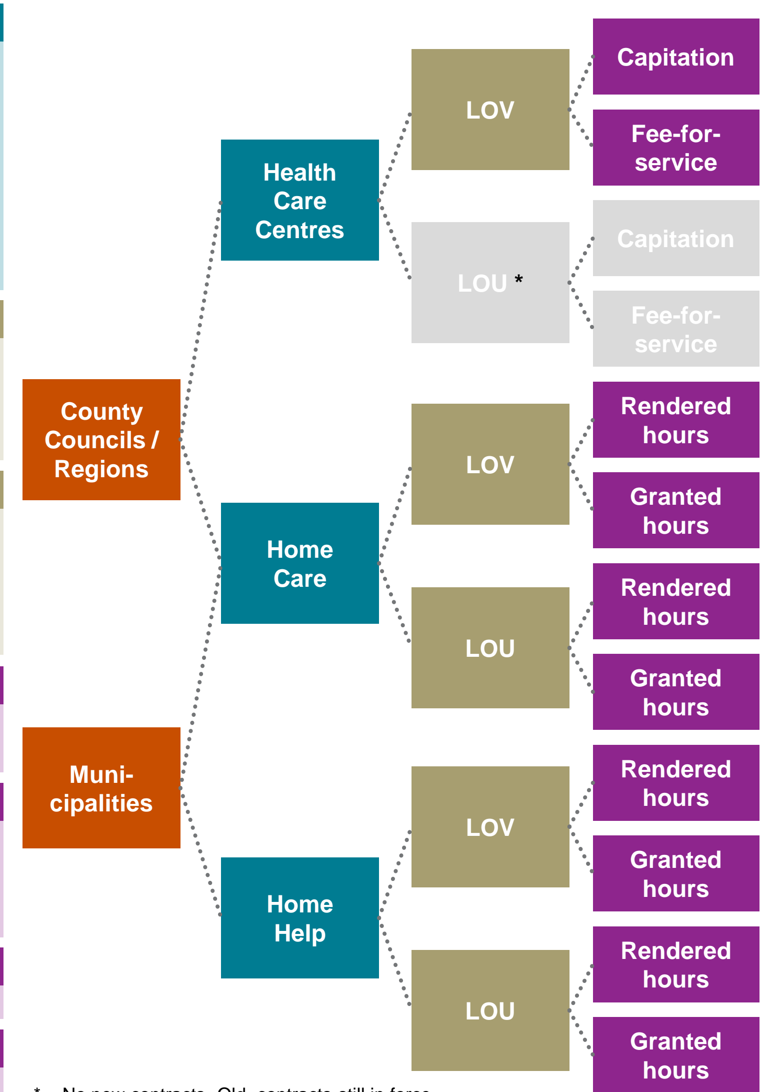
- Compensation based on Health Care Centre visits as well as performance based for meeting targets (patient satisfaction rates, compliance with governmental recommendations)

Home Help / Home Care rendered hours

- Variable compensation

Home Help / Home Care granted hours

- Fixed compensation



* = No new contracts. Old contracts still in force

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The Business Case for Buurtzorg/ Grannvård in Sweden

Summary of market characteristics

Key market drivers	
Key market drivers	▪ The increased budget pressure for the Health Care providers will drive treatment from hospitals to treatment in homes (this is clearly stated e.g. by Stockholm County Council who foresees a significant increase in home-care in the near future) ▪ Lack of patient beds will increase the need for home-care solution ▪ An ageing population will increase the costumer base and need for home-care services throughout Sweden ▪ Even though there are different opinions on how the health care and home-care market should be organised and financed, there is a general strong will to have integrated solutions for home-help and home-care
Current market situation	▪ The current market for health care centres, home-help and home-care is mature and stabile ▪ The market for home-help and home-care are served by both small and large local and national organisations offering both home-help and home-care or a combination of the two ▪ The market for health care centres is served by both small and large local and national organisations ▪ The competitors in the market can easily give the impression that they too are offering an integrated solution

By expanding Buurtzorg's original concept, with a strong operating model, with health care centres, there is a significant opportunity to create a complete integrated offer to actively participate in driving the market development

However, the growth must start in areas with the right structural prerequisites

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Preferred structure for Buurtzorg's operations

County Councils vs. Municipalities

- Both parties will act as contracting authorities in a completely integrated solution
- If possible, areas where the municipalities have the responsibility should be prioritised over areas where the councils are still responsible. This is especially true in areas where Buurtzorg has yet to incorporate primary care
- Stockholm County is an exception since home-care is incorporated in the responsibility of the county council

Health Care Centres, home-help and home-care

- Home-help and home care should always be included in the offer
- The objective should be to include HCCs in the offering where and whenever it is possible to do so
- HCCs should be incorporated from the beginning in Stockholm County due to the organisation of home-care primarily being delivered through the HCCs.
- Given Buurtzorg's current operating model, HCC:s in areas without an obligation to perform child health services and reproductive health services should be prioritised.

LOV vs. LOU

LOV is the preferred procurement scheme, offering the following distinctive advantages:

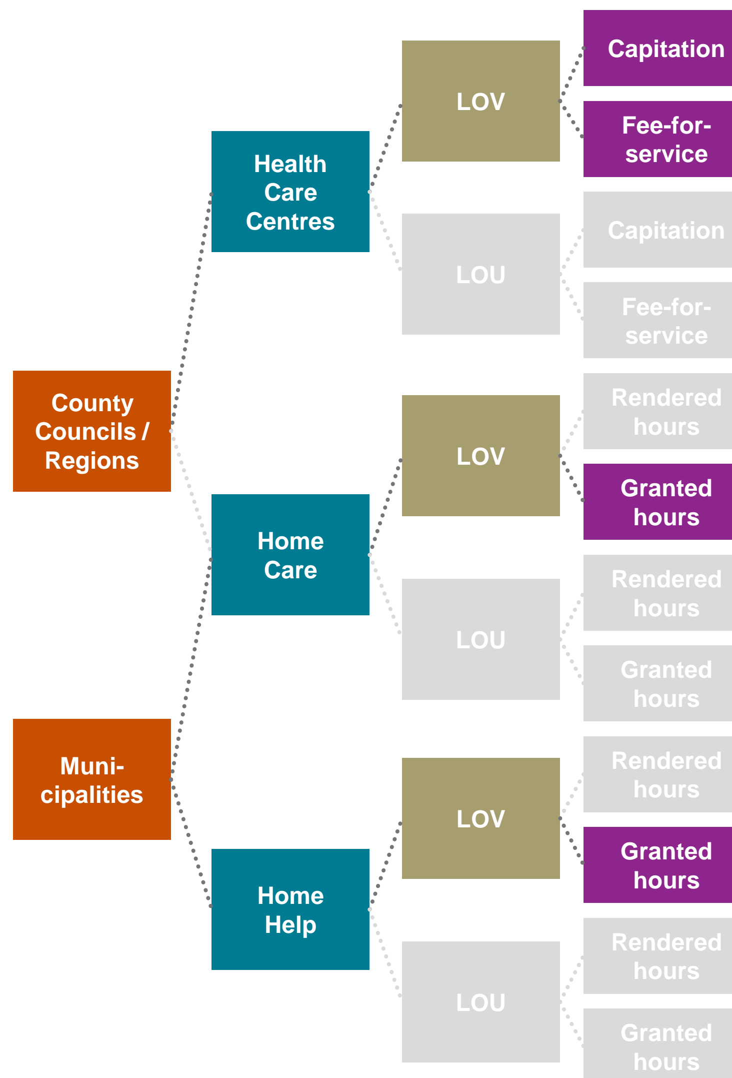
- Long-term solution if persistent customer base
- Scalable in accordance to a changing customer base
- Synergies and investments can be harvested over a long period of time

LOU offers a less than advantageous market for Buurtzorg:

- Most likely a closed market for Buurtzorg due to lack of previous experience in Sweden and competitive disadvantage compared to major established player
- Competitive tendering under LOU is not common in targeted areas

Fixed vs. variable compensation

- Whenever possible, fixed compensation should be favoured over variable due to Buurtzorg's integrated offer aiming to capitalise on realised synergies



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Focus areas for Buurtzorg/Grannvård

Focus area	Rationale
Provide a complete offer (HCCs, home-help and home-care) from day one	■ In order to establish the most favourable operating model early ■ As a new actor for the majority of potential customers, it would be advantageous for profiling purposes ■ Although the business case is still viable without the HCC:s, it would be significantly stronger by including the HCCs
Focus on areas with municipality controlled home-care	■ In areas where Buurtzorg is not aiming to, or has yet to, include health care centers, municipality controlled home-care results in only having one counterpart. ■ Since there is a trend towards municipality controlled home-care, there should be an advantage to focus on areas where the shift has already been made.
Focus initially on areas that adopted LOV in all offered services areas	■ LOV enables stable and long term operations and enables expansion of operations in a controlled pace (procured operations would require significant recruitment from one day to another and put unnecessary stress on the operations) ■ A way of avoiding significant costs for competitive tendering under LOU ■ At present, Grannvård lack of benefits of scale compared to established competitors who will have a competitive advantage through synergies with established nearby markets, which would be a disadvantage in competitive tendering
Focus on areas with attractive compensation models	■ Whenever possible, fixed compensation should be favoured over variable due to Buurtzorg's integrated offer aiming to capitalise on realised synergies ■ Preferred compensation models should enable capitalisation on realised synergies in offering an integrated operating model
Focus on areas where the HCCs obligation does not include child health, and reproductive health	■ In accordance with Burtzorg's current operating model, the service offering at HCCs should focus on the elderly in order to maximise synergies with the home-help and home-care service offering
Focus on establishing operation in metropolitan areas	■ Large customer base ■ Simplified logistics ■ Increased access to staff ■ Easier to hire staff from established providers in order to handle rapid fluctuations in demand in the initial stages of establishment
Acquire established HCCs	■ The transaction activity and pricing of HCCs in attractive areas indicates a saturated market and raises the case for existing HCC with an established customer base unless local opportunities due to unmet needs arise.

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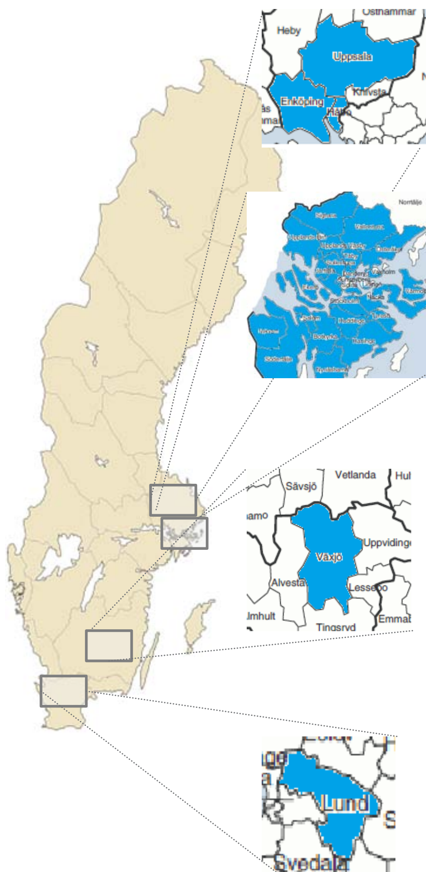
Recommended areas for establishing Buurtzorg/Grannvård

Identified areas that fulfils optimal requirements for new operations

Our analysis of contracting authorities, procurement schemes and payment mechanisms followed by a mapping of which municipalities (enclosed in Appendix) that fulfils the desired requirements leads us to recommend two regions and two medium-size municipalities for Buurtzorgs further expansion.



Expansion around existing operations (Bro, Enköping, and Uppsala)

Continue focusing on expanding Grannvårds operation in present geography and expand operations to neighborhood municipalities, such as Västerås and Uppsala.

Complement current offer with health Care Centres in Enköping Uppsala since the compensation model for home care includes coverage for nurses, thus making it possible to create fully integrated solutions. Enköping and Uppsala has a compensation model that pays for delivered hours as long as it is equal to or below that granted number of hours. The compensation level per hour is above that national average for both services and for care. In Bro, Enköping and Uppsala (Uppsala County), child health services (BHV) and reproductive health services (MHV) is organized in a separate choice of care (i.e. separate from the HCC).

Stockholm Region

The rational for starting operation in Stockholm has less to do with favorable conditions and more do to with the stated fact from the County Council that home care is one of the major solutions to handle the lack of capacity in the existing hospitals.

In Stockholm the home care is delivered via the HCCs (during day time) and is part of LOV. During odd hours the home care is delivered by private operators delivering care in exclusivity in defined areas via LOU. Entering the Stockholm market requires controlling a health care centre that could preferably be acquired. In Stockholm County, BHV and MHV is organised in a separate choice of care

Växjö

With a population of approximately 85 000 inhabitants in the municipality and + 60 000 in the City offers a large client base in a limited geographically area favorable conditions, Växjö is a natural area for establishing the Buurtzorg concept.

The compensation model is constructed so that should be possible to create a fully integrated service delivery with home help, home care and health care centers. Furthermore the compensation model is constructed so that the operator receives compensation equal to the granted number of hours regardless of the number of executed hours, which means that realization of synergies is kept by the operator. Not in favour of Växjö (Kronoberg County), is the fact that BHV is a required duty for HCCs.

Lund

With a population of approximately 112 000 inhabitants in the municipality and + 80 000 in the City offers a large client base in a limited geographically area favorable conditions, Lund is a natural area for establishing the Buurtzorg concept.

The compensation model is constructed so that should be possible to create a fully integrated service delivery with home help, home care and health care centers. Furthermore the compensation model is constructed so that the operator receives compensation equal to the granted number of hours regardless of the number of executed hours, which means that realization of synergies is kept by the operator. In Lund (Region Skåne), BHV and MHV is organised in a separate choice of care.

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General risks associated with privately operated health care and services

The risk for structural changes are both related to business related risk, such as changes in compensation levels as well as political risk.

The last couple of years elderly care in general, and privately operated in particular, has received lots of bad press.

The major general risks associated with the planned operation could broadly be grouped in changed conditions for operation and publicity related risks. Risks associated with changed conditions could be further divided in general changes and changes how profits should be handled by private operators

Risk for changed conditions

General structural changes

General changes in terms and conditions for operation could and do change over time – primarily related to compensations levels and models and related legal and contractual changes.

In this category is the risk not only related to changes, but even more so related to lack of changes, should the counter party not adjust the compensation model to sector specific price increases

Structural changes related to profit limitations

In the light of historically high profits in the welfare sector in general and the health care sector in particular, strong vices has been raised advocating restriction for private operators to generate excess returns on the operations. Among the suggested solutions the most extreme is that no profits should be aloud and that all excess funds should be re-invested in the operations to more moderate suggestions that the profit levels should be capped and exceeding funds should be re-invested in the operations. This will potentially be a topic prior the upcoming (September 2014) election in Sweden)

Publicity risk

One of the major themes in Swedish media the last decades, and in particularly the last years, has been the miss-conditions within the health care in general and elderly care in particular and also the financial and governance aspects of the operations of privately owned operations with in health care sectors. The former has large been related to the miss care of elderly and sick people with examples of care givers neglected to clean patients, not feeding them properly and not tending to their needs in general resulting in sever suffering and even death. The latter has been related to high dividends to owners of private operations, advanced tax planning, and municipalities selling operations to below market prices to private organizations that shortly thereafter re-sells them for substantial profits.

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Incorporation of Health Care Centres in Buurtzorg's operations

Establishment of Health Care Centres is associated with high initial costs and potentially very low revenue streams for the initial years of operation

Acquiring established Health Care Centers is likely a more viable route for Buurtzorg

Establishing a Health Care Centre

Even though a number of privately operated HCCs is started each year, the market is saturated in areas with the prerequisites for successful implementation of Buurtzorg's operating model. This is also supported by the fact that there is a active market for existing HCCs and their customer bases, resulting in a number of transactions each year.

Privately operated HCCs established after the implementation of LOV have around 50% lower average number of listed patients per clinic, compared with private providers established before the LOV-reform, which indicates that competition in the sub-sector has increased.

Although there could be opportunities for starting new HCCs to be explored, it is not without significant investments and uncertainties regarding the time for acquiring a sufficient the customer base, resulting in operational losses and delays in market penetration in selected areas.

Partnerships, Joint Ventures or other forms of cooperation with existing Health Care Centres

Neither the large corporate owners, the local franchises, nor the staff-owned HCCs would have any logical incentives to sell parts of their units. The balance between realised synergies such as sharing of resources and increased administrative load is difficult to manage, which would also be the case in a partnership with an established HCC. Grannvård's contribution to such a partnership would be to broaden the offer to include home-help and home-care. Since capitation is the prevailing payment mechanism for HCCs, it is unlikely that HCCs receives more patient listings just as a result from a broader service offering. In addition, it is likely that establishment of such services would be more cost efficient to perform with resources from the existing organisation. Furthermore, cooperation with HCCs, formalised or not, are more or less a prerequisite for home-help and home-care services. Therefore a contractual and exclusive partnership would not necessarily be something to strive for.

Acquiring a Health Care Centre

Acquisition of a HCC could be a divestment of either the county council or a private entity. According to the Swedish Competition Authority there is no requirement that HCC must be procured. Therefore, a county council has the right to unilaterally offer a private company to acquire a HCC, under the precondition that the transaction occurs at market value.

County councils have statutes that stipulate that the value of a HCC in the event of a divestiture shall be determined by an independent valuation and may not be below the determined value. Nonetheless, the set values of comparable HCC:s in recent transactions differ significantly and there are occasional lapses from the minimum value principle. Valuations are typically based on capitalisation of earnings and customer base.

- In 2012, Uppsala county council reached an agreement with the current operator of 3 HCCs. The operator, Carema, was offered to acquire all 3 HCC for SEK 9 million even though initial valuation amounted to SEK 19,5 million.
- In 2010, a HCC in Bålsta, where Grannvård have operations, was valued at SEK 13-16 million with an asset book value of SEK 425 194. 3 bidders out of 10 indicative offers were shortlisted.
- A divestiture of a staff owned HCC in Stockholm recently rendered much attention. In 2007, when six employed physicians took over the business, they paid just under SEK 700 000 for equipment and premises. In January 2012, they sold to Capio for at least SEK 20 million.

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APPENDIX 1

The Structure of the Swedish Health Care System

Sweden overview

Financing largely through public funding – part of the social security system

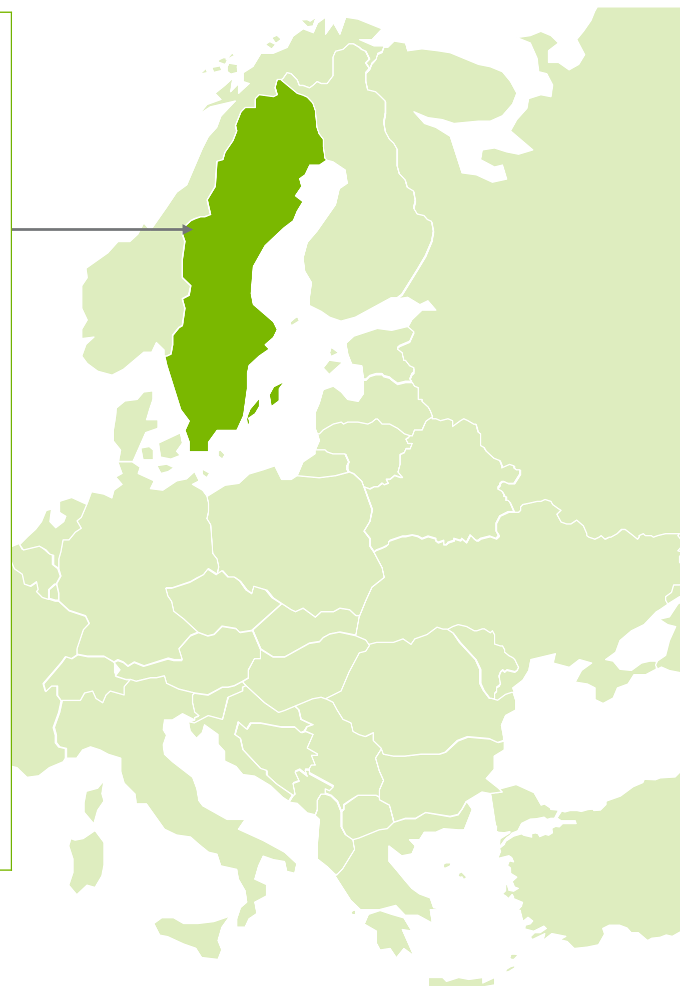
- All Swedish residents are entitled to publicly financed health care. The bulk of health and medical costs in Sweden are paid for by county council and municipal taxes. Contributions from the national government are another source of funding, while patient fees cover only a small percentage of costs.
- The 21 county councils provide funding for mental health care, primary care and specialist services in hospitals. For specialist services, patients can choose any public or private hospital or clinic accredited or funded by the county council. The 289 municipalities provide funding for home-care, home services, and nursing home-care.

Trend towards more private health care providers and a decentralised specialist services offer

- County council costs for health and medical care, excl. dental, were SEK 196bn in 2010, an increase by 2.4% from 2009. Approximately 12% of health care is financed by county councils but carried out by private care providers.
- Most hospitals are owned and operated by the county councils. Private hospitals mainly specialise in elective surgery and work under contract with county councils. However, two emergency hospitals (S:t Göran and Bollnäs) and some local hospitals are operated and/or owned by private vendors.
- New regulation, public sector challenges and political developments are likely to favour private providers. Public and private partnership is expected to increase as county councils expand “free choice of care” (law implemented in 2010 supporting choice by the population and privatisation of primary care providers) to include specialist care or if already included the number of specialist care areas.
- Hospitals in each region are developing regional clusters or networks of specialised services. This trend is being supported at the national level with the advent of regional cancer centres.

Sweden’s first public private partnership hospital is under construction

- New Karolinska Solna is planned to open in 2016 and will be Sweden’s first and the world’s largest PPP (Public Private Partnership) hospital. A consortium consisting of Skanska and Innisfree, with Coor as exclusive FM provider, will stand for the financing, construction, maintenance and operation of the new hospital up until 2040. The construction contract is worth SEK 14.5bn.



Source: KPMG Sweden

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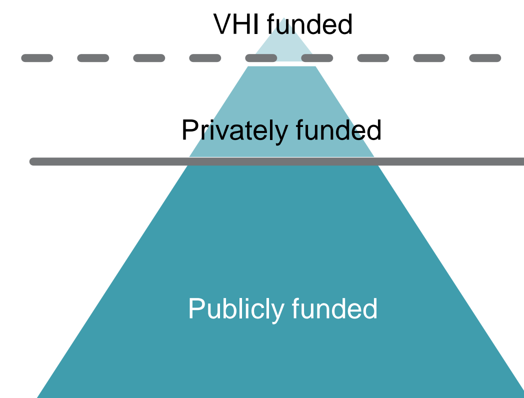
Financing of the Swedish Health Care System

Sweden is probably one of the world's most generous countries when it comes to public spending on eldercare. However, for several decades, public spending on eldercare has not kept pace with the ageing population. Between 1990 and 2000, public resources for eldercare in relation to the number of people aged 80 years and over in the population were reduced by 14%. Between 2000 and 2009, the spending decreased not only in relation to the ageing population but also fell 6% in absolute terms. Health expenditures 9.9% of GDP.

- Approximately 80 % of the health care is publicly funded
- Private practitioners can be reimbursed by the County Council by agreements
- No general national payment model – it is up to each County Council to decide methods for paying providers
- Agreements between the municipalities and County Councils in order to keep care chains
- The part that is financed directly of the individual accounts for 15-18 % (including non-subsidised services) and 2-5% for subsidised services
- A small part (2 %) is financed by Voluntary Health Insurances, VHI, and 4,5 % of the citizens are estimated to have a VHI, and in most cases the premium is paid by an employer. Healthcare paid by an VHI is only delivered by private entities. The VHI is a complement to traditional Healthcare and aimed for specialist care with short waiting times
- Small private sector accounts for 10 % of the public financed health care but this figure is increasing.
- The trend is that parts of the public financed Healthcare is excluded from the services offered and has to be completely financed by the individual, this includes vaccinations, cosmetic surgery etc



Healthcare service	User charge
Primary care	■ Determined by each County Council EUR 11-22
Out-patient specialist visit	■ Determined by each County Council EUR 25-35
Out-patient prescription drugs	■ Uniform nationally* ■ Full cost up to EUR 122
In-patient stay	■ Determined by each County Council ■ Approximately EUR 9 per day
Dental care	■ Uniform nationally** ■ Patient pay up to EUR 33 then partially subsidy

Source: KPMG Sweden, Swedish Government Official Report (2004:68)

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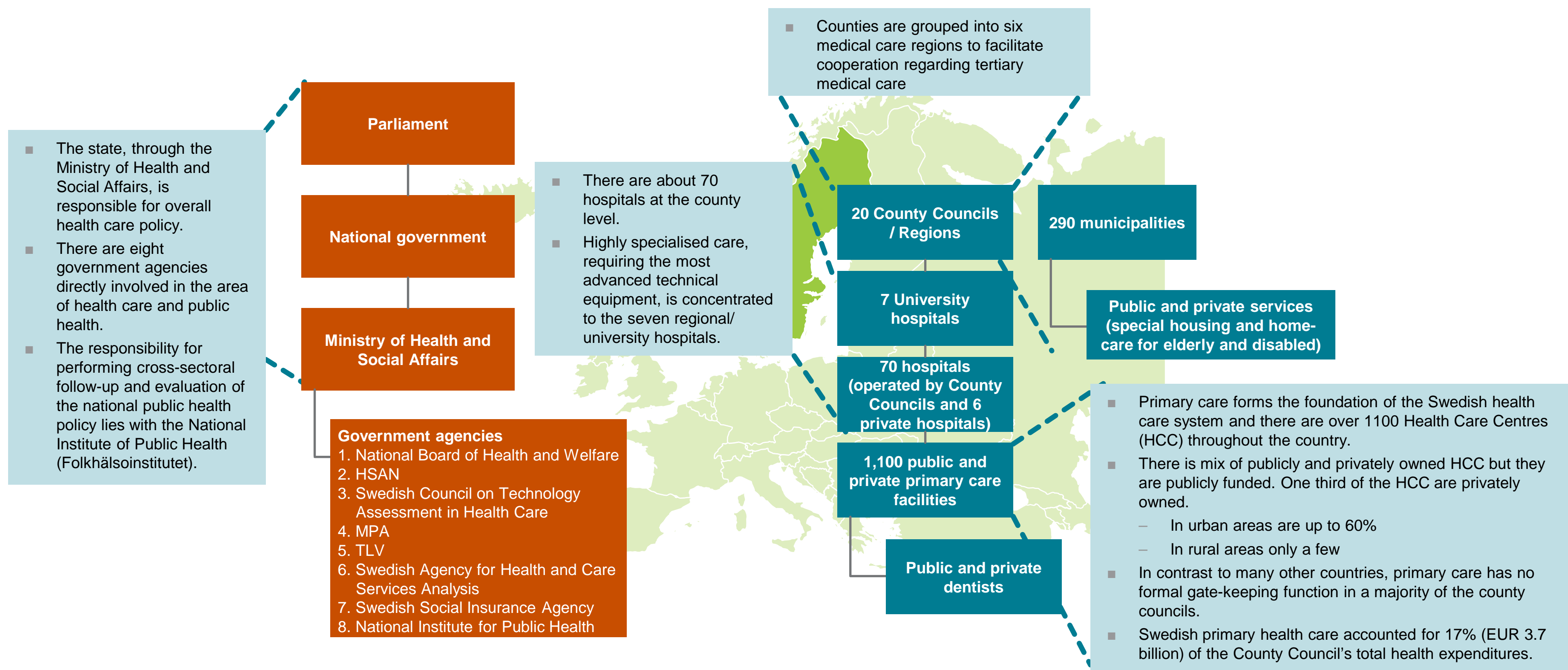
Legal and institutional framework



Source: KPMG Sweden, WHO: Sweden: Health system review. Health Systems in Transition, (2012), EU Commission: The Interlinks Project

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Elderly care in Sweden

In 20 years' time, one Swede in four will be over 65

Elderly care-consumers will be increasingly heterogeneous

Municipalities have cut down on the supply of care and applied more strict needs-assessments

The for-profit actors have a strong position of in Swedish elderly care, especially in larger cities with local right-wing governments

The private sector is highly concentrated and dominated by large companies

The Free Choice System have replaced competitive tendering

Elderly care includes both home-care and home-help services, i.e. varying forms of assistance in a home environment, and institutional or special-housing care (old people's homes, nursing homes and similar). The number of senior citizens that receive either of the two forms of elderly care is roughly 250 000 persons, which equals 15% of all old-age pensioners (65+). Around 95 000 of these live in some form of institutional facility. Especially for persons above the age of 80 the number of recipients of elderly care is high , with a share of home-help services of 72%. Regarding special housing care, they represent 80% of the recipients.

An ageing population calls for initiatives

All Swedish residents are entitled to a state-financed guaranteed minimum pension from the age of 65, the standard retirement age in Sweden. In 20 years' time, one Swede in four will be over 65, and most of the people in this age group will be active and healthy. Several initiatives aimed at meeting future needs are now being put in place around the country:

- The Government has appointed a "Commission on the Future" whose task is to present the latest strategies for dealing with four specified social challenges facing Sweden in the years ahead. One of these is the country's aging population.
- To meet the coming demographic challenge without jeopardising welfare levels, people will have to work longer. An inquiry has begun analyzing pension- related age limits and the potential obstacles to a longer working life.
- The Government is investing SEK 4.3 billion up to 2014 in measures to improve health and social care for the most infirm members of the 65+ age group. The aim is to improve coordination of home health care, elderly care, hospital care and HCC care provided to elderly people.

The number of elderly immigrants (aged 65+) today totals 170 000 and the number will increase. In the future, elderly care-consumers will be increasingly heterogeneous with regards to language as well as ethnic, cultural and religious characteristics. Elderly services provided by the municipalities must be adapted to these conditions and become more pluralistic.

Private suppliers

Since 1990, the economic situation for local governments has been rather difficult. Elderly care has largely become concentrated on pensioners with extended care demands. Municipalities have made adjustments by cutting down on the supply of care (reducing certain services) and applying more strict needs-assessments and thereby excluding persons with more limited needs from municipal elderly care. This has resulted in elderly people purchasing market-based care services to a greater extent and voluntary organisations becoming increasingly involved in elderly care. Privately managed elderly care has established itself mainly in metropolitan areas dominated by right-wing regimes

Source: Bengtsson (red.): Population ageing – a threat to the welfare state?: the case of Sweden (2010), European Centre for Social Welfare Policy and Research, Swedish Institute, Health & Social Care in the Community (2012)

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APPENDIX 2

Contractual framework

Contract models

The modes of operation, collaboration and purchase of services that a municipality or county / region may choose from

Service delivery can occur through a variety of different agencies and organizational solutions. In elderly care the majority of the municipalities have introduced the so-called purchaser-provider model, separating needs-assessment and purchasing of services and care from the provision. They have opened up for competitive tendering and introduced consumer-choice models meaning that home-care teams and residential homes for the elderly have become ‘business units’ with greater financial responsibility for their activities, and they are now obliged to compete with private entrepreneurs for contracts.

Public ownership

Activities operated in the form of public administration. The municipality or county / region control, fund and operate the business. Politicians have direct control over the activities often through a committee, and the administration's own employees perform the services. Operating in-house dominate in many parts of the municipality, especially in the so-called 'soft' activities as elderly and disabled individuals and families. The totality of legal forms of public ownership are:

- Public ownership
- Public ownership by a joint committee
- Local federations of municipalities (”Kommunalförbund”)
- Wholly or partly owned municipal enterprises (companies, foundations, cooperatives)
- Financial coordinating associations

Procured activities

Activities on behalf of a municipality or county in exchange for financial compensation to be procured. The specifications in the Request for Proposal (RFP) and the contract with the supplier forms the basis of how the business is run. Whoever wins the tender can be a private party, such as private corporation, non-profit organisation or cooperative. Although the municipality or county council procures a business, their responsibility remains, and they remain principal with the duty to ensure that the citizen / user receives the services he or she can expect. Monitoring shall be done under the contract and terms of reference. A service concession (franchise) is a public contract where compensation for services is paid in the form of a right to use the services, or a mixture of right of utilisation and payment. One of the hallmarks of a franchise is that the supplier assumes an obvious risk. The supplier is usually dependent on the revenues received from users. The Act on System of Choice (LOV) has been interpreted as a service concession. The totality of legal forms of procured activities are:

- Procurement under the Act on System of Choice in the Public Sector (“LOV”)
- Procurement under the Public Procurement Act (“LOU”)
- Procurement under the Act on Procurement in the Water, Energy, Transport and Postal Services Sectors, (”LUF”)
- Service concession / franchise

Individual grant-financed activities:

- Private schools
- Individual pre-schools

Source: KPMG Sweden, SALAR

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Contracting authorities – Health Care Centres

Health Care Centres – the responsibility of county councils

The number of private companies in the social-service sector increased fivefold between 1995 and 2005. Recent media investigations have unearthed alarming shortfalls among several private care companies. In subsequent criticism, the companies were accused of letting profit have a negative impact on the standard of care.

The 3 largest county councils

Stockholm County Council
Stockholm County Council is one of Europe's largest health care providers with 6 hospitals (56 emergency clinics) and 235 HCCs. The majority of care is provided under the County Council's own management. Around one third is dealt with by private care providers. Yet, Stockholm is the county purchasing absolutely the most production. Last year, almost a quarter of the Stockholm county health care costs to buy production from private companies, which is twice the national average.

Region Västra Götaland (Gothenburg Region)
Region Västra Götaland operates 17 hospitals, 210 HCCs. About 80% of HCCs are operated directly by Region Västra Götaland (approx. 40 private centres).

Region Skåne (Malmö Region)
Region Skåne operates 10 hospitals and 172 HCCs About 80% of HCCs and 8out of 9 hospitals are operated directly by Region Skåne.

The TioHundra Project

In 2006, the healthcare company TioHundra was founded in Norrtälje, a municipality in the northern part of Stockholm County. The company gathered services within nursing, hospital and social care that naturally belong together under joint management. In this way the project has been able to create an organisation in which co-operation and the exchange of knowledge are at the core of all activities. What distinguishes TioHundra from other healthcare providers in Sweden is that a private company have major contracts from both the county and the municipality.

Source: Swedish Institute, Stockholm County Council, Region Västra Götaland, Region Skåne

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Contracting authorities – Home Help and home-care

Home Help and Home Care – a shift to the responsibility of municipalities

In 1992, a major reform was introduced (the “ÄDEL-reform”), that transferred the responsibility for long-term medical care for elderly people from the county councils to the local authorities, except for attendance from physicians. The aim of this reform was to gather all public care for elderly people under one authority, the municipalities. An elderly care inquiry was appointed in April 2003 to conduct a review of health and social care ten years after the ÄDEL-reform. In its simplest interpretation, the proposal means that ownership of home-care in ordinary housing is transferred from 12 counties - Stockholm, Södermanland, Östergötland, Jönköping, Kalmar, Blekinge, Västmanland, Dalarna, Gävleborg, Västernorrland, Västerbotten and Norrbotten - to its 147 municipalities. For the 143 municipalities that have already been responsible for a comprehensive home-care the proposal clarifies alternatively a certain expansion. A transfer of responsibility for home-care from the county councils to municipalities is settled financially through a tax shift between municipalities and counties. This means that the receiver (municipalities) in agreement increase the tax rate by the same percentage that the county council cuts its tax rate.

An increasing number of municipalities are choosing to privatise parts of their elderly care, letting private care providers run their operations. In 2011, private care provided services for 18,6 % of all elderly people getting home-help. All recipients can choose whether they want their home-help or special housing to be provided by public or private operators. However, the municipality always has overall responsibility for areas such as funding and allocating home-help or a place in a special housing facility.

One issue raised by researchers is the problem that relates to the lack of interest from municipalities to accept care demanding elderly people from other communities. It is likely that old people wish to live closer to their children but with the present local municipal financing, elderly persons with care demands only represent a cost to the receiving municipality.

Home Care transferred from the County Councils to the Municipalities

2013

- Blekinge
- Jönköping
- Västmanland
- Gävleborg
- Dalarna
- Västerbotten
- Norrbotten

2014

- Östergötland
- Västernorrland

2015

- Stockholm will not implement municipalization 2015 as previously announced

Source: SALAR, Swedish Government Official Report (2011:55), Bengtsson (red.): Population ageing – a threat to the welfare state?: the case of Sweden (2010)

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Contractual framework

Pros and cons in relation to home-based care

Contractual framework - Pros and cons in relation to home-based care				
Unit/activity	**Procurement scheme**		**Payment mechanism**	
	LOU (Competitive tendering)	**LOV** (Free choice system)	**Capitation** (as main source of compensation)	**Performance-based payment** (
Health Care Centres ("Vårdcentral")	✓Could serve as additional revenue stream in the future if other operations serves as a basis ×Most likely a closed market for Buurtzorg due to lack of previous experience in Sweden and competitive disadvantage compared to major established player ×Competitive tendering under LOU is not common in targeted areas	✓Long-term solution if persistent customer base ✓Scalable in accordance to a changing customer base ✓Synergies and investments can be harvested over a long period of time ×Substantial investments must be made by the private supplier either by acquisitions or new development	✓ There is a potential upside in the possibility of attaining synergies with a broad service offering including home-care ×Risk that the cost of care exceeds the compensation	✓Encourages hard work and treating many patients, reducing congestion. ×Costs increase sand unnecessary procedures are performed.
			Rendered hours	**Fixed compensation**
Home Help ("Hemtjänst") **Home Care ("Hemvård/ Hemsjukvård")**	✓Could serve as additional revenue stream in areas where Buurtzorg have operations according to LOV, for example nights and weekend. ✓Low risk due to a high degree of predictability ×Pre defined operations with limited degree of freedom ×Time-limited contracts ×Associated with high initial start-up and exit costs ×Loss of contract in competitive tendering will make the investment blow up in smoke	✓Large degree of freedom in combining offered services ✓Large possibility to successfully repeat the Buurtzorg delivery from the Netherlands ×Investments must be made by the private supplier ×Risks associated with changes in compensation models, political and legal risks	×No possibility to capitalise on realised synergies or efficient deliveries	✓ Possibility to capitalise on realised synergies or efficient deliveries

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APPENDIX 3

Data tables for recommended areas for establishing Buurtzorg/Grannvård

Data tables for recommended areas for establishing Buurtzorg/Grannvård

Översikt hemsjukvård och äldreomsorg i hemmet 2013

Län	Kommun	Folkmängd	Vårdval Husläkarverksamhet med basal hemsjukvård.	Vårdval vårdcentraler	Kommuner med valfrihetssystem i drift	Ersättnings-modell	Privat service	Egen regi service	Privat omsorg	Egen regi omsorg	Glesbygds-ersättning	Hemsjukvård	Kommentar
Landstinget i Uppsala län	Enköping	40 015		x	X	Utförd	328	0	359	353	Ja	Hela	Uppstartsersättning för ny kund. Särskild ersättning för privat momspliktig
Landstinget i Uppsala län	Uppsala	200 001		x	X	Utförd	337	328	357	347	Ja	Hela	Natt: Schablonersättning per utfört besök för omvårdnad. HSL dag/kväll
Landstinget Kronoberg	Växjö	83 710		x	X	Annan	271,41	253,12	299,93	253,12	Nej	Hela	HSL-insatser ersätts som omvårdnad samt fast ersättning till enheter med egen sjuksköterska utifrån hur många hemsjukvårdspatienter enheten har.
Region Skåne	Lund	111 666		x	X	Beviljad	0	0	0	0	Nej	Hela	Hemvård ersätts i 7 nivåer med 815:- - 8781:-/per person och

Översikt hemsjukvård och äldreomsorg i hemmet 2013

Län	Kommun	Folkmängd	Vårdval Husläkarverksamhet med basal hemsjukvård.	Vårdval vårdcentraler	Kommuner med valfrihetssystem i drift	Ersättnings-modell	Privat service	Egen regi service	Privat omsorg	Egen regi omsorg	Glesbygds-ersättning	Hemsjukvård	Kommentar
Stockholms läns landsting	Botkyrka	84 677	x										
Stockholms läns landsting	Danderyd	31 799	x		X	Utförd	339	334	339	334	Nej	Nej	Startersättning 2 timmar, OB-ersättning faktureras separat.Avbokat besök
Stockholms läns landsting	Ekerö	25 767	x		X	Utförd	332	305	375	344	Ja	Nej	0
Stockholms läns landsting	Haninge	78 326	x		X	Utförd	233,85	221,5	330,7	325,55	Nej	Nej	Ersättningen likvärdig privat/kommunal. Egenregi har fria nyttigheter. + 103:-
Stockholms läns landsting	Huddinge	99 049	x		X	Beviljad	0	0	305	288	Nej	Nej	Tidsdifferentierad ersättning
Stockholms läns landsting	Järfälla	67 320	x		X	Utförd	320	315	320	315	Nej	Nej	0
Stockholms läns landsting	Lidingö	44 081	x		X	Utförd	274	267	311	303	Nej	Nej	0
Stockholms läns landsting	Nacka	91 616	x		X	Utförd	284	266	335	317	Nej	Nej	Avrundad tid, omställningstid finns utöver ersättningen.
Stockholms läns landsting	Norrtälje	56 245	x		X								
Stockholms läns landsting	Nykvarn	9 331	x		X	Utförd	340	340	0	340	Nej	Nej	0
Stockholms läns landsting	Nynäshamn	26 248	x		X	Utförd	0	0	339	318	ja	Nej	0
Stockholms läns landsting	Salem	15 694	x		X	Utförd	330	312	330	312	Nej	Nej	0
Stockholms läns landsting	Sigtuna	41 329	x										
Stockholms läns landsting	Sollentuna	65 891	x		X	Utförd	333	314	333	314	Nej	Nej	Startersättning 1353:-. Ersättning ges för sjukhusvistelse upp till 7 dagar
Stockholms läns landsting	Solna	69 946	x		X	Utförd	327	327	365	365	Nej	Nej	0
Stockholms läns landsting	Stockholm	864 324	x		X	Annan	0	0	0	0	Nej	Nej	Stockholms stad övergår till timersättning fr.o.m. 2014.
Stockholms läns landsting	Sundbyberg	39 539	x		X	Utförd	0	0	342	335	Nej	Nej	Preliminaära belopp. Slutligt pris fastställs när OPI är klart.
Stockholms läns landsting	Södertälje	87 685	x		X	Utförd	308	308	308	308	Ja	Nej	0
Stockholms läns landsting	Tyresö	43 328	x		X	Utförd	281	265	366	345	Nej	Nej	Avlösning och ledsagning har samma ersättning som service
Stockholms läns landsting	Täby	64 558	x		X	Utförd	275	0	312	0	Nej	Nej	0
Stockholms läns landsting	Upplands Väsby	40 194	x		X	Utförd	305	0	305	0	Nej	Nej	0
Stockholms läns landsting	Upplands-Bro	23 984	x		X	Utförd	350	350	350	350	Nej	Nej	0
Stockholms läns landsting	Vallentuna	30 715	x		X	Beviljad	301	290	333	320	Nej	Nej	Hemtjänstinsatser nattetid, larminstallation och larmutryckning ingår inte.
Stockholms läns landsting	Vaxholm	11 141	x										
Stockholms läns landsting	Värmdö	38 894	x		X	Utförd	0	0	394	388	Ja	Nej	0
Stockholms läns landsting	Österåker	39 792	x		X	Utförd	0	0	378	367	Ja	Delegerad	0

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APPENDIX 4

Compensation levels for Health Care Centers in selected counties/regions

Compensation levels for Health Care Centers in selected counties/regions

Different compensation models and compensations levels in different regions and counties makes comparisons difficult

The compensations models differ between different county councils both in level of compensation and structure making it difficult to make meaningful comparisons. On the highest level the compensation models could be divided in three different categories:

- Capitation – Fixed monthly/yearly fee per patient listed/registered at the Health Care Centre
- Compensation per visit
- Other compensations – including bonuses, extra compensation for specific activities etc

The following table is only intended to give an overview of the basic framework for the compensation models for Health Care Centres in the counties and regions identified as attractive for Buurtzorg in this report. Please observe that the “other compensation part” could make up a significant portion of the compensation, not reflected in the table below.

County	Compensation per listed individual (per age category)	Compensation GP	Nurse	Comments
Uppsala	0 - 5: 1 035 kr/year 6 - 64: 1 035 kr/year 65 - 74: 2 706 kr/year 75 - : 3 751 kr/year	313 kr per visit	282 kr per visit	Compensation varies between different municipalities within the county but the state figures serves as a basis for the compensation
Stockholm	0 - 5: 751 kr/year 6-64: 629 kr/year 65- : 1 634 kr/year	484 kr per visit	210 kr per visit	
Skåne	General compensation per listed individual is 2 772kr/year (base level)	No basic compensation per visit	No basic compensation per visit	Basic compensation is individually calculated based on Adjusted Clinical Groups and Care Need Index. The compensation is complemented by compensation for specific activities. The compensation level could then be both higher and lower then the given base level
Kronoberg	General compensation per listed individual is 3 564kr/year (base level)	No basic compensation per visit	No basic compensation per visit	Basic compensation is individually calculated based on Adjusted Clinical Groups and Care Need Index. The compensation is complemented by compensation for specific activities. The compensation level could then be both higher and lower then the given base level

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cutting through complexity

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