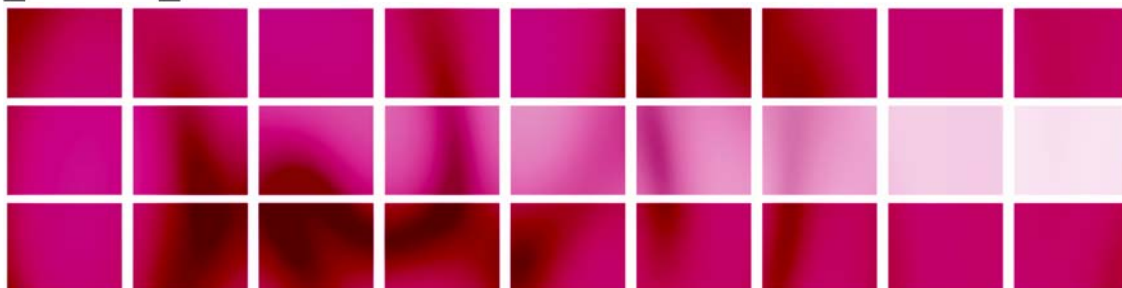


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**PRIVATISATION OF PUBLIC SERVICES AND THE IMPACT ON
QUALITY, EMPLOYMENT AND PRODUCTIVITY (PIQUE)**

***Liberalisation, privatisation and regulation
in the Swedish healthcare sector/hospitals***

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Country report on liberalisation and privatisation processes and forms of
regulation

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1. INTRODUCTION

1.1. Healthcare sector – a complex institutional field

This paper presents an analysis of the Swedish healthcare sector focusing on hospital care, concerning the change of market structures, regulations, actors and ownerships before and during the liberalisation/privatisation process.

Citizens' skills in swimming and the quality of their dental health are considered as signs of welfare. Neither of these will be treated here, but another highly emblematic side of the welfare state which equally invokes a lot of feelings and ideological positioning, and that is healthcare. Healthcare is one of the most obvious symbols of collective goods, perhaps because being healthy or unhealthy is linked to the human conditions of vulnerability and insecurity. In the PIQUE project healthcare is considered as one of the key sectors for understanding and comparing the European process of liberalisation and privatisation.

The hospital/health sector is a complicated one because of the issues of financing, national/regional government control, role of primary/secondary care, etc. A reform within healthcare is embedded in a complex context shaped by the interchange between actors, content and process. This means that the results of a reform vary according to the settings, the period of time, different stages of monitoring and execution and the actions of different stakeholders (Walt 1998). To summarise, it appears that a broad policy is not enough for changing practice in healthcare, attention has to be paid to the macroeconomic and microeconomic factors as well as quality issues.

2. SPECIFIC FEATURES OF SWEDISH HEALTHCARE

In Sweden, healthcare is planned, provided, financed, regulated and followed up within the framework of a political organisation. This includes ownership of facilities, setting up the system for financing and control as well as employment of physicians and other professionals. It is therefore of outmost relevance to consider the political system and the political context for Sweden when describing and analyzing the healthcare system. It implies Sweden as a whole (the national political majority) as well as the political parties in head positions within regions and local authorities.

Sweden is a monarchy with a parliamentary form of government. The Swedish healthcare system is organised on three independent government levels: the national government (*Riksdag*), the county councils (*Landsting*) and the municipal councils (*Kommuner*). Elections are held every fourth year at all three levels.

The basic structure of the Swedish healthcare system is about 150 years old, and originates from the establishment of the county councils in 1862. At the same time the first county hospitals were constructed. The year is also important because it marks the start of more structured public responsibilities. Responsibilities that have been gradually transferred during the years from the central government to local levels.

Today the political responsibility for the financing and provision of health services lies with the county councils, whereas local municipalities are responsible for delivering and financing long-term care for the elderly, the disabled, and the long-term psychiatric ill. The independence of the county councils and the municipalities is based on their ability to levy taxation from its citizens, which makes them stronger than their counterparts in other countries.

The Swedish system of self-governance contributes to the construction of a local offer of public service and opens up for large geographical variations within the country. It is equally important to observe that the local municipalities are not subordinated, or accountable to the county councils. Instead they are two parallel systems connected to the government. The Swedish system is closely similar to that of the four other Nordic countries, Denmark, Finland, Norway and Iceland. Therefore is appropriate to distinguish a Nordic model, based on the healthcare system as a central part of the society. Significant features of the Nordic as well as the Swedish welfare regime are the discourse/strive of justice, democracy and equity (Calltorp 1996; 2005).

According to the fundamental Health and Medical Service Act of 1982, the overall aim of Swedish health and medical service is for the entire population to have equal access to good care service. The emphasis is however put on equal access as opposed to, for instance, freedom of choice in the Netherlands. But it is equally a service hard to organise, because of its characteristics and multiple actors/stakeholders.

In Sweden, where coalition governments are the norm, healthcare reforms have had a more incremental approach than in countries with strong stable majority governments. The Swedish reforms are essentially county specific within the framework of each county's freedom to develop its own model. The Stockholm County council, for instance, decided early on to establish an internal market for hospital service, on which hospitals are paid for the service they provide.

This kind of self-government has been characterised as 'bottom-up' strategies within the decentralised Swedish system. The bottom is the counties and the municipalities, and they differ largely from each other. The result is a variety of municipality/county initiated changes with no overall structure or model being imposed nationally (Calltorp 1996, Ham 1997).

2.1. *The demand of healthcare*

The demand of healthcare is dependent on geographical, cultural and socio-economic factors. Thus regulations initiatives have to be considered focussing on, for example, prioritisations, rationalisation, legal cost-sharing policies and price ceilings.

Considering demography, the Swedish population reached 9 million in 2004. With a length of 7,300 km, the Swedish coastline is the longest in Europe. However, more than 57% of the country is covered by forest, and mountains dominate the north-west part. The majority of the citizens are living in the coastal regions and in the southern part of the country. 83% of citizens are concentrated to the urban areas (Statistics Sweden 2004). In 2002, the capital of Stockholm had 1,684,000 inhabitants, the second biggest city is Göteborg with 500,000 inhabitants, followed by Malmö with 270,000 inhabitants. About 12% of the population are immigrants, originating mainly from the Nordic countries, the former Yugoslavia and the Middle East.

Life expectancy in Sweden is among the highest in the world: in 2003, it was 82.4 years for women and 77.9 years for men. During the past 30 years, the average life expectancy rose by 5.5 years, and Sweden currently has one of the world's oldest populations. Infant mortality decreased substantially during the same period from 11 to 3 deaths per 1000 live births in 1970 and 2002 respectively (WHO 2005: 9). The natural population growth was however negative. Being one of the world's oldest populations implies that more than 17% of the Swedish population is at least 65 years and 5.2% are at least 85 years old. The ageing of Sweden has important social and political implications.

The general assessment of Swedish healthcare is that it offers good outcomes and a generous system of healthcare compared to other European countries, but patient rights and information are modest and access to healthcare is really bad.

In a survey of 2006 Sweden gained the position as the fourth major healthcare country among those presently within the EU.¹ This position is primarily explained by very good health outcome, i.e. low mortality regarding heart infarcts, breast cancer and colorectal cancer, comparatively few infant deaths, few MRSA infections together with a satisfactory level of 'avoidable' deaths. Whereas patient rights and waiting time for treatment do not score equally well in Sweden. The top positions were taken by countries with many general practitioners, such as Belgium, France, Germany and Luxemburg.

However, diseases of the circulatory system are still the leading cause of mortality, accounting for almost half of all deaths in 2001. The second largest cause of death is cancer although the mortality from cancer has fallen by slightly more than 4% in the last 20 years. Deaths due to mental illness and diseases of the nervous system, eyes and ears increased between 1970 and 2001. Programmes designed to prevent accidents have also been successful in Sweden. Since the mid-1970s, deaths due to traffic accidents have been reduced by more than 50%. Currently, Sweden, Norway and the United Kingdom have the world's lowest rates of mortality due to traffic accidents (WHO 2005: 9-10). Although the overwhelming majority of Swedes enjoy good health, there are some worrying tendencies, considering self-reported mental illness, anxiety, alcohol-related problems and overweight. Excess weight and obesity, for instance, are

¹ Comparisons within the framework of a Euro Health Consumer Index made by Health Consumer Powerhouse (2006).

nowadays common in all socioeconomic groups (National Board of Health and Welfare 2004).

2.2. *The supply of healthcare*

The supply of healthcare is dependent on geographical, cultural and socio-economic but also legal policies, price ceilings, rationalisation, prioritisations, taxations for mobility and allocation, New Public Management (NPM) split between purchaser and provider, contracting, outsourcing and out-contracting.

‘Sweden has spent more than any other country in Europe on its private sector, at least until recently’ so does Dent start his presentation about Sweden (2003). Until the peak year of 1982, when 9.7 per cent of the Swedish gross domestic product (GDP) was allocated to the health service, Sweden’s spending on healthcare sector was above the European average. Since then healthcare expenditure has increased from costs of around 7-5% of GDP up to 9.2% of GDP in 2002 (WHO 2005).

The Swedish healthcare system is primarily funded through taxation. About 80 per cent of healthcare is financed by local taxation and the rest is derived from the state and the patients. Both the county councils and the municipalities levy proportional income taxes on the population to cover the services they provide. The mechanisms for paying providers vary among county councils but payments are either based on global budgets or a mix of global budgets and per-capita payments (WHO 2005:3). The part which is publicly financed healthcare has however decreased over the last 20 years, while the patients’ share (co-payments) has increased within total healthcare costs (WHO 2005: 53).

During the first half of the 1990s inpatient care fell quite dramatically for the county councils on the behalf of the municipality. The reason was that patients who were considered, by the hospital doctor, to be fully medically treated were transferred to nursing homes and home-based care, which are the responsibility of the municipalities in Sweden.

The introduction of the ‘American way’ of organising European public service came about in the early 1990s. The movement towards market-orientation has from then on invoked a change in the style of governing. But the nature and the scope of liberalisation has been characterised by the government in power. Sweden has been described as a configuration shaped by the broad social democratic ethos of decentralisation and placing decision-making as close to the activity as possible (Dent, 2003: 50). The social democrats have been in power since 1932 (and in coalition with the centre party) with the exception of two periods with right-wing governments in 1976-1982 and 1991-1994 and the recent shift in government starting from 7 October 2006.

2.2.1. *The challenges for the future*

The challenges for the future are discussed in terms of the needs/demands of an ageing population, the voice of the patient, increased expectations of the population in general and especially of the younger generation, the high cost but necessity of technology, innovations and research. But like other European countries Sweden shares the problems of lacking resources, high total cost, bad efficiency and an ageing population. This, in combination with insufficient access to healthcare and a low ratio of physicians, creates the specific salience of Swedish healthcare and the problems for the future.

Rationalisation and the need to make the process of medical service more efficient are related to increasing demands of healthcare as well as a lack of resources. With the Swedish version of New Public Management, the concepts of professionalism and accountability have taken on a new meaning. The legitimate and financial crisis of the welfare state is stated as a reason for a focus on efficiency and management. Decentralisation and flexibilisation have been executed under the guise of enlarged responsibility for the municipality, reorganised hospital structures, i.e. first, the former so-called bed blockers at hospitals are transferred to home care and homes for elderly people, and second, the time for the average patient is drastically reduced in order to shave resources from expensive hospital care. Furthermore, healthcare is carried out in new forms of human service organisations and new steering mechanisms have been established, such as the split between the roles of purchaser and provider. Although extended discussions about outsourcing and the privatisation of public functions within Swedish healthcare, most of the activities are still carried out by public actors.

2.3. *Labour market and healthcare staff*

The female participation in the labour market is high, with about 48% of the entire manpower, but part-time work is more frequently held by women than men. In 2004, 27% of the Swedish population between 16-74 years had a university degree (Statistics Sweden 2004). The official unemployment rate has ranged from 5.70% in 1992 to 5.20 in 2002, with changes to 9.30% in 1993 and a peak of 10.10% in 1997 (according to World Bank 2004 in WHO 2005).

Swedish physicians and other categories of staff are generally salaried employees.

Considering Sweden as a whole, there is a shortage of staff mainly regarding service for the elderly and the disabled, because of the socio-demographic pattern in Sweden as well as a high degree of staff who are absent for reasons of sick leave (WHO 2005:70). But there is also a general shortage of healthcare staff. Swedish physicians are mainly specialists (approx. 60% out of all) and found in hospital care, consequently there is a lack of general practitioners for primary care. Compared to its Nordic neighbours and to the EU average, Sweden has fewer registered physicians (3.3/1,000 inhabitants). In terms of nurses, Sweden is above the EU average (10.2 nurses/1,000 inhabitants), and at the same level as Denmark, but below other Nordic countries (WHO 2005:66-71). The

number of physicians has to increase by an estimated 30% in order to meet the population's future demand of physicians (WHO 2005).

Table 1: Numbers of physicians and nurses per 1,000 inhabitants

	Physicians	Nurses	Total
Austria	3.4	6	9.4
Belgium	4.5	10.8	15.3
Germany	3.4	9.9	13.3
Sweden	3.3	10.2	13.5
The UK	2.1	?	2.1
EU average	3.4	7.8	11.2

Source: WHO Regional Office for Europe health for all databases, June 2005:69.

The Swedish medical profession includes a limited number of general practitioners and few private GPs in comparison to other EU countries. The Swedish amount of specialised nurses is considered as relatively high in a European perspective. It might reflect the relatively low ratio of doctors with respect to the Swedish population and to the country's rapid expansion from the 1950s. Finally, it should be noted that, contrary to doctors in several other European societies, Swedish doctors have not accepted the introduction of standardised protocols for use in diagnosis by the State; instead some protocols have been developed internally by the Swedish medical association (Dent 2003).

3. MARKET STRUCTURE AND LIBERALISATION PROCESS

3.1. Market structure before liberalisation

3.2. Phase I: 1945 to 1983 – Some key points of welfare state development

Post-war healthcare development in Sweden followed the general enlargement of the Swedish welfare state. The time from 1945 to the 1980s was characterised by a rapid expansion of somatic hospitals and primary healthcare.

The peak of the wave of nationalisation took place during the 1960s. In combination with compulsory national health insurance for all citizens, the "Seven crowns" reform eliminated private practitioners, as the private alternative became too expensive for patients. Thus, no private practice was carried out within the walls of public hospitals (Immergut, 1999).

During the 1960s and the 1970s, Swedish healthcare expansion showed a strong belief in big hospitals and a rational treatment of patients.² A great divide in public administration, however, occurred in the 1970s, because of the economic recession, and subsequently led to a first crisis of the welfare state. By this time, different levels of care were introduced in order to keep up with the pace of technological development, and attempts to eliminate increasing health costs.

3.3. Phase II: 1983-1991 – the Process of liberalisation

From the 1980s onwards, primary healthcare (the polyclinics) was formally considered the base of Swedish healthcare.

After the peak year of 1982, Sweden was one among the OECD countries with the most vigorous cost-containment programmes built on cost-saving campaigns, wage freezes, cuts in budgets for equipment and buildings. These were followed by efforts to monitor and steer clinical activities and to rationalise services by structural changes and mergers between units at county council level (Harrison and Calltorp 2000). In the Göteborg and Stockholm areas, private providers of emergency and outpatient care were expanding their services under the name of “Cityakuten”, as well as Sophiahemmet and Carlanderska for inpatient care.

3.4. Phase III: 1991 - present

The wave of deregulation and introduction of competition for public services, such as electricity, air transport, postal services, telecommunications and the railways started seriously during the 1990s. Increased competition and the privatisation of previously public organisations, goods and services in general in order to increase efficiency naturally also had an influence on the healthcare sector. Healthcare, however, was only partly privatised.

With the right wing holding power in the government and in county councils from 1991 to 1994, a range of reforms was introduced concerning new payment schemes, internal markets, etc., and the focus was pointed at decentralisation, efficiency, transparency, freedom of choice. Quasi-markets were created for both public and private actors. From 1990, providers and purchasers of health service were separated into different roles, distinguishing politicians from public administrators. Because of self-governance different models of financing were developed, for instance, the Stockholm, the Dala and the Bohus model.

Between 1992 and 1995, three major reforms took place, namely the ÄDEL reform (focussing on long-term elderly care), the handicap reform and the psychiatry reform with the common aims to change the institutional organisation of healthcare. As a result

² The supply of medical service ranged from primary healthcare with general practitioners and district nurses to the highly specialist hospitals in the seven Swedish regions.

the accountability for patients with high caring needs (such as elderly, handicapped and patients with mental disorders) were transferred from hospitals, provided by the county councils, to the municipalities. As pointed out by Wärvik (2005), it is important to note that the reforms concerned people in strong need of nursing care and/or rehabilitation, of course demanding supplementary medical treatments, but whose medical treatment came in second hand.

Considering the privatisation of hospital care, the transformation of S:t Görän's hospital was initiated in 1994, changing the public hospital into the very first independent Swedish healthcare company. Within the Swedish system, S:t Görän constitutes the first and most outstanding example of privatisation within hospital care. Its conversion into an independent subsidiary company (*bolagisering*) took place in 1994, then understood as an indicator of structural and cultural restructuring. The wind of change in Swedish society led to the privatisation of the same hospital in 1999. As a result, several hospitals, predominantly within the county of the capital of Stockholm have followed the path taken by S:t Görän. Huddinge Hospital, Danderyds Hospital and S:t Erik's hospital for ocular care are recent examples of conversions into independent subsidiary companies (WHO 2005). However, these companies are still (2006) owned by the county council. Söder hospital and Karolinska Hospital were also previewed to be independent companies in 2000, but the trend was reversed by the co-called 'Stop Law' of 31 December 2002 prohibiting the selling of emergency hospitals to commercial for-profit companies. The main purpose of the Stop Law has been interpreted as halting an up-going trend of privatised hospitals, but keeping already established agreements with private actors (DI 2005-03-09).

In 2006, a new wind of change is blowing ... The recently appointed conservative Minister of Health and Social Affairs, Göran Hägglund, has stressed that 'it is the quality that has to guide, not the ownership of the providers' and he as well as the new government is very positive towards the privatisation of public companies (SvD 2006-10-11).

Table 2: Market structure

Before the process of liberalisation	After the process of liberalisation
<p>During the 1960s and 1970s the Social Democrats, who held the majority in both Chambers of Parliament, were committed to the mission of nationalisation.</p> <p>A combination of compulsory national health insurance for all citizens and the "Seven crowns" reform (1969) ensured that no private practice was carried out within the walls of public hospitals.</p> <p>The trend was reversed by the co-called 'Stop Law' from 31st December 2002 that forbidden the selling of emergency hospitals to commercial for-profit companies.</p>	<p>The first wave of marketisation started from 1976 with the centre-right wing government. From the early 1980s, in the Göteborg and Stockholm areas private providers of emergency and outpatient care were expanding the offer under the name of "Cityakuten", as well as Sophiahemmet and Carlanderska for inpatient care.</p> <p>The second wave of privatization came about from 1991. In 1994, the hospital of S:t Göran was converted into an independent subsidiary company. This was the first and most outstanding example of privatisation within Swedish hospital care.</p> <p>In 1999 Huddinge Hospital, Danderyds Hospital and S:t Eriks hospital for ocular care are more recent examples of conversions into independent subsidiary companies, but still owned by the county council. Söder hospital and Karolinska Hospital were also previewed to be independent companies in 2000.</p> <p>The third wave of privatisation is to begin from 2006 with the new centre-right wing government, which is very positive towards the privatisation of public hospitals.</p>

3.5. Drivers of change and determinates of pace and directions

In the mid-1970s, a halt in a long phase of economic growth paved the way for the Thatcher and Reagan era in the late 1970s and a wave of privatisation in Europe as well as in the entire Western world. The first step of marketisation in Sweden came about with the right wing government in 1976.

The second step followed in the shadow of repeated problems (disinflation, unemployment, loss of credit) caused by the major recession of the early 1990s. A political change from a Social Democrat to a right-wing majority government (1991-1994) led to a major shift in ideology.

The contemporary debate concerned alternative solutions and hence a shift towards regulation based on rules, directives and bureaucracy, to focus on operations based on competition. The main reasons for internal markets were the aim to increase competition in order to improve access, cost-efficiency and to maintain good quality standards.

Swedish arguments towards privatisation have generally been built around the expansion of the public sector and subsequent pressure from taxation on single citizens. But in contrast to radical reforms aimed at completing the abolishment of 'the society' in some Anglo-Saxon countries (e.g. Thatcherism), the Swedish issue of marketisation has so far been driven within the responsibility of the state. It means that in the case Sweden the reforms are to a large extent built on internal markets or the construction of

“quasi-markets” in which private providers should constitute a complement to the public one.

The drivers of change have been discussed in terms of a shift in the positions taken by powerful policy-makers, not only on governmental level but also, and particularly, with the county councils. During the years between 1989 and 1996, the elections moved liberal and conservative politicians, who were the most enthusiastic supporters of competition, in and out of control of most county councils (Harrison and Calltorp 2000). Their major concern was controlling health expenditure during a period of recession, at the same time as politicians resisted taking measures in order to determine prices and distributions. Additionally, health sector employment was considered a sacred cow and a very delicate issue to handle (Harrison and Calltorp 2000). The reforms in Sweden from 1989-1996 went from uncritical support by a broad spectrum of stakeholders to gradually escalating tensions among the goals, reform programmes and fundamental social and political values, unrealistic assumptions of the effect of competitions as well as technical and organisational obstacles to implementation and the threats of interest groups. In 1997, if we believe Harrison and Calltorp (2000), Sweden entered another stage of experimentation of market-oriented reforms (ibid.).

The liberalisation and outsourcing debate is eternally constructed on the limited resources of the 20th-century society. The lack of resources is described as putting bounds to the possibilities to directly and fully respond to the overwhelming needs and hopes of an ageing population.

In Sweden as well as elsewhere the State seeks different ways to control public spending. According to Saltman et al. (1998), there has been a general perception since the 1980s that resources are not always deployed in an optimal fashion. In Sweden this has been linked to a wish of enhancing patient choice and to make providers more responsive to patients as ‘consumers’. The background to these discussions can be related to the fundamental developments in society: Fast medical-technical development brings help, but these increased possibilities also raise people’s expectations. Demography is changing as well as health conditions (with an older population multi functional needs increase. At the same time, as we are physically ‘healthier’, we feel psychologically poorer). Different generations have different values, young people are to a much higher extent used to fast communication, autonomy and individual treatment (according to Ham’s analysis of the critical challenges for the future (1998)). The old dilemma, where the population’s needs seem limitless must again be set in relation to society’s limited resources.

3.6. Future challenges

As a result of demands for increased productivity (efficiency and effectiveness) new methods of public administration, such as New Public Management, and new financing models have come into being. And the patient is supposed to be more empowered. The meaning of empowerment is however very hard to define bearing in mind that

healthcare is a service characterised by asymmetric knowledge and high levels of uncertainty.

Furthermore, the a main driving force for change in healthcare in the early years of the 21st century is the idea is that healthcare should be carried out at an adequate level, and consequently the most cost-efficient possible. A strong economic incentive is that the municipalities have to pay for hospital care of patients when the medical care is completed. This is expected to eliminate the risk of “over-caring” in expensive hospitals and a lack of beds, transferring patients to the cheaper municipality care.

At the centre of today’s healthcare debates is the specialisation of medical science, the different levels of healthcare, and the accountability of the different providers. The aimed goal appears to be a situation where all patients are treated at the most adequate level in the so-called chain of care without any overlaps or any unnecessary costs within a well-organised network of coordination. However, the rationale of patients/users and, especially, of particularly demanding users who suffer not from a single disease but multiple problems does not follow this logic. Additionally, healthcare is provided within separated borders of specialties which also cause trouble for an ideal healthcare delivery.

Many county councils, embracing their healthcare providers, have more or less changed their economic control systems since the 1990s to be able to follow up care paths and to be able to handle the situation as a question of rational decision-making.

The most important factors for the privatisation of healthcare seem to be the ideology of the government in power, followed by the political composition within the country councils and the local authorities. Between 1991 and 1994 the right wing introduced internal markets and the split between purchaser-provider into a model equally carrying the names of the actors in question. An entire kit of concepts new to the healthcare sector wrapped in with the changes concerning decentralisation, quasi-market efficiency, transparency, freedom of choice, public and private actors, etc.

In Stockholm and in Malmö, (the third Swedish city by size), the right-wing majority has pushed privatisation in the area surrounding the capital and in the South of Sweden, whereas the left-wing majority in Göteborg has had a restrained attitude towards private actors in the West of Sweden. Different attitudes towards privatisation have provoked different liberalisation patterns within healthcare.

According to the authors of the WHO-report (2005) the reforms within the Swedish healthcare sector have very much been targeted towards addressing unique and limited problems. For example, the transition of care for elderly persons, the disabled and those suffering from psychological disorders from the county council to the municipality’s account, relieved acute-care hospitals from so-called bed blockers. The elderly do no longer stay in hospitals when their treatment is considered to be complete, and therefore institutional nursing homes and long-term hospitals have been created. But some problems have remained unsolved and new ones have appeared: the lack of physicians and their involvement in municipal care, poor access to nursing homes, defaulting

coordination between county councils and municipalities necessary for ensuring patients' care and right within the division of responsibility (WHO 2005:98).

3.7. The EU level

The European Union has indirectly been an important driver in the process of liberalisation.

Policy priorities have included the control of inflation and the pursuit of macroeconomic stability, and thereby put a pressure on the concerned nations to implement a drastic reduction of fiscal deficits and overall government debt levels.

The major focus on private care concerns cost containment, budget control, target and manpower, the reduction in length of hospital stays and budget for doctors. Institutional changes are furthermore driven by new technology, cost efficiency, highly specialised staff, cost transferred to the community, etc.

Within the EU area there are three issues of major common concern. First, regarding the common actions toward infectious diseases and non-antibiotic management. Second the treatment of diabetes and diseases related to the central nervous system, to age and to factors of a psychosocial character. Third, problems related to diet, habits and life style are considered very relevant.

In terms of a European perspective, healthcare services will in the near future be generally available cross-border in the European market. But they are so far excluded from the EU Service Directive soon to become law. The EU Health and Consumer protection Commissioner Markos Kyprianou has declared three important things for the future. First, there will be legal regulations of cross-border care (reimbursement limits, matters of responsibility, etc.). Secondly, patient mobility now is a given and will grow with volumes and treatment panorama. Third, there is the dimension of "health tourism" (Hjertman 2006).

Consequently, the European Commission has an ambition to increase cross-boarder collaboration of highly specialised medical services and within areas for ICT and control of infectious diseases (Vårdkonsumentindex 2006).

4. ROLE OF GOVERNMENT AND OTHER STAKEHOLDERS

A government has different roles to play. Normally, it will create different organisations for each role to reduce the inherent tensions that exist between these roles, but such differentiation is not always evident or possible. The different roles of government can also be found in its relation to the healthcare sector.

First of all, the government is also responsible for guarding public interest. The nature and the scope of liberalisation has been characterised by the government in power. In Sweden it has been described as a configuration shaped by the broad social democratic

ethos of decentralisation and placing decision-making as close to the activity as possible (Dent 2003: 50). The Social Democrats have been in power since 1932 (and in coalition with the centre party) with the exception of two periods with right-wing governments in 1976-1982 and 1991-1994, and the recent change in government starting from 7 October 2006.

Since 1971, Sweden has had a one-chamber parliament (*Riksdag*), which is the highest decision-making body. The parliament is constituted by direct elections, which occur every fourth year (the last elections were held in 2006). The parliament has 349 members in proportion to the votes cast for them nationally.

Second, the government will act as a policymaker towards this sector, involved in planning and processing. The parliament – which appoints the prime minister – and the government have the overall responsibility for the state-financed healthcare system. The responsibility for healthcare is taken care of by the Ministry of Health and Social affairs. Accordingly, when it comes to policymaking, it is this Ministry, and its department that play the major role. Swedish ministries are relatively small – the staff is approximately 150 people – and their responsibility is to prepare and process the government's bills and resolutions. A characteristic of the Swedish administrative system is the division of responsibility between the ministries and national agencies. At the county/regional level, it is the Council and the County/Regional office (WHO 2005) that prepare, plan and process the actions. The government is also responsible for medical universities and the nursing education through the National Agency for Higher Education (NAHE).

Third, the government also acts as a principal and an owner. The healthcare sector is one of the major employers in Sweden. The employers are either the State, the County Councils (Regions) or the local authorities all with own rights of taxation. 11% of Swedish employees work in the 15 major Swedish groups. Seven out of these 15 groups are local authorities, counties /regions or public administrations.

Fourth, the government should supervise the sector. The main role of the *central government* is to establish basic principles for the health services by means of laws and regulations (mainly the Health and Medical Services Act of 1982), through The Ministry of Health and Social Affairs (Socialdepartementet), and through the central advisory and supervisory agency The National Board of Health and Welfare (Socialstyrelsen) together with the Council of Technology Assessment in Health Care (SBU).

According to the Swedish Law on Professional Activities, publicly funded healthcare has to be accountable to the National Board of Health and Welfare. Healthcare providers are therefore obliged to have a system in place in order to report incidents connected to medical treatments and interventions (WHO 2005).

The movement towards market-orientation has invoked a change in the style of governing. According to Saltman and van Otter (1992) a decentralised healthcare system implies less detailed regulations and more freedom to the single actors regarding how to carry out the service. However, it has been argued that decentralisation requires

a new role of the government in terms of steering, and not an abdication of the government. Many states have difficulties in adopting such an indirect role focused on regulation and supervision. It means that, despite market forces, the state has the responsibility to ensure that reforms are properly planned and evaluated (Rathwell 1998). But it is a tricky thing and the development seems to catch the Swedish politicians in the horns of a dilemma: how to retain public accountability for healthcare services, while leaving direct involvement in strategic and operational matters.

The nature and the scope of liberalisation are generally characterised by the government in power. In Sweden, where coalition governments are the norm, healthcare reforms have had a more incremental approach than in countries with strong stable majority governments. Sweden has been reluctant to take major political risks (Rathwell 1998).

In Sweden attempts have been made by the last Social Democratic government to move towards more state centralisation combined with a higher degree of self-government. A committee has been established for the issue of accountability (*Ansvarskommitten*), whose mission is to evaluate the appropriate level for different kinds of decision-making. Accordingly, it is considered of highest priority to create conditions in order 'to develop the receivers', i.e. the county's or region's habit of adaptation to scientific findings in order to achieve faster impact/effectiveness/pervasive force of the base of knowledge for clinical decisions. The ambition is to hereby create more coherence in Swedish healthcare, and a more efficient way for the state to steer healthcare (NBHW 2006).

5. PUBLIC OWNERSHIP/ACTORS

This part deals with the public actors, while the next section of market structure will explore private providers. Below the relation between the actors will be roughly analysed.

5.1. *Politicians and public administrators*

As previously described, the Swedish healthcare organisation is planned and governed at different political and administrative levels: the central government, the county council and the local authority (municipality). In comparison with other European countries (Dent 1999), the Swedish system is considered as decentralised. The health services in Sweden rest largely in the hands of local politicians, directly elected, for 290 local authorities, 18 county councils and two regions. The regions are the ones of Västra Götaland and of Skåne.

Medical services are provided at *county level and in two cases at regional level* for conditions that require hospital treatment. The county and regional councils decide on the allocation of resources to the health services and are responsible for the overall

planning of these services. It is also the county or regional councils which own and run the hospitals, health centres and other health institutions.

However, a big and growing category of healthcare, namely the care of elderly and disabled people, is the responsibility of *the municipality*. The municipality manages the nursing homes and the service apartments and shall guarantee access to nursing services 24 hours a day. Local authorities are also obliged to pay for patients whose hospital treatment had been concluded but who have to remain in hospital because the local authority cannot offer them a place in, for example, a nursing home. Local authorities are, similarly, responsible for the living arrangements, employment and support services for people suffering from long-term mental illness (WHO 2005).

The Swedish system of self-governance contributes to the establishment of local public service offers and is open to great geographical variations. It is equally important to observe that the local municipalities are not subordinated, or accountable to the county councils. Instead they are two parallel systems under the government.

5.2. *The professionals – employed physicians, nurses and healthcare staff*

Nevertheless, it is the interests of national and local politicians that predominantly determine the shape of the agenda on healthcare provision in Sweden. This agenda is also influenced to a considerable extent by the medical profession (Dent 2003:66). Hence, according to Dent, it would be wrong to interpret the situation of Swedish physicians as subordinated. An important part of their autonomy derives from the particular institutional context. Considering the relation between health professionals and the state, the links between the two parties are very strong. But as the central government has been less directly involved in the delivery of care, the central level has become relatively less reliant on the medical profession as compared to its counterparts with the county councils (Dent 2003).

The most common structure of a hospital involves a hospital director, an advisory physician (who has no managerial responsibilities) reporting to the director, and the departments, each of which has a head of department and two levels of physicians. The departments match the medical specialties, with sub-departments for subspecialties (WHO 2005: 51).

The training of physicians and other healthcare occupational groups is entirely financed by the central government.³ The number of medical students accepted for medical education is limited to approx. 1,100 persons per year (WHO 2005:71). But the amount would actually need to increase by 30% in order to meet the population's estimated demand of physicians for the future. This prognosis is provided by the National Agency for Higher Education (NAHE), which also provides the government with information for planning and deciding on educational policies.

³ There are 13 universities and 23 university colleges throughout the country. Six out of them are medical universities.

The number of persons beginning nursing training is about 5,500 per year. Swedish nurses complete a three-year full-time degree (compared to four years in, for example, the Netherlands). The nursing programme is locally designed by the individual university or university colleges, and it is divided between theoretical studies and clinical training. This means that there is no standardised syllabus or curriculum, except the need to comply with EC regulations. However, the Swedish profession is based on the North American 'nursing theory', which is characterised by a holistic approach to patient care with an emphasis on a capacity of feeling and empathy as well as being able to document, develop and evaluate the work (Bentling 1992 in Dent 2003).

To become a registered physician, a student must successfully complete a study programme of five and a half years followed by a 21-month training period of clinical work and a written examination. However, most physicians choose to qualify as a specialist after five years of service in one of the 62 recognised specialities. In order to become a consultant or head of a department, physicians need five years of postgraduate specialist training.

Sweden has a relatively high amount of physicians working in hospitals in comparison with other Nordic countries – about 60% out of all physicians are employed in hospitals. The numbers of physicians and nurses has increased slightly since the mid-1990s, but the overall amount of so-called healthcare staff has decreased because of the structural change with a shift from hospital to primary care since the beginning of the 1990s (from 46.7 in 1992 to 31.9 in 2002). During the same period (1993-2002) the number of hospital beds was reduced by 40% and, as a consequence, the average length of a hospital stay. In 2002 about 27,000 registered physicians and 91,000 registered nurses were to be found within the Swedish county councils.

There is a shortage of staff mainly regarding service for the elderly and the disabled, because of the socio-demographic pattern in Sweden as well as a large number of staff on sick leave (WHO 2005:70). But there is also a shortage of staff in healthcare as a whole. With approx 3.3 physicians per 1,000 inhabitants, Sweden has fewer registered physicians compared to its Nordic neighbours and compared to the EU average. In terms of the amount of nurses, at 10.2 nurses per 1,000 inhabitants, Sweden is above the EU average and at the same level as Denmark, but below other Nordic countries (WHO 2005:66-71).

Swedish physicians are mainly specialists and found in hospital care, consequently there is a lack of general practitioners for primary care.

5.2.1. Tensions/Conflicts

Nowadays, a large part of Swedish healthcare governance distinguishes two main roles, the purchaser and the provider, separating allocative from operational decisions. Accordingly, all occupational groups, including physicians have to undergo budgetary and clinical performance control in order to control cost and increase efficiency. In Sweden the 'doctors retain their control over their work (operational decisions), but

allocative decisions are the preserve of management qua management' (Dent 1998:208). The evidence is that healthcare provision continues to rely upon medical expertise and the autonomy of the doctors. Physicians remain in the exclusive position to measure and evaluate the outcome and quality of their work though peer-review and professional associations.

The main purpose of the purchaser-provider model was to redefine the roles of politicians and of professionals: politicians should act as representatives of the patients (through purchasing organisations), whereas health professionals were made responsible for the provision of healthcare. Although purchaser-provider models created incentives for more efficient management, there were concerns that market-based mechanisms would damage social equity and, because of high transaction costs, save little money.

In the second half of the 1990s, the word "cooperation", instead of "competition" started to be used. As a result of increased dialogue between purchasers and providers, there emerged a tendency towards a shift from specifying the number of specific medical interventions to defining broader health programmes that included more than one provider. County councils cooperated to improve the distribution of workload between hospitals. The administration of some hospitals was extended over several nearby hospitals to increase efficiency. Moreover, some types of activity (e.g. laboratory work) have been combined.

The organisational structure of hospitals varies among counties, depending on their size and the political committees in charge. However, even if differences exist, the structure basically consists of a hierarchical organisation with traditional departments.

5.2.2. *Care process – reform to distribute responsibilities and costs*

In Sweden there is an on-going reform concerning the care process, distinguishing between primary healthcare (in polyclinics), acute hospital care, hospital care and specialised hospital care.

Accordingly, the formal organisation of Swedish healthcare is conducted at four different levels:

The primary level, including primary health centres, dental services, ambulance care and telephone advice nursing (TAN), shall have the overall responsibility for the local health status. The aim is that 80% of all appointments shall take place at the primary level. In addition, primary care is also provided by district nurse surgeries, by clinics for child and maternity health as well as by private physiotherapists and other private care-givers.

Furthermore, Sweden has 79 hospitals divided into local, central county and regional hospitals. The second level consists of *hospitals of special care*, which are mainly focused on planned surgery, and to a limited extent on immediate care service of internal medicine. At the county hospitals, the levels of medical competence and

equipment enable treatment of patients suffering from almost all kinds of conditions, including psychiatric problems. Both inpatient and outpatient care are provided.

Currently, there are approximately 20 central county hospitals in Sweden, i.e. one hospital for each county council area. In these hospitals, there are about 5–20 specialties.

The third level consists of *accident and emergency (A & E) hospitals*, which ought to have large competences focusing at immediate care day and night.

Finally, *nine regional hospitals* shall provide highly specialised care and constitute the engine of research and development within six geographical areas. The county hospitals are found in the six medical care regions, each serving a population averaging between one and two million people. These specialised hospitals are also dedicated to research and teaching (eight of them are affiliated to university medical schools (WHO 2005:23).

5.3. *Citizens*

An open healthcare market, as well as other service markets, requires citizens and patients who are empowered about their well-being and take responsibility and constructive actions. The basic thought is that parameters such as influence over information, appointments, treatment and follow-up impact positively on the outcome of care.

Talking about citizen participation and patient choice, Saltman, Figueras and Sakellarides (1998) present a useful summary of cross-national approaches to the issue based on a well-established ‘ladder of participation’ model. Like other aspects of healthcare reforms, participation and empowerment are also ‘shaped’ by national and local values and norms.

However, citing Groenewegen (1994), it is an interesting observation that despite the strong emphasis it put on enhancing patient choice and competition between healthcare ‘delivers’, the patients’ perspective itself is often missing in official investigations and policy documents (in Rathwell 1998).

6. *PRIVATE OWNERSHIP/ACTORS*

In its annual report on the finances and activities of the Swedish counties/regions, the Federation of County Councils (FCC) has collected statistics regarding private physicians and physiotherapists in outpatient departments reimbursed by the public means. In 1994, the responsibility for costs, including reimbursing private actors, was decentralised from the state to the counties/regions. In 2003, 1,151 private physicians (out of 26,873 in total) were reimbursed according to the national standard for 2.4 million medical visits, and 1,509 physiotherapists with 3.4 million visits. The majority of private physicians and physiotherapists are to be found in the county of Stockholm.

6.1. *One of four citizens chose private care in 2000*

In September 2000, the newspaper reported that the government was liberalising healthcare.

Table 3: Regulating actors

Before the process of liberalisation	After the process of liberalisation
91 hospitals	4 private hospitals out of 91 (two in Västra Götaland, one in Stockholm and one in Skåne)
996 primary healthcare centres	118 out of 996 primary healthcare centres were run by private companies or cooperatives
46 family doctors	31 out of 46 Family doctors practices were private

Source: FCC 2000.

The Social Democratic government opened the healthcare sector for liberalisation, within the National Plan for Healthcare, from June 2000. According to the National Plan multiple variations of management should be encouraged. The then Social Minister, Lars Engqvist, drew the line at Acute and Emergency hospitals, which should not be privatised. The ‘Stop Law’ emergency care constituted an important part of total healthcare, and the government considered that persons needing immediate care should not have to decide on a hospital in the ambulance on their way to the hospital.

In Stockholm, where the privatisation is most extended, one subsidiary of Praktikertjänst is responsible for parts of Löwenströmska hospital, and another subsidiary has been running a major part of Nacka sjukhus since 1999-2000. S:t Görän’s hospital was bought by the international healthcare company Capio (former Bure) in 1999.

6.2. *Market structure 2006*

The turnover in the healthcare sector is about 260 million SEK. Excluding elderly care activities in the municipalities, it still amounts to 164 million. In 2006, 85% of providers are still public, but this will certainly change when the government opens the doors to private actors (SvD 2006-10-11).

Table 4: Private healthcare companies

Name	Owner	Yearly turn-over (2005), billions	No of employees	National and international activities
Capio	Company on the stock market	SEK 2	2,500	The Nordic market, but also 20 highly specialised hospitals and on of the major provider in France, 12 hospitals in Spain +

				clinics for outpatient care
Aleris	High risk company EQT	SEK 1.5	1,500	One of the major private providers in Sweden, Norway and Denmark
Carema	High risk company 3i	SEK 2.8	5,500	Sweden, Norway and Finland Also manning company
Praktikertjänst	Cooperative Minor providers	SEK 9	13,000	The Swedish market funded in 1960

Source: Svenska Dagbladet 2006-010-11.

6.2.1. *Praktikertjänst AB*

Praktikertjänst AB, in Stockholm, is the major private group and the oldest within Swedish healthcare. It covers nearly 50% of the outpatient care within primary care and more than 45% of the dental care within Sweden (Konkurrensverket 2004). The group is run in the form of a producer cooperative and was founded in 1960 (then Medical Service, i.e. Läkartjänst AB). Praktikertjänst AB got its current name in 1977 after a merger with its counterpart, Dental Service (founded in 1966). The activities are described as entrepreneurial driven dental, health and personal care. The concept is based on small, local practices combined with the resources of a large company. Praktikertjänst provides the external conditions of a commercial enterprise, but the driving force is said to come from within; from the producers themselves. The practitioners managing the practices are entrepreneurs and they are responsible for running their own operations. This includes responsibility for the odontological and medical aspects as well as finances, human resources, business development, and ensuring that the practices are properly staffed and equipped. The entrepreneurs are employed by Praktikertjänst, as are the staff members at the practices. Considering wages and benefits, they are based on the practices' results and linked to part of the group's overall wage policy. Praktikertjänst is particularly important within dental care because of a reform of dental care since 1999, with 1,400 dentists connected to the group. 70% of the group's overall turnover derives from dental care. However, one third of the total 2,200 practitioners within Praktikertjänst (about 770 persons) are physicians, physiotherapists, occupational therapists, psychoanalysts/therapists, nurses, midwives, certified social workers, chiropractors and dieticians, who develop and run their own practices throughout the country. Most of the businesses are operated under healthcare agreements with the local/regional authorities or through the national health system. The turnover in 2004 amounted to SEK 1.9 million. (Homepage for Praktikertjänst AB 2006).

6.2.2. *Aleris*

Aleris was founded in March 2005 and today is among the major healthcare companies, with activities in Sweden, Norway and Denmark operating in areas such as specialised

care, audiology, physiological laboratories, radiotherapy medilab, elderly care and psychiatrics (www.aleris.se).

6.2.3. *Carema*

Carema is one of the other leading producers within medical services and social care in the Nordic Countries. It manages polyclinics, smaller local hospitals, specialised clinics for outpatient care, homes for the elderly, disabled and mentally ill on behalf of the counties and the municipalities. Carema is also the main actor regarding manpower and manning of healthcare staff on the market. It operates in Sweden, Norway and Finland (www.carema.se).

6.2.4. *Capio*

Capio has approx. 18,000 shareholders. The foreign-owned proportion of the share capital was 44% (2006). In June, the shares on the stock market were based on high risk companies and minor posts on Swedish insurance, risk and pension funds (like the Second Swedish AP Fund 6.3%, Fourth Swedish AP Fund 5.3%, Orkla ASA 5.1%, AFA Insurance 3.7%). The Nordic healthcare market is Capio's home market, especially the healthcare sectors in Sweden, Norway and Denmark. Their market share accounts for approximately 9% of each country's GDP. On their homepage, Capio say that 'despite strained public finances and a partially unclear political direction, Capio's view is that there are considerable opportunities for further development in the Nordic countries'. Besides the Nordic market Capio also refers to itself as a leading actor in European healthcare, for instance in the UK, Spain, France, Portugal and Germany (www.capio.se).

S:t Görän

S:t Görän is one of the private hospitals under the portfolio of Capio. Jan Öhrming and Mats Sverke (2003) have analysed two hospitals in Sweden with a focus on all (management) employees. One of the hospitals, S:t Görän's Hospital Inc., was made a non-profit public stock company in 1994 and a for-profit private stock company in late 1999. The other Södertälje Hospital remained a non-profit public administration unit over the course of the study. Both hospitals are a part of Stockholm county council, which also is the most privatised region in Sweden. The process started with S:t Görän in 1994.

However, few studies have been undertaken of privatised Swedish hospital care, except this longitudinal research study (1994-1999) carried out by a business economist and a psychologist. Their aim was to explore the private owners' organisation, the insecurity of healthcare management and service provision and how problems were dealt with within this context (Öhrming and Sverke 2001).

7. REGULATION

7.1. Rules, regulations and contracts

In Sweden, distributive justice was a leading vision in the 1970s and 1980s. According to the fundamental Health and Medical Service Act of 1982, the overall aim of Swedish health and medical service is for the entire population to have equal access to good care service. The Sweden (as well as in other Nordic countries and in the UK), the emphasis is on equal access as opposed to freedom of choice (as, for instance, in the Netherlands).

A general overview furthermore exemplifies how the focus was on cost containment in the late 1980s, and on efficiency in the early 1990s. As a result of the introduction of new management systems and new organisational structures, the efficiency issues came to the fore, such as prospective payment schemes, purchasing-organisations and increased rights for patients. In the latter part of the 1990s new delivery systems and new ways of organising healthcare were in focus. More recent reforms of the 2000s are again addressing a renewed concern about cost containment (WHO 2005: 95ff).

Dalarna, Stockholm and Bohus were the first county councils to introduce reforms (using methods referred to as the Dala Model, the Stockholm Model and the Bohus Model) that included most issues discussed in the 1980s, i.e. resource allocation according to the needs of the residents, per-case payment schemes, total cost liability for departments, and interdependent transfer pricing systems (WHO 2005: 65).

Accordingly, several county councils introduced solutions in which separate purchasing organisations were established. The hospitals became more independent in relation to political bodies, and, in some cases, have been transformed into county-council-owned limited companies. In some county councils (Stockholm and Skåne), some of these companies were transformed back to county council boards after the 2002 General Election.

By 1994, 14 out of (at the time) 26 county councils had introduced the purchasing-provider models. The purchasing organisations vary among, as well as, within the county councils. Some county councils have introduced one large central county council purchasing organisation, while others have introduced purchasing organisations at district level (WHO 2005: 50).

Contracting in practice is based on the purchasing organisations negotiations with the hospital healthcare providers in order to establish financial and activity contracts. These contracts are often based on fixed prospective per-case payments (based on diagnosis-related groups) and complemented with price or volume ceilings and quality components. Prices are determined by historical costs and negotiations between purchasers and providers. The use of diagnosis-related groups and other classification systems, however, varies among regions and county councils. Per-case reimbursements for outliers, such as complicated cases that grossly exceed the average cost per case, may be complemented by per-diem payments (WHO 2005: 51).

7.2. *Regulating actors*

The main role for the *central government* is to establish basic principles for the health services through laws and ordinances (mainly the Health and Medical Services Act of 1982), through The Ministry of Health and Social Affairs (Socialdepartementet) and through the central advisory and supervisory agency The National Board of Health and Welfare (Socialstyrelsen), together with the Council of Technology Assessment in Health Care (SBU).

SBU shall reviews the benefits, risks and costs of methods used in healthcare, with the aim to identify which method is the most appropriate for treating a specific disease, but also to determine which methods are ineffective or not cost-effective, so that they can be avoided. It also an obligation to identify important knowledge gaps – areas in which further research is urgently needed. SBU organises its work on a project basis. For each project, a multidisciplinary team, consisting of leading experts from Sweden and abroad, is recruited (WHO 2005: 36). SBU is also responsible for producing and disseminating its reports. One strategy is to develop a network of “local ambassadors” for technology assessment, who inform various target groups (e.g. physicians) at the municipal and county levels (Calltorp 1999).

It is then the National Board of Health and Welfare which is commissioned by the Government to provide evidence-based guidelines for the care and treatment of patients with serious chronic illness. The National Board of Health and Welfare has equally a supervisory function over all healthcare personnel. The Board is also the licensing authority for physicians, dentists and other health service staff, and private as well as salaried employees.

Several bodies share the task of safeguarding patients’ interests in receiving adequate and safe healthcare, e.g. patients’ committees, the National Board of Health and Welfare and HSAN. Every institution providing health services has a legal obligation to provide compensation for injuries that occur in the course of their services. Under the terms of the Patient Injuries Act, any person suffering an injury in connection with medical or dental care in Sweden is, in certain cases, entitled to compensation under the patient injury insurance scheme. The institutions are insured to meet demands for financial compensation from patients who have suffered such injuries (WHO 2005: 35).

However, it is the county councils that regulate the private (and public) practitioners’ market, by approving or not approving an establishment. A county council also approves public reimbursement for the respective practitioner. However, a county council cannot prevent a practitioner from establishing a private practice; the regulatory power is restricted to controlling the public financing of private practitioners. The agreement between the private provider and a county council is normally concluded after a public procurement process. The private healthcare providers are then reimbursed in accordance with the conditions in the agreement.

7.3. *Instruments in order to regulate the demand*

The fundamental law for Swedish healthcare is the Health and Medical Services Act. In the following, the overall framework regarding aims, scope and ethical considerations will be outlined.

The three basic principles for public health and medical care are: the principle of human dignity, the principle of need and solidarity and the principle of cost-efficiency. These are also the terms for prioritisation of healthcare, meaning that it is most important that all individuals are treated with dignity and have the same rights, regardless of their status in the community. Second, those in greatest need should take precedence. Third, if a choice has to be made regarding different healthcare options, 'there should be a reasonable relationship between the costs and the effects, measured in terms of improved health and improved quality of life' (WHO 2005: 1). These guiding principles have then been converted in four priority groups:

The first group includes persons with life-treating diseases, palliative care and care for chronic diseases. The second group concerns prevention and rehabilitation. In the third group care of persons with non-acute and non-chronic diseases is included. Finally care for other reasons than illness and injury forms a fourth group, e.g. cosmetic surgery, which is not financed by public means (WHO 2005: 101).

An example of a general liberalisation practice is the contracting out in Sweden. However, scepticism among practitioners has been important. Accordingly, the Swedish purchaser-provider split was adopted with an incremental approach. Instead of a national reform package as in the UK, the Swedish counties have chosen different ways of provision and financing.

Within health, the control over operations is important. One way to combine competition with the state government is based on tender procedures. The county or municipality in control have a procedure for bidding that is open to competition, i.e. in order to make it possible for private actors to provide a service within the framework of a subcontracting organisation. The process is built on competition *with a market* and is to be distinguished from competition *on a market*. Through bidding, the state wants to guarantee the lowest cost.

7.3.1. *Out-of-pocket payments from the patients*

There are direct, small fees for medical attention to be paid by patients; these fees are in the form of flat-rate payments. In 2003, the county councils received SKr 5,130 million in patients' fees and other fees (including those for dental care), which accounted for 2.8% of the county councils' total revenues (WHO 2005: 45-46). The parliament has however set ceilings on the total amount that any citizen must pay in any 2-month period.

In 2004, the fee for consulting a physician in primary healthcare varying from SKr 100 to SKr 150 (approximately €11-17) between county councils. In the same year, the fee

for consulting a specialist at a hospital varied between SKr 200 and SKr 300. For inpatient care, normally a fee of SKr 80 per day is charged, but reductions are possible for pensioners and those in low-income groups (Federation of Swedish County Councils 2004).

The Government’s ceiling for out-of-pocket payments means that an individual’s total charges on healthcare for a period of 2 months, i.e. for visits to physicians, district nurses, physiotherapists, etc., cannot exceed SKr 900 (€100), not including inpatient care. After this cost ceiling has been reached, the patient pays no further charges for the remainder of the 2-month period, which is calculated from the date of the patient’s first visit to a physician. The exemption scheme is included in national health insurance, financed by the Swedish Social Insurance Board and administered by the county councils.

7.4. *Financing the supply of healthcare*

Swedish citizens pay taxes to the local authority and to the counties/region, which accordingly have a great deal of freedom to organise the activities in their area. Supplementary grants from the state are provided in general and for specific targets. The general grants are paid per inhabitant, while target grants are provided to finance specific activities, and sometimes for a limited period of time (The Swedish Association of Local Authorities and the Federation of Swedish County Councils 2005).

Table 5: The allocation of public net costs of healthcare

Highly specialised healthcare	6%
County care	65%
Primary care	19%
Other care	10%

Source: WHO 2005: 16

In addition, healthcare might be procured from public organisations as well as private companies. Comparably to France, Germany and the UK, only a minor part of healthcare is privately run. But private health centres and practitioners are relatively common in major Swedish cities and in urban regions. In 2002, 27% of all physician consultations in outpatient care with public funding were conducted at private facilities (Federation of Swedish County Councils 2004).

Private companies that carry out activities on behalf of the local authority, the county or the region are financed through public funds, i.e. as an outsourced department. Using the tax revenues, the private actors have to offer service equal to public service in terms and conditions, i.e. ‘the citizens pay the same for a service irrespective of whether it is provided by the public sector or by a private company’ (the author’s translation from SALAR 2005: 7).

The market for voluntary health insurance is growing in Sweden. However, it is still small in comparison with other European countries. In 2003, about 200,000 people (2% of the Swedish population) had some kind of supplementary insurance (Swedish Insurance Federation 2004). It should be noted that the number of surgical operations that are privately financed is quite low. Even in the few private hospitals, an overwhelming proportion of the activities are financed by public money, i.e. they are purchased and contracted by county councils (WHO 2005: 47).

One of the reasons behind the growing market for voluntary private health insurance is the long waiting lists for elective treatment within the county councils. The main benefit of having supplementary insurance is the possibility to get quick access to a specialist in ambulatory care when needed. Another benefit might be the chance of jumping waiting lists for elective treatment.

The private insurance company named IF has reported that they believe in a boom of private care. More and more Swedes are willing to spend money on their health. They want better and quicker access to healthcare, according to the CEO of IF Torbjörn Magnusson. More people are exercising at gyms, sign private healthcare insurance and go to the Baltic countries to get treatment. But it is still the employers and not the citizens who are urging the development because employers are concerned by absences for health reasons and sign private insurances (IF 17 Nov 2005).

7.5. *Standardisation (guidelines & protocols) and instruments for comparisons*

Within the healthcare sector the possibilities of standardisation are limited (despite TQM, medical audits, clinical guidelines, etc.) and the medical knowledge is ubiquitously in the hands of the medical professions. The Swedish system includes so far no national performance indicators for healthcare, no overall quality registers, or private information systems (Dr Foster) like in the UK or in the Netherlands.

The National Quality Register of intensive heart care and stroke care is the nearest equivalent to a national quality register concerning a national ranking of public care undertaken by the Swedish state. There are also guidelines, for example regarding diabetes (The Swedish Diabetes index 2006). Both the national quality registers and the guidelines are made public and hereby one could note distinctive differences from one hospital to another as well as differences between counties. They also point to inequalities and weaknesses in Swedish diabetes care county by county. Not one single county follows the National Board of Health and Welfare's guidelines stipulating bi-annual eye check-ups. In order to collect citizens' experience and attitudes the following initiatives have been made:

- Information to the public is given about *queues mainly to surgical treatments*. This information about queues to all Swedish hospitals and special clinics is provided by the federation of county councils and municipalities (SKL).
- A *Consumer Index* has been developed by the network of/company EuroHealth as an answer to the demand of performance indicators for Swedish healthcare. The need is

described to consider national, authorised, regular repetitive, multi-dimensional *evaluations on healthcare quality and efficiency* with the possibility to compare healthcare nationally within different counties, and internationally with other European and international performance indicators. The EuroHealth Consumer Index is a tool for ranking and comparing national healthcare systems across the EU from the consumer/ patient's viewpoint⁴.

- *The Swedish Health Care Consumer Index (VKI)* compares the 21 Swedish county councils with each other, showing to what extent consumer aspects have been taken into account in the design of publicly funded healthcare. Every county council in Sweden constitutes a regional healthcare system with extensive liberty to decide emphases, priorities and service according to its own needs and values. Accordingly, the degree of consumer adaptation says a good deal about the policy pursued.
- One continuously on-going survey is *Vårdbarometern*, which strives to collect experiences with and attitudes towards healthcare without any rankings. However, critical voices have been heard that the respondents are 'residents'/'citizens' rather than healthcare consumers. Consequently, interviewees might have limited/little experience of the healthcare provisions. The public has taken first steps towards creating an information system similar to Dr Foster. The Swedish Board (*Socialstyrelsen*) has a mission to collect and design users' information, although the consumer perspective is still missing (*Vårdkonsumentindex 2006*).

⁴ The key areas are patient rights and information, waiting times for common treatments, care outcomes, provision levels (called 'customer friendliness') and access to medication. It takes a consumer-centred position, excluding from its perspective conventional public health indicators such as the number of hospital beds and life-span expectancy. The Index is compiled from a combination of public statistics and independent research. The 2006, the Index covers all 25 EU member nations. In 2005, the project embraced a 12-nation pilot (including Belgium, Germany, Poland, Sweden, and the UK but not Austria).

Table 6: Instruments of regulation

Before the process of liberalisation	During the process of liberalisation
<p>Health and Medical Services Act including healthcare incl. prevention The Ministry of Health and Social Affairs (<i>Socialdepartementet</i>) The central advisory and supervisory agency The National Board of Health and Welfare (<i>Socialstyrelsen</i>) The Council of Technology Assessment in Health Care (SBU) Allocation based on global budgets</p>	<p>In addition: Since the 1990s new management system and organisational structures, prospective payment schemes, the purchaser-provider-model (from 1994) and increased rights for the patients. Tender procedures/ Contracting-out/ subcontractors guarantee the lowest price. Contracts based on fixed prospective per-case payments (based on diagnosis-related DRG- groups) and complemented with price or volume ceilings and quality components, i.e. Reimbursement based on performance (system of capitation) + quantitative targets/contract Yet, is still the County councils that regulate the private (and public) practitioners' market, by approving or not an establishment and their reimbursement, through contracts. Higher patient fee (the patients' relative share of the total health cost has increased) but there is a ceiling for out-of-pocket payments Regulation aiming for prioritisation of healthcare So far few voluntary, supplementary health insurance the major part of private care is publicly financed Some standardisation as medical audits, clinical guidelines e.g. national quality register of intensive heart care, stroke care, diabetes index Distinctive differences from one hospital to another as well as differences between counties Info regarding waiting lists for surgical treatments Consumer Index evaluations on quality and efficiency comparison between Swedish counties and between countries within EU. Users' information Vårdbarmetern</p>

8. CONCLUSIONS

8.1. *What are the impacts of liberalisation and privatisation on productivity, quality of service and employment?*

This section tries to summarise the description and analysis of the Swedish health sector with a focus on hospital care. Finally, the paper concludes by presenting some empirical findings and studies, where other researchers have attempted to answer the question of the impacts of liberalisation and privatisation on productivity, quality of service and employment. There is a lot of ideological disagreement concerning healthcare, such as centralisation versus decentralisation and privatisation, the role of the state professionals and the market, etc. While centralisation is at the centre of the Social Democrat vision, the centre-right wing argues for a decentralisation of responsibility and for privatisation. Another great divide concerns state employees, entrepreneurs in their own practice versus healthcare companies, driven by high risk funds on the stock

market. Considering access as one of the major problems of Swedish healthcare, a reviewed and strengthened version of the Guarantee Act came into practice in 2005 (WHO 2005). Unsatisfactory access to healthcare has also been discussed in terms of primary care centres/polyclinics versus family doctors. The Social Democrats desire primary care close to the residents (and close emergency department), while the right wing is emphasising the need for family doctors and possibilities of visiting patients in their homes.

Above all, these issues embrace the overall vision of healthcare – equity, justice or more freedom of choice?

In Sweden changes of political parties in majority in the different county councils and the Government in power, have affected the actions undertaken. The presence of different administrative levels in a decentralised model, opens up for different political parties to hold the power at municipality, county council/regional and national level including large variations among the large geographical area of Sweden.

8.2. The impact on productivity and quality of service

Healthcare as an integrated system is moreover hardly affected by circumstances in society in total, recessions in the labour market from the early 1990, and national politics on tax levels. Furthermore, as a political system, healthcare lacks the stability that follows from long term planning, and it is as an integrated societal system highly exposed to national (European and global) trends as well as insecurity in general.

- A majority of the self-governed county councils/regions and municipalities have welcomed the purchaser-provider-model since the 1990s. Accordingly, public as well as private providers are concerned by reimbursement based on performance (system of capitation) instead of allocation based on global budgets. Quantitative targets/contracts for healthcare given despite a risk of providing for ‘profitable’ care instead of for ‘necessary’ care (Panfilova 2004).
- The split between purchaser (politicians) and provider (staff and management within primary care, hospitals, homecare, etc.) is intended to create an internal market on which different actors, both private and public, can compete. In practice, it means no real competition, as healthcare is in the hands of the county councils. In Sweden, the county councils regulate the payment of both public and private healthcare providers. A private provider must have an agreement with the county council in order to be reimbursed from social insurance. Providers without an agreement have to charge their patients the full cost, which is very expensive for the patient in question (WHO 2005: 23). Furthermore, financing models, such as, for instance, the Bohus model, include a volume ceiling restricting how much care the county council will reimburse each year. All medical/care activity that is carried out above the ceiling is not reimbursed. Accordingly, the capitation system is suppressing an increase in productivity (Panfilova 2004). Consequently, the county councils regulate the new private practices, including the numbers of patients that the provider can see in a

year. Hence, there is no free entrance or exit on the market. Second, higher supply than demand does not exist and third, there are no possibilities to increase productivity at a faster pace. Fourth, because of centralised decisions it is very hard to bring about even minor changes (Panfilova 2004).

- Additionally, the existing system based on capitation is unfair, in the sense that the reimbursement does not take into account patients' social economic status, level of education or similar factors that might influence the need of medical service or their expectations. The distribution of resources is primarily done according to age, giving higher points for children and elderly persons. Hereby, the reimbursement favours healthcare areas with a healthy and prosperous population rich in children and elderly people not in need of expensive hospital care. Regarding quality, the system does not consider how well resources are used in order to cover the needs of the population (Panfilova 2004).
- A study comparing private and public primary health centres observed significant differences in favour of private providers, regarding increased productivity, enlarged range of service, reduction of costs, better access and access to the same staff because of lower turnover (Panfilova 2004). According to Panfilova, the driving forces towards private ownership were related to the obstacles of public organisation. Private clinics were better at eliminating obstructive factors at the same time as better conditions for practice were created. The main changes have occurred in absence of competition (Panfilova 2004).
- To summarise, the system of third-party financing creates major challenges either based on reimbursement by capitation or according to performed activities. In Sweden, it is argued that the finance/expenses as well as the tasks are more or less fixed. As a result, internal conflicts become tenser, and the importance of prioritising provisions and the citizens' needs are highly stressed (Rosen 2002).
- The small-scale concept (private entrepreneurial provider) is described to be beneficial in healthcare because it fosters efficiency, motivation and therefore also good profitability in the long-term perspective.
- The advocates of marketisation, deregulation, and increased competition propagate gain of efficiency that will favour the entire society, whereas those arguing against it regard it as a cause of social injustice and gaps between different classes within society.
- Competition is not necessarily more cost-efficient. Free competition of municipality activities (not healthcare) has shown to be more cost-efficient by in some studies, and more costly in others (e.g. Ohlsson's study of Swedish garbage management 2003 in Karlsson 2005).

8.3. *The impact on employment*

- The forms of labour - state employees or entrepreneurs in own practice - might influence salary, working conditions and motivation. Discussing salary and work conditions, the right-wing parties are propagating the importance of competition between employers (more private healthcare providers). They are welcoming small companies owned and run by the professionals themselves, such 'intraprenads' are seen as new possibilities to seize the creativity and empower the staff within the county councils. It might involve easier communication and decision-making because of less bureaucracy and less people concerned. In Panfilova's case a better working environment, coherency between the staff and higher flexibility were among the positive outcomes of privatisation. Panfilova (2004) does however argue that such factors are dependent on the selection, motivation and character of the staff choosing to work in private environments.
- One implication of free competition might be lower salaries for the employees. A major part of the cost structure in service provision is built on cost for salaries (Baumol 1993). Price negotiations have consequently an impact on variable costs such as salaries and compensations. Studies in the UK and in the US have focussed on free competition as a way to cut salaries, whereas the Swedish debate has concentrated on effects in terms of work conditions and job security (Karlsson 2005: 37-8).
- Other effects of free competition might be related to the gender issue, as a predominant share of public employees consists of women. The gender effects of free competition are, however so far, poorly studied within the Swedish context.
- Liberalisation and privatisation imply a power shift from publicly elected politicians and public administration officers to actors within the private sector. An effect which, in the short term at least, might weaken possibilities for the trade unions to act on behalf of the employees.
- Bös (1991) has argued that privatisation reduces inefficient production and superficial cost level, and down-sizing might be one first obvious result when introducing competition. Domberger and Jensen (1997) summarised the debate of labour market consequences by concluding that the negative side concerns salaries and a deterioration of work conditions with privatisation, while positive aspects are related to deregulation (re-regulation) estimating the effects as marginal (referred in Karlsson 2005: 8).
- The long-term effects might be unemployment, which normally is met in three ways when it is a question of outsourcing: replacement within the public authority, employment at the outsourced employer or unemployment. Empirical studies have shown that persons with a higher education are more probably employed by the outsourced unit (Domberger and Jensen 1997).

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