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The Swedish Health Care System: Recent Reforms, Problems, and Opportunities

by Ragnar Lofgren

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Executive Summary

The Swedish health care sector expanded rapidly during the 1960s and 1970s. In the 1980s, the nation experienced budget deficits and increasing problems with long line-ups. It became evident that global budgets and a lack of incentives to be efficient caused problems that needed to be addressed. Although the health care system continues to be publicly financed, the views regarding who should provide health care are shifting in favour of private caregivers. This shift started with patients outraged by poor treatment and long line-ups, as well as with hospital staff frustrated with low wages and poor working conditions. Swedish taxpayers, who pay the highest taxes in the world, were not impressed with rising health care costs and the possibility of increases in taxes to cover these costs. By the early 1990s, it was time for a major restructuring of the system. This report focuses on Greater Stockholm, where most of the restructuring initiatives have been implemented to increase accessibility, competition, and patient choice.

The patient choice and care guarantee

The public outrage over long line-ups led to the Patient Choice and Care Guarantee in 1992. With this guarantee, patients were promised treatment within three months of being diagnosed and were given the right to go to another hospital, even in another county, if they did not receive elective care at the hospital of their choice within that time frame.

At the same time, to guarantee prompt treatment for certain procedures with long waiting lists, the central government granted the county councils extra money. Between 1992 and 1993, waiting lists were reduced by 22 percent and ceased to be a political issue.

This reform laid the foundation for limited competition between hospitals. The competition centred on access to care and to a lesser degree on the perceived quality of medical care, not on price. Since there was also a need to reduce costs, more reforms were necessary.

The purchaser-provider split

Traditionally, the public health care system in Sweden provided most of the country's medical care. Global budgets, where hospitals receive a fixed sum to produce all care, were eventually deemed inefficient for containing costs, and there was a belief that competition would lead to decreased costs and increased efficiency. Of all the reforms, the requirement that hospitals get paid according to the services provided increased efficiency the most. Implemented in the early 1990s by a number of county councils, including Stockholm, it introduced competition for contracts between traditional public providers and private ones. Often the cheapest bid was accepted, and care was provided at a lower cost.

To calculate the cost, the DRG (Diagnosis Related Group) points system was used. Some 1,000 medical procedures were analyzed to determine their cost, and then a list of all the procedures and their DRG points was compiled. The compensation for the hospital was calculated on the basis of the total cost of the treatment for the hospital. The purchaser then buys a certain medical procedure, which may cost, for example, two DRG points. The hospital is then paid based on how much it costs that specific hospital to produce two DRG points. This approach means that the most efficient hospital, with lower costs and therefore lower DRG points, receives less revenue for each point. Stockholm County uses the most efficient hospital, St. George's (St. Gorans), as its benchmark and partly bases the money it gives to less

efficient hospitals on St. George's DRG points. This forces the less efficient hospitals to increase efficiency in order to get revenue that matches their costs.

St. George's was the first emergency hospital in Sweden run (since 1994) as a company, which since 1999 has been run as a publicly-traded company. It is the most efficient hospital in Greater Stockholm. The difference in efficiency between St. George's and Södertälje Hospital, an emergency hospital still run by the county council, was 19 percent in 1994 and 11 percent in 1998. These results indicate that revenue based on the specific hospital and partly based on the benchmark hospital has indeed reduced the difference and increased efficiency at the less efficient hospital.

A study by Gerdtham et al. (1997) shows that county councils with budget-based allocation save a potential 13 percent by introducing a purchaser-provider split. There are still a large number of such counties.

A study by Svalander and Lindqvist (1998) shows that St. George's is 10 to 20 percent more efficient than the hospitals run by the Stockholm County Council.

A study by Svalander et al. (1997) shows that private primary health care centres run by Praktikertjänst AB (Plc) are about 20 percent cheaper than those run by municipalities or county councils. The study also shows that salaries for doctors in the privately run centres are higher. Due to differences in administration and the use of the nurses' time, the overall cost is nevertheless lower, according to Söderström and Lundbäck (2000).

The purchaser-provider split focuses on cost and, to a lesser extent, quality. Since quality of care for the elderly has long been a problem, more reforms are needed.

The Ädel Reform

Care and after-care for the elderly has long been a problem in Sweden. In 1992, the Ädel reform was implemented. It aimed to increase the quality of care for the elderly. Since home-care of the elderly is the responsibility of the municipalities, the idea was to extend that responsibility to the care of the elderly in institutions as well. As a result, a patient ready to leave the hospital became the municipality's financial responsibility. If the municipality failed to find home care or care in a home for the elderly patient, it had to pay the expensive hospital bill. Before the reform, patients who did not need to be in the hospital occupied 20 percent of all acute care beds. One effect of the reform was to free up hospital beds, and it dramatically reduced the average number of days patients stayed in the hospital. In 1992, the average number of days was 10.1; in 1998, it was reduced to 6.6. This reduction resulted not only from the reform but also from technological advances that allowed day surgery (for example cataract operations) as well as the introduction of new drugs that reduced the need for surgery (for example ulcer medication).

There were initial problems with the reform. The municipalities often lacked the experience to take care of these patients, and they often awarded contracts to low bidding private health care providers. The quality of care was seldom part of the contract, and there were incidents of mistreated elderly patients reported in the media. Today, contracts include measurements of quality.

The prescription drug reform

During the 1990s, the cost of drugs increased rapidly. The central government implemented a prescription drug reform in 1996/97 to shift costs to the patient and the county councils. In 1996, the patient paid 21.1 percent of the total cost of prescription drugs; in 1997, that increased to 27.8 percent. A high use protection system ensures

that no patient has to pay more than 270 dollars a year for prescription drugs. In addition, the government will reimburse patients unable to pay the 270 dollars.

Since the county councils are in charge of hospital health care, the central government's reform also shifted the responsibility for the cost of drugs to the county councils. This new responsibility increases the overall understanding of the total health care cost and reduces the rapidly increasing cost of drugs. Before the reform, the cost of drugs increased by some 10 percent per year. After the reform, the increase fell to about 5 percent per year. The county councils relied increasingly on generic drugs, which explains part of the decrease in costs.

Effects of the changes: the views of patients, staff, unions, and politicians

A survey of quality of care at emergency hospitals in Greater Stockholm shows that the privately operated hospital St. George's is rated the highest among all hospitals on issues relating to information. It was rated second on accessibility, treatment, care, the physical environment, the working environment, and the overall level of the quality of care.

All the staff I interviewed at St. George's clearly prefer working for a private company rather than the county council. Gunilla Granath, a budget holder at the hospital, says,

The leadership is much clearer. It is possible to speak to the President and address problems. Before, it was almost impossible to talk to the democratically elected politicians in the county council.

She also says that the purchaser-provider split means that both she and her staff get a much clearer picture of what things cost and how much revenue different procedures generate. The bo-

nus system, now in place, also stimulates her efficiency and that of the rest of the staff. Also, today most employees are hired full-time, whereas part-time hiring was very common when the county council ran the hospital. Since many employees fought hard to work full-time, they are very pleased with the private employer.

Kevin Thompson, assistant nurse and the local chairman of the union Kommunal, also prefers working for Capiro, a private health care company that owns St. George's hospital. The company offers staff training not offered by the county council. He points out that many on the left are against private health care, but he only cares about how the health unit is run, not by whom. Even though there have been reports of private caregivers mistreating the elderly, such reports also occur in publicly operated units. As long as the county council monitors the provision of care in both private and public units and uses contracts that include quality measurements, lower costs and higher quality can be achieved with competition.

Lars-Åke Almqvist, vice chairman of Kommunal (the largest union in Scandinavia), says, "We're not afraid of private companies in the health care sector. . . . competition creates the driving forces for development."

Elisabeth Brolin, health expert at Kommunal, writes:

Our members were sceptical at first, working for a private company. Today, they say that they wouldn't want to go back to work for the county council. They feel they are close to the boss, they get answers, they have the opportunity to influence the work, and they are allowed greater responsibilities.

Eva Fernvall, head of the nurses' union, believes that "Health care should be produced in different forms and by different caregivers... This gives us the opportunity to try different methods and to

compare. Thereby we learn more about how to operate health care units, while at the same time it enables us to meet the needs of the individual patient.”

Robert Wahren from the doctors’ union writes:

It is pivotal that the union try to capture and talk about the changes necessary to better use the skills of the medical profession... All the health care unions have expressed their interest to act together and facilitate alternative ways of running health care units.

The conservative political parties are all in favour of private health care. They have been the driving force behind the efforts to make health care in Greater Stockholm more efficient. Ralph Ledel of the Conservative Party notes,

The agreement between the Stockholm County Council and the emergency hospital St. George’s is very agreeable. The purchaser was able to buy the production of health care services for 30 percent less than the County Council could it provide themselves.

The Left Party writes,

It is important for the Left Party to continue the ideological struggle against the market as well as against the privatization of health care... at the same time, our alternative cannot be a return to the old top-down bureaucracy.

The Social Democrats have been very reluctant to embrace private health care, but a number of county councils run by the Social Democrats have nevertheless opened private units in the past. At the national level there is still confusion over whether to stick to ideology or to embrace a system favoured by hospital staff and patients, who are ultimately voters.

The lesson for Canada is that private, for-profit hospitals can be a source of increased efficiency within a publicly financed health care system. Competition between different kinds of providers for contracts that include specific measures of quality produces lower cost, more responsive care delivery. Most importantly, these results are accompanied by greater staff satisfaction, to the point that health care unions prefer the private hospital model.

Introduction

According to Folkhälsorapport (2001), the level of Swedish health care is very high compared to other countries. During the 1990s, great progress was made in the areas of heart diseases, hip replacements, and cataracts. The result was an increased living standard for many elderly Swedes.

Swedes live longer than people in most other countries (SOU, 2001, p. 79 Valfärdspolitikens förutsättningar och utmaningar). Women are expected to live an average of 82.1 years and men an average of 77.5 years. Compared to 100 years ago, men live 20 years longer and women 25 years longer (Folkhälsorapport, 2001). Can this increase be attributed to the Swedish health care system? According to Bunker *et al.*, (1994), only 15 percent of the increase in average lifespan can be attributed to the effects of better medical care. More important factors include what people eat, how much alcohol they drink, how much they exercise, if they smoke, etc. Doctors play a role in educating individual patients, but when it comes to changing the attitudes and lifestyles of a whole population, doctors and hospitals play only a limited role.

Perhaps more important than how long a person lives is how healthy he or she is. Treating people and making them healthier is the primary task of the health care system. Today, technology and medicine make it possible to treat patients who would have been untreatable a decade ago. The health care system can make a huge contribution to enhancing the individual's quality of life.

As more people receive treatment and survive, one has to assume that improved general health does not automatically lead to less demand for health care. However, it does lead to an improved quality of life and reduces the risk of "premature death." People who survive illnesses that would likely have been fatal a decade ago will also likely

get other illnesses during the rest of their lives. This process will result in a paradox: the efficiency of the present health care system will lead to increased demand and higher costs in the future.

Sweden has a very old population. At the beginning of the 20th century, Sweden was a young country where over 40 percent of the population was under 25 years old. Today only 25 percent are under 25 years old. At the same time the number of people over 65 years old has increased from 8 to 17 percent. A hundred years ago, most of the public funds were spent on young people, whereas today and tomorrow more and more money will go to the elderly. There tends to be increased spending and higher taxes in countries with an aging population. (Palme *et al.* 2001).

A study in the southern Stockholm district shows that five percent of the population accounts for 46 percent of all appointments with a doctor and 41 percent of the overall health care cost (Pockettidningen R 1/2000 "Förnedrande sälja ut de sjuka till lägstbjudande" Stig Linnell). According to the study, these patients are often elderly and have a number of illnesses. Those with cancer and heart diseases form the largest group.

Taxes in Sweden are already high, and even though the number of elderly will increase in the coming years, there is little public sympathy for increased government spending and higher taxes. If revenue does not increase enough to meet the growing needs of an aging population, two possible responses remain to meet this projected increase in demand.

Greater efficiency and productivity in the health care system can make the available resources last longer and meet more demand. This paper focuses on the steps that have been taken in the past decade to increase productivity, especially in

Greater Stockholm, by introducing competition, increasing choices for patients, and increasing accessibility. These steps were initiated, not only because of budget constraints, but perhaps even more importantly because people grew increasingly disappointed with the health care system, where long line-ups were common. (One effect of improved efficiency has been shorter waiting lists, and the nation-wide project to deal with line-ups will be examined thoroughly in a separate report).

The second way of meeting an ever-increasing demand, with fairly fixed government expenditure, is to introduce private solutions. If the general public is unwilling to pay more for health care through higher taxes, but individuals are willing to pay for more services, shorter waiting lists, or services not covered by general health care, then private insurance may be one solution. In general, people have more money to spend today than they did when today's system was designed in the 1950s. They may feel that it is up to them to decide how to spend their money.

If the government is unwilling or unable to meet all the needs of an affluent aging population, the

demand for alternative solutions will increase. With better technologies and medicine, more people than ever before can be treated. There is a growing debate over whether or not a public health system should treat everyone for everything. Viagra and facelifts are two examples of luxury treatments that taxpayers are unsure about paying for.

The percentage of the population 65 years or older is lower in Canada than in Sweden, but will reach the present Swedish level within 15 years, according to Statistics Canada projections (Blomqvist, 2001). The Swedish reforms started in 1984/85, a process in which new ways of increasing efficiency, competition, and choices for patients are still being tested. If decisive steps are taken now in Canada, some of the problems that will occur over the next decades might be avoided. Because of budget constraints, increased demand and costs will not likely be met. It is therefore important to examine closely some alternatives. It is possible to produce a more efficient health care system and reduce demand by introducing user fees and allowing competition and private alternatives.

The Welfare State in Sweden

In the early 1960s, Swedish government spending was at the same level as that of most OECD countries; by 1985 it became the highest. In 1960, public spending was 31 percent of the GDP in Sweden, compared to 29 percent in Canada. By 1986, it was 64 percent in Sweden and 46 percent in Canada. Public sector spending increased from 45 percent of the GDP in 1973 to 60 percent in 1978. In 1982, it peaked at 67 percent of the GDP. The public deficit for the fiscal year 1982–83 was 15 percent of the GDP for the Swedish central government and 13 percent of the GDP for the public sector as a whole. Salaries increased rapidly, along with inflation, and constant currency devaluations were part of life in Sweden. There were devaluations in 1976, 1977, 1981, 1982, and 1992 (Blomqvist *et al.* 1993).

These figures seem to indicate that the Swedish welfare state ballooned during the 1960s through to the mid-1980s. However, one has to keep in mind that the figures are influenced by factors that make them higher than comparable figures for other countries:

- About 25 percent of government spending represents old-age pensions to retirees. A substantial part of these payments comes out of pension funds to which the retirees contributed. These contributions were implemented in the late 1950 and early 1960s.
- There are a number of transfer payments to households, such as family allowances, unemployment insurance benefits, sickness benefits, etc. To the extent that these benefits are taxable, their net burden to the taxpayer is reduced. In Sweden most transfer payments are taxable.

With these pensions and transfer payments taken into account, the Swedish figures correspond

more closely to those of other OECD countries. Health care expenditure in the mid-1980s was about nine percent of GDP; in Canada it was just under nine percent. Sweden has a large elderly population, who use more health care, so Sweden is likely to spend a lot on health care (Blomqvist *et al.*, 1993).

The role of the doctor in health care

The Swedish health care system was modernized after the Second World War. The public health care system in place today started in 1955. During the 1960s and 1970s, the system rapidly expanded. The doctors opposed a universal, tax-based system because it gave them less freedom. The doctors wanted to be self-employed or privately employed. Then in 1970, the so-called seven-crown reform was implemented. Because of this reform, most doctors became salaried public servants. Before the reform, part of their salary was based on performance.

After the reform, most private health care in Sweden disappeared. Also after the reform, it cost 7 crowns (\$1) for all patients to see a doctor. The Dagmar reform in 1984 decreased the powers of the doctors even further: they found it harder to work extra hours as private practitioners in their free time. The power to decide when and where doctors should work was transferred to the county councils, so now the doctors were in the hands of county politicians (Blomqvist and Rothstein, 2000).

The Dagmar reform also shifted power from the central government to the county councils. Clinics and hospitals had asked for money each period, and the use of global budgets (a lump sum for all hospital functions) was widespread. The hospitals revealed the annual costs of its

clinics and on the basis of those costs, they asked for money for the next year. The budgets were usually soft, and if more money was needed, it was usually given. There were no incentives to save money or to be efficient. Instead, as costs grew so did the money requested for the next year. During the 1980s, Sweden, as well as most other OECD countries, faced rising health care costs and an aging population in need of more care, at a time when technological and medical advances increased treatments and cures, thereby increasing demand for health care. At the same time, public finances did not allow the expansion to continue at the rate of previous decades.

Comparing health care costs: Sweden versus Canada

In the early 1980s, the cost of Swedish health care was about nine percent of the country's GDP. To control costs, incentives to increase productivity had to be implemented. Below is a table showing the total expenditure on health care, as a percentage of GDP, for Sweden and Canada, as well as for the US and the UK.

As table 1 shows, rapid Swedish expansion during the 1960s and 1970s was followed by reduced spending during the 1980s and 1990s. Canada, on the other hand, increased spending during the whole period.

From 1993 onward, the OECD figures reflect the Ädel reform, which transferred certain costs from the county to the municipal level. This transfer of costs is not reflected in the Statistics Sweden figures on health care spending. A new study by Socialstyrelsen, The National Board of Health and Welfare (2001), shows that the OECD figures seem to be off by 0.3 percentage points. For example, Statistics Sweden gives health care spending as a percentage of GDP as 7.7, while Socialstyrelsen estimates the real cost to be 8.4 percent. The OECD figures add one full percentage point to the Statistics Sweden figures from 1993 onward, while a more accurate adjustment would be 0.7 percentage points. To account for the adjustment made by Socialstyrelsen, the Swedish figures in the table from 1995 onwards should probably be reduced by 0.3 percentage points.

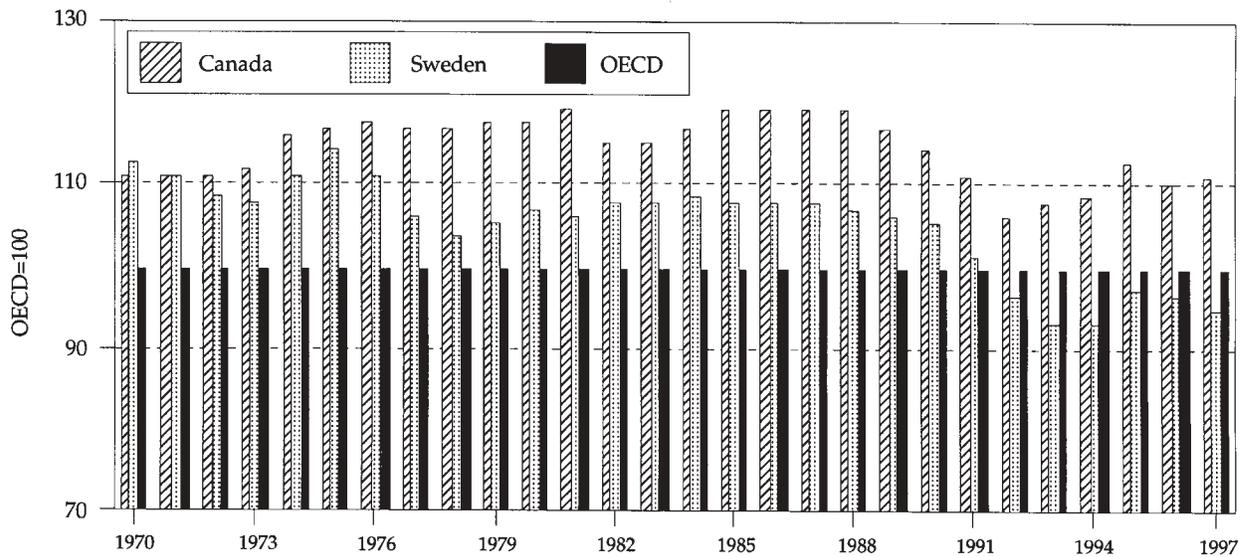
Since health care expenses are often measured as a percentage of the GDP, it is interesting to see how the GDP has increased in the two countries.

Figure 1 shows the GDP per capita using PPP (Purchasing Power Parity). Compared to Canadian purchasing power, Swedish purchasing power has deteriorated since 1970, when it was roughly on par with Canadian purchasing power. Sweden has reduced health care spending as a percentage of the GDP at a time when PPP-adjusted GDP has decreased significantly. This means that Sweden produces high-quality health care for much less money than Canada.

Table 1: Total Expenditure on Health (%GDP)

	1960	1965	1970	1975	1980	1985	1990	1995	1996	1997	1998
Canada	5.4	5.9	7.0	7.1	7.1	8.3	9.0	9.3	9.1	9.0	9.3
Sweden	4.5	5.3	6.9	7.6	9.1	8.7	8.5	8.1	8.4	8.1	7.9
United Kingdom	3.9	4.1	4.5	5.5	5.6	5.9	6.0	6.9	7.0	6.7	6.8
United States	5.1	5.6	6.9	7.8	8.7	10.0	11.9	13.2	13.2	13.0	12.9

Source: OECD Health Data, 2001.

Figure 1: GDP per Capita Indices Using Current Purchasing Power Parities

Source: OECD.

Comparing Sweden's and Canada's Health Care Acts

Both countries have similar health care acts. A comparison will be presented below with the assistance of Blomqvist (2001).

The main legal statute that governs Sweden's health care system is the 1982 Health and Medical Services Act (HMSA). While it has been amended in many ways since it was passed, the main provisions for the division of jurisdiction and therefore responsibilities between the central government and the county councils remain unchanged. A direct comparison with the five principles of the Canada Health Act (CHA)—comprehensiveness, universality, accessibility, portability, and public administration—is difficult because the terminology in the two acts is different. At first glance, it might seem that the HMSA is less precise than the CHA in several respects. For example, a Canadian critic could argue that the absence of clear language prescribing comprehensiveness and universality in the HMSA renders it a less effective instrument than the CHA for the Swedish

central government to enforce these principles in the Swedish system. However, in paragraphs two and three of the HMSA, it is stipulated that the goal of the health care system is "good health and care on equal terms for the entire population" and care "of good quality."

It can be argued that these provisions—and others that refer to the patient's right to information about their health and the available treatment, as well as their right to choose from among "scientifically accepted and proven" treatment alternatives—are at least as specific as the CHA provisions on comprehensiveness and universality. (An interesting aspect of the HMSA is that it specifies, in paragraph six, the county councils' obligation to offer transportation to those who need treatment that cannot be provided close to where they live. In this respect, the HMSA is more specific than the CHA.) Paragraph two in the HMSA also specifies that, in order to qualify as "good," health care has to be "easily accessible."

However, Sweden does not view user fees as inconsistent with "accessibility," and the county

councils are free to determine their own user fees, subject to certain limits. (Paragraph 26 specifies the “stop-loss provision” that stipulates no one will have to pay more than 900 SEK per twelve-month period in user fees for hospital and medical care, or more than 80 SEK per day for hospital care. The stop-loss provision for pharmaceutical costs is contained in a separate act but reflects the HMSA stop-loss provision: no one has to pay more than 1800 SEK per twelve-month period.

The HMSA indirectly ensures a form of “portability” by requiring each county council to provide

care to non-residents that need “immediate care” (i.e., emergencies). County councils are also allowed to negotiate agreements to provide each other’s residents with non-emergency care. Finally, no provisions in the HMSA require “public administration.” On the whole, therefore, one may argue that the only substantial (as opposed to terminological) difference between the HMSA and the CHA is that the former allows user fees up to certain levels and does not require public delivery of care. The latter provision has proved quite important in recent developments.

Swedish Ideology and Political Preferences

In Sweden, with its population of 8.9 million, health care services are predominantly (90 percent) provided by a public system. There are three political and administrative levels in the system: the national government (legislation and control), the county councils (primary and secondary care), and the local municipalities (elderly care and nursing homes). All three levels have directly elected politicians and they levy taxes to finance their activities. The Health and Medical Services Act prescribes that the county councils are responsible for the promotion of the health of their residents, and for maintaining care that is of high quality and accessible to all citizens.

The hospitals and specialist physician care are the responsibility of 20 county councils and one local authority (Gotland). In total there are 89 acute care hospitals in Sweden. A typical county council runs two to four district hospitals and a county hospital. For tertiary care there are 9 regional hospitals linked to six medical regions in the country. The county councils employ and pay all hospital staff, including doctors. The head of a hospital department (Urology, Pediatrics, etc.) is, almost without exception, a doctor

with the overall responsibility for management. This responsibility extends to medical services, as well as administration, finance, and personnel (Marianne Hanning, Federation of County Councils, personal correspondence).

In 1970, all political parties favoured a publicly financed and operated health care system. According to the Left Party, the former Communist Party (www.vansterpartiet.se), the history of health care over the past 30 years (summarized and translated by the author) is as follows:

In the 1970s, all political parties agreed that health care, schools, and daycare should be government-run, not operated by markets or driven by profits. The reason for this belief was different for each party. The Conservative Party often stated that professional competence must not be compromised by a short-sighted drive for profits. The left defended *égalité et solidarité*. Health care, schools, and daycare must be the same for everyone. Private schools and private doctors were few in number and therefore did not pose a threat to the views of the day.

Most doctors wanted to work for the government. Instead, the debate focused on how to accommodate and recruit personnel for a growing public sector, which was an increasingly important share of total employment and the economy as a whole. In Stockholm, the conservative parties [Sweden has a multi-party system which includes several parties on the conservative side] were in the majority throughout the 1970s, and even they raised taxes by 3.50 crowns per 100 crowns earned (in the 1990s, the Conservative Party became a strong proponent of lower taxes).

Privatization was not an option for the Left Party during the 1970s and 1980s. Even though the right and the left had different reasons for preferring a public system, the outcome was a majority in favour of a publicly financed and run system.

During the 1990s, there was a widespread belief that health care funding was insufficient and that money could eventually run out. Part of the problem was that an aging population increased pressure on the health care system. At the same time,

there was talk of over-capacity and hospitals were merged with other hospitals, or just shut down. In that time of crisis, ideology had to give way to reality.

One important result of the wave of privatization in the past decade has been that even those health care units that are still run by county councils and municipalities have largely embraced market-oriented organizational structures. This means that the 1990s saw increased decentralization, that is, financing based on performance and market principles, both in private and public health care (SOU 2001:79). This development is in stark contrast to the views of 30 years ago, when all parties favoured a publicly financed and operated health care system.

While the public sector expanded rapidly during much of this era, the opposite is true for the past decade. As a result of budget constraints, public distrust in the system, and especially dissatisfaction with long line-ups, all parties now see the need for change and increased efficiency.

Trends and Reforms in the 1990s

Sweden experienced a deep recession, and consequently health care budget constraints, in the early 1990s. These changes, together with the health care reforms that took place, is the main reason behind the increased efficiency in medical care delivery during that decade. The decrease in hospital staff, especially non-medical, during the 1990s increased the need for those still working to improve productivity, since demand did not decrease. The structure of the publicly owned and run hospital proved to be less than optimal. Although in the past the county councils both provided and purchased health care, the quest for increased productivity demanded alternative approaches.

The old system, still in place in many hospitals, allows for hospitals that run out of money for any number of procedures to ask the county council for more. This approach does not allow for measurements of efficiency, cost, and revenue. To make matters worse, hospitals run by county councils lack a clear leadership structure. A board of politicians that lacks the knowledge to operate a hospital decides on the hospital's everyday business. Nurses and doctors feel powerless to influence the way work is done. It is unclear what should be done, and why. When asked about workplace problems, nurses cite the lack of leadership as the biggest concern, not the heavy workload. They see how budget cuts lead to the

deteriorating quality of patient care. Politicians who know little about the actual situation in the hospital make cuts without realizing the consequences for the patients (Gunilla Granath, Budget Holder and Unit Head, St. George's Hospital, September 2001 interview).

During the 1990s, a gradual shift toward a market-driven model began. The reason for the reforms was a need to increase efficiency and the influence of the patient through more choice and increased availability of services. While preserving the system's public financing, the reforms tried to combine efficiency and the patient's freedom to choose with the equal treatment of all citizens. Whether or not these sometimes conflicting goals can be combined will be studied below.

The shift towards the market has not followed any generally applied plan, but rather a step-by-step approach in which different players have followed many paths. Because the system is so decentralized—with county councils, hospitals, clinics, and even individual doctors deciding much of what should be done to increase efficiency—an overall picture of all the changes is hard to get. The Swedish finance department's consideration of a purchaser-provider split in the late 1980s represented another step towards the market, but a decentralized one in which the individual county councils and municipalities would negotiate tenders with private and public caregivers.

The Swedish Federation of County Councils was active during this period, spreading the word about accessibility and competition, as well as introducing the principle of patient choice, which became part of a declaration at the 1989 annual Swedish Federation of County Councils meeting.

During 1991–94, the central government was formed by a coalition led by Moderata Samlingspartiet (a conservative party). The coalition took an active part in stressing the formal rights of pa-

tients and the need for more choice, i.e. private alternatives. Although it did not implement a new model for the health care system—since that is a task for the County Councils—many counties implemented reforms in line with the intentions of the central government. The main results of these reforms were:

- The separation of purchaser and provider
- Decentralized budgets and revenue based on DRG (Diagnosis Related Group) points
- Competition between private and public caregivers, and
- Increased choice for patients

All companies, public and private, bid on large public contracts according to a procedure for tenders. The LOU, *Lagen om Offentlig Upphandling* or “the public purchasing act,” regulates this procedure. Laws passed in 1992 and 1993 made it possible for county councils to allow private contractors to run county council-owned health care units.

The rest of this chapter presents the major reforms in Sweden during the 1990s, with the focus on Stockholm County. Open to ideas on competition and choices, Stockholm county has implemented the most reforms.

The patient choice and care guarantee

The lack of vision, and perhaps competence, in the publicly run hospitals led to funding shortfalls and long waiting lists that angered the public so much that the government implemented a reform aimed at increasing accessibility and freedom of choice. Before the 1990s, doctors would see their patients only when the doctors had time available, and patients would be sent to their nearest hospital, even if that hospital had year-long waiting lists. Typically, a doctor spent

only about 20 hours a week seeing patients (Werkö and Enkvist, 2000).

Traditionally, county councils have been the sole providers of public hospital care. A few private hospitals have catered to the needs of those with private health care insurance and those with money to pay for treatment, but on the whole the county councils have been both purchasers and providers of hospital care. This conflict of interest led to a lack of competition and incentives to be efficient, since the only goal of the county councils was to provide the best possible care at the lowest possible total cost. Hospitals, in turn, had no guidance for achieving this goal of the best care at the lowest cost since they operated under a global budgeting system, as has been noted above.

The Patient Choice and Care Guarantee of 1992 meant that patients were promised treatment within three months of being diagnosed. They also had the right to go to another hospital, even in another county, if they did not receive elective care at the hospital of their choice within that time frame. The reform laid the foundation for limited competition between hospitals. This competition centred on access to care and, to a lesser extent, on the perceived quality of care, not on its cost. At the same time, to guarantee prompt treatment and to discourage long waiting lists for certain medical procedures, the central government granted the county councils extra money (Hanning, 1996). Furthermore, the Guarantee of 1992 extended the boundaries within which patients could receive treatment. According to Hanning, only a small percentage of the county councils' health care budgets finance out of county patients. So far, not many people have exercised their right to be treated in another county hospital in spite of lengthy waiting lists. The reasons why people stick to their county hospitals is unclear. Perhaps they do not want to travel. Perhaps they receive adequate treatment at their county hospitals, or perhaps they are unaware of their right to choose a hospital in another county.

The logic behind the reform was to let the money follow the patient. This approach would give hospitals and doctors a strong incentive to increase efficiency in order to attract patients from outside their hospital's catchment area and avoid losing patients to other hospitals. Allowing patients to choose between hospitals removed the perverse incentive of managers and doctors to allow long waiting lists in order to justify additional funding (Harrison and Calltorp, 2000). Between early 1992 and late 1993, waiting lists were reduced by 22 percent and ceased to be a political issue (Swedish Federation of County Councils 1993). In recent years, waiting lists have again become a major problem in a number of counties, and they will likely be an important issue in the 2002 election.

Since this reform dealt only with accessibility, not cost or quality, more reforms were necessary. Competition was believed to lead to lower costs and better quality care, so eventually a reform aimed at increasing competition was implemented in several counties.

The purchaser-provider split

In the 1990s, several county councils introduced a purchaser-provider split, separating the provider from the purchaser. The purchaser (the county council) often assumed it could ask the provider (sometimes a private company) for additional procedures without compensation. Under the new system, the provider usually rejected these requests. As county councils learn to live in this new environment, they are forced to be market-driven and to increase effectiveness. Counties that have adopted the new system now understand the true cost of medical treatment and surgery. The counties that still rely on global budgets and do not follow the procedure for tenders aimed at increasing competition are less efficient in some respects.

Bruce and Jonsson (1996) have studied the effects of the new system and compared county

councils that implemented the purchaser-provider split to those that did not. They come to the conclusion that county councils that implemented the purchaser-provider split increased productivity more than the county councils that did not implement the split. The main reason for this improvement in productivity was the large number of procedures performed in health care units that base revenue on DRG (Diagnosis Related Group) points or other ways of measuring the cost of specific treatments. The units that kept the old system of global budgeting did not increase productivity as much, though they do seem to be able to contain costs better than the units that are now paid only for the procedures they perform (Jonsson, 1996; Svensson och Nordling, 1996).

Separating the purchaser from the provider was, therefore, the most important step towards competition and greater choice. It allowed private companies to compete for contracts. In the beginning, the purchaser was focused on costs, and quality was seldom an issue. As more procedures have been tendered over the years, the purchaser has become increasingly professional and today quality plays a larger role in the process.

The Quality of the Services Purchased

One way of ensuring that the quality is high when purchasing services from companies with no history of doing business with the county council is to rely on certification. The Stockholm County Council does not buy laboratory services from any provider unless they are accredited. In addition, a QUL (Quality, Development, and Leadership) system measures performance at hospitals like St. George's and Södertälje Hospital. The QUL system comes from a contest called the Swedish Quality Contest. Every year, the Swedish Federation of County Councils awards a prize to the hospital or clinic with the best leadership and organization.

One of the largest problems in the system was, and still is, the quality of treatment of elderly patients. Once they are treated and ready to leave the emergency unit, there is often no place for them to go. A separate reform was needed to deal with this issue. Ädelreformen will be presented in section 3.3. However, the introduction of competition via the purchaser-provider split helped open up new possibilities for better care and after-care for the elderly. The next section gives an example of how this chain of health care can be improved.

The Chain of Health Care

Competition and the purchaser-provider split opened up interesting opportunities to provide a "chain of health care," through which patients move without difficulty from one facility to another as their health care needs change. This easy transfer from facility to facility seldom occurred in the past. For example, the Stockholm emergency hospital, St. George's, used to treat patients and then send them to another health care unit for after-care. These often elderly patients sometimes failed to find a suitable clinic to accept them. One of the purchasers in Stockholm, the Northwestern Healthcare District (NVSO), signed a contract with St. George's Hospital on June 19, 2001 that took effect on January 1, 2002. Under the contract, the hospital is responsible for and operates the Geriatric Clinic at Löwenströmska Hospital. The contract extends to January 31, 2006.

The Geriatric Clinic will become a unit within St. George's Hospital, and all staff will be offered employment by the hospital. Åke Strandberg, Chief Executive of St. George's Hospital, says,

This assignment marks a breakthrough for St. George's. As an emergency care hospital, our ambition is to create the best possible chain of health care services . . . which focuses on the provision of local care to elderly patients, combined with a preventive-care working method and an

emphasis on co-operation with neighbouring health care facilities. This fits in extremely well with the type of health care concept that we want to develop. (*www.capio.se*)

Sonja Weiland, (the Conservative Party) chairman of the NVSO, notes,

Care of the elderly is an important part of our operations. We have now concluded a successful tender process based on several competing bids. The result is a new provider of care services, St. George's Hospital, which will now assume responsibility for part of the Northwestern Geriatric Clinic. St. George's is a highly regarded provider of health care services and will contribute both experience and professionalism. I am convinced that St. George's has all the necessary means to also provide sound care services in the geriatric area. (*www.capio.se*)

The DRG (Diagnosis Related Group) Price List

When the purchaser-provider split was introduced, the need to measure cost and revenue became evident. The county councils decided to use the DRG-points to measure productivity.

The idea for using the DRG points came from a study on how to increase efficiency. That study collected data on real cost for medical procedures at a number of hospitals. The National Board of Health and Welfare together with the Swedish Federation of County Councils are responsible for this ongoing collection of data. A list for the southeast health care region for 2001 shows some 1,000 illnesses and treatments priced according to the number of DRG points they require. The clinic or hospital gets paid for each patient according to the list.

The system is based on the cost to produce a DRG point. It measures provided care in relation to to-

tal costs for the hospital or clinic. A hospital may use two points to perform a specific surgery. In 1994, the cost per point was 15,700 crowns at St. George's Hospital and 18,700 crowns at another hospital in the Stockholm region, Södertälje Hospital. Therefore, the overall cost for Södertälje was 19 percent higher than the cost at St. George's. Södertälje Hospital has been, and continues to be, run by the Stockholm county council, whereas St. George's has been run as a company since 1993/94 and operated as a publicly traded company since 1999. Table 2, based on a study by Öhrming and Sverke (2001), shows the total cost of a DRG point for different hospitals in the Greater Stockholm region.

The largest difference in efficiency between Södertälje Hospital and St. George's occurred in 1996, when the cost per DRG point at Södertälje was 24 percent higher. In 1998, the difference was still 11 percent. Between 1994 and 1998, St. George's was the most efficient of all emergency hospitals in the Greater Stockholm region. In 1994, the cost at St. George's was 15,700 crowns per DGR point. It was 17,600 at Karolinska, 17,900 at Södersjukhuset, 18,700 at Södertälje, and 19,300 at Danderyd Hospital. By 1996, the figures were 18,900 for St. George's, 21,700 for Norrtälje Hospital, and the rest are between 22,400 and 23,700. In 1998, the trend among the other hospitals towards the productivity level of St. George's continued. The cost was 20,200 per DRG point at St. George's, 21,200 at Södersjukhuset, 22,200 at Danderyd, 22,400 at Södertälje, 22,800 at

Table 2: Total Cost per DRG Point

	1994	1996	1998
St. George's Hospital	15,700	18,900	20,200
Södertälje Hospital	18,700	23,400	22,400
Huddinge Hospital	18,600		22,800
Danderyd Hospital	19,300		22,200
Karolinska Hospital	17,600		23,500
Norrtälje Hospital		21,700	22,900
Södersjukhuset	17,900		21,200

Huddinge, 22,900 at Norrtälje, and 23,500 at Karolinska Hospital. One reason for the DRG point system is to increase efficiency at the hospitals that are less efficient than the most efficient one.

Exchanging ideas and being open to different ways of performing procedures is, therefore, essential for the survival of the less efficient. Today St. George's is about 12.5 percent cheaper than the other hospitals, which therefore reduces the value of each DRG point. In the long run, the other hospitals have to be equally efficient if they want to cover their costs, since revenue is partly based on the most efficient provider's DRG points. The result is that all efficient providers, which are usually the private ones, force the less efficient providers to become more efficient. If the less efficient hospitals can improve without decreasing quality, then society as a whole benefits.

One has to keep in mind, though, that a number of hospitals have problems increasing efficiency enough to enable them to compete with the most efficient hospital. Ultimately, the results are budget deficits for those hospitals, and the county council has to cover their deficits. It comes down, therefore, to whether the hospitals will be forced to become more efficient or whether in the future the county council will allocate more money to the less efficient hospitals. According to Johan Hjertqvist of Timbro, the Stockholm County Council no longer expects that all hospitals will be equally efficient. More money will be allocated to the less efficient ones, even though they are now—with St. George's as the benchmark and the desire of politicians for as much efficiency as possible—under pressure to become more efficient.

The Ädel reform

This reform was implemented in 1992. It aimed to increase the level and quality of care for the elderly. The government established the principles

for the care of the elderly in 1988. These principles are the right of the individual to decide, integrity, safety, and choice (prop. 1987/88:176). Since home care of the elderly is the responsibility of the municipalities, the idea of the Ädel reform was to extend that responsibility to the care of the elderly in institutions. This reform reduced hospital costs, since it shifted responsibility for geriatric nursing care from the counties to the municipalities. With this reform, the municipality became responsible for paying the hospital bill, unless it could arrange for a bed in a nursing home or provide home care for the patient within three days after the patient's discharge from the hospital. The reform solved the major problem of needing to move patients quickly from acute care to other forms of care.

Before the reform, up to 20 percent of all acute care beds were occupied by patients who did not need to be there. Some patients stayed in the acute facilities for years, even though they should have moved to other forms of care. The hospitals were sometimes unable to find space elsewhere for those patients. When the municipalities acquired their new responsibility, they had to find alternatives for the patients, and this process freed up beds at the acute care hospitals, dramatically reducing the average number of days patients stay in the acute unit (Socialstyrelsen, 1998).

One of the major problems with the reform was the transfer of elderly patients from professionally-run hospitals to municipally-operated facilities. The municipalities often lacked the knowledge to run these facilities, and reports by the media of mistreated elderly patients were common. The municipalities often relied on a procedure for tenders in which the lowest bidder was awarded the contract to run a care facility for the elderly. Very little attention was paid to quality. This lack of attention to quality resulted in part from the financial strains of the early 1990s, and in part from the lack of experience in awarding contracts. Today, professional municipal pur-

chasers often use quality as one of the criteria for choosing which tender to accept.

During the 1990s, the number of health care units run by private companies increased fourfold. In 2000, private companies operated 11 percent of Sweden's homes for the elderly and 9 percent of the home care services—visits to the elderly at home to help with the cooking, cleaning, shopping, medicine, etc.—for the elderly. The for-profit companies are the most common and have increased in number the most. Of all employees in the private health care sector, 75 percent worked for a for-profit company in 2000, an increase from 28 percent in 1993. Private companies were most common in large cities and municipalities with large percentages of well-educated citizens (Trydegård, 2001). A small number of large companies run an increasingly large part of the care for the elderly. In 1999, the four largest private care companies accounted for over half of all private care (Socialstyrelsen, 1999).

Prescription drug reform

During the 1990s, the cost of drugs increased rapidly. To reduce the public cost for medicine, the government implemented a new reform in 1997. One year later, the cost had been reduced by 1.5 billion crowns (about Can \$220 million). In 1996, the patient paid 21.1 percent of the total cost. By 1997 it had increased to 27.8 percent. The provides that in a given year, the patient pays 100 percent of the cost of prescription drugs for the first 900 crowns (about Can \$135) and a reduced percentage up to 1,800 crowns. After that, almost all prescription drugs are free for the rest of the 12-month period, particularly significant to those patients who need many prescription drugs. Those who need less have to pay 100 percent of the cost, which can lead some to avoid buying their prescription drugs. A 1997 study by Socialstyrelsen (The National Board of Health and Welfare) revealed that less than five percent of all households said they sometimes avoided

buying a drug because of its cost. No clear evidence suggested that any social group was over-represented. In most cases, the prescription drugs not purchased were for adults, whereas medicine for children was almost always purchased.

Part two of the reform is the transfer of costs from the central government to the county council. This part of the reform started January 1, 1998 and has been implemented slowly ever since. The county councils will receive 56.1 billion crowns (about 8.3 billion Canadian dollars) from the government for the years 2002 to 2004, to cover the cost of subsidized prescription drugs sold to the public, that is, that part of the cost not paid by the patients themselves. Over the past ten years, the cost of prescription drugs has increased by over ten percent annually. The government is trying to reduce this increase by delegating responsibility and shifting costs to the local county councils.

The 56.1 billion crowns the county councils will receive represent an increase of 15 percent over the three-year period. If the costs continue to increase by ten percent annually, the county councils will have to pay an ever-increasing part of the increase not covered by predetermined increases in the program's budget. The budget increase is 6.3 percent for 2002, 5.1 percent for 2003, and 4.9 percent for 2004. In 2001, the government and the county councils each paid 50 percent of any costs not covered by the budget. This percentage amounted to 250 million crowns for the county council. For the next three years, the county councils will pay 100 percent of the deficits up to 1.5 billion crowns, 75 percent of the next 1.5 billion crowns, 50 percent of the next 1.5 billion, and then 25 percent of the next 1.8 billion (www.lf.se/ia/download/lakemedel16_01.pdf).

The central government hopes this graduated "penalty" structure will provide the local county councils with an incentive to control costs.

This way of managing local budgets has been tried in Great Britain, where during the first three years cost increases diminished. This decline was due in part to prescribing generic drugs, which are cheaper. After the policy shift, increases returned to their pre-reform levels (*Läkemedel i förändring* issue 16, June 2001). The Swedish reform has so far followed the British pattern. To a great extent, prescriptions rely on generic drugs, and over the first three years cost increases diminished. A follow-up study in a couple of years will show whether or not, in the long term, the Swedish reform was more successful than the British reform in controlling costs.

Since the county councils now have a greater responsibility for covering costs, they have asked the government for better tools to control costs. The central government promised to look at three major areas in 2001: a change in the pricing system, an improved follow-up system, and an improved benefit system. But it remains unclear whether the county councils will get this promised assistance anytime soon. In a statement from September 28, 2001, the Swedish Federation of County Councils expressed doubt over the central government's commitment to passing laws aimed at increasing the follow-up procedures necessary to contain costs. The statement also mentioned that many elderly receive over 20 different prescription drugs and that no one knows if all these drugs are necessary or even safe to mix. Rules and regulations to monitor who gets which prescription drugs is essential, according to the Federation (*Regeringen bryter mot avtal om läkemedelskostnader Landstingsförbundet kräver överläggningar. www.lf.se/nyheter/nyhet.asp?id=450*).

Socialstyrelsen (The National Board of Health and Welfare) recommends that the government change the law so that local drugstores, which maintain records of an individual's drug purchases, send that information to the local county council. The information would include a per-

son's name, the drug purchased, the instructions for taking the drug, the drug's strength and price, and the date it was prescribed and purchased. The county council would then combine this information with its own data on the patient's hospital stays, treatment, etc.

Håkan Vestergren, of the Swedish Federation of County Councils, says,

This step will increase quality and follow-up. It will increase safety for the patient as well as efficiency for the health care system as a whole. Up 'til now, we have been unable to do follow-up on the individual level. Now we will be able to tie prescription drugs to diagnosis, age, geography, other treatments, number of days in hospitals, etc. Even though the information is de-identified, it is possible to follow up a certain type of medical treatment for different patient groups and compare costs and effects of different treatments for the same illness. It is also possible to account for the total costs for a group of patients throughout the whole chain, the so-called Cost per Patient (CPP). This is important in order to increase cost efficiency. (*Läkemedel i förändring* issue 16, June 2001)

So one of the potential benefits of the proposed follow-up procedure is that the county councils will know more about the overall costs of medicine and health care. After all, they pay a large part of both these costs. With the right follow-up system, they will, for example, be able to determine the overall effect of increased spending on drugs, which should reduce the number of surgeries and hospital procedures. One good example is Losec or Prilosec, a drug that helps people with ulcers. The cost of prescription drugs is up dramatically, but because of the drugs the number of surgeries performed on patients with ulcers is almost down to zero. So far, no one has been able to calculate the total cost or benefit of such drugs.

Increased user fees

Socialstyrelsen (2000c) notes that there are four reasons for user fees in Sweden:

- to reduce demand and thereby costs
- to guide the patient to the right level of care
- to increase people's understanding of health care costs
- to contribute to the financing of health care

The most important point is to try to get patients to the right health care level. The aim is to get as many as possible to the primary health care centre first. The cost of seeing the family doctor is about 120 crowns (about \$18), and the cost seeing a specialist 240 crowns.

The report also says that user fees must be applied in accordance with the health act. Among other things, the health act stipulates that care is for everyone according to need, regardless of age, sex, lifestyle, or ability to pay. Children and youth under the age of 19 are excluded from paying user fees. So how have these conflicting goals worked out during the financially strained 1990s?

During the 1990s, the government tried to reduce the cost of the health care system. One way of doing this was to increase user fees. In 1999, the cost of health care was 120 billion crowns (Statistiska Centralbyrån, 2001). User fees paid by individual patients added up to over 23 billion (Socialstyrelsen, 2000c).

Table 3 shows the percentage of the total cost for health care paid for by patients between 1993 and 2000.

These figures may not indicate a huge increase in costs, but some of the individual costs rose substantially. In 1990, seeing a doctor in a hospital or in the primary health

care sector cost 60 crowns. In 1999, seeing a GP cost on average 100 crowns, and seeing a specialist on average 200 crowns. If the cost of seeing a GP had followed inflation during the 1990s, the cost should have been 75 crowns. In 1990, patients paid only up to 75 crowns (about 12 dollars) each time they went to the pharmacy to buy prescription drugs. Ten years later, patients have to pay the first 900 crowns (about \$135) and part of the rest up to 1800 crowns (Socialstyrelsen, 2000c). It is thus very costly to buy a large number of prescription drugs today, compared to 10 years ago.

Since people have to pay part of the medicine bill, some of them will not buy prescription drugs or see a doctor because of the cost. In 1999, one in six surveyed said that they had at times, though seldom, not gone to a doctor or bought for themselves the drugs they were prescribed because of the price (Hjertqvist, 2000 HSN survey 1999). Medicine for a child, however, was almost always purchased.

One reason the government believes in user fees is that they are supposed to decrease the number of people seeing doctors and asking for drugs. All citizens are promised health care whether or not they can afford it. So, the cost of prescription drugs is covered by the state if patients cannot pay for them. It is interesting that in spite of these arrangements, some people still do not buy the drugs prescribed by their doctors. The reasons behind this reluctance may be that those eligible for financial aid find it embarrassing to seek help, or they are overwhelmed by the bureaucracy, or they lack the time and energy to actually get the money. Whatever the reasons, user fees some-

Table 3: Percentage of Total Cost for Health Care Paid by Patients, 1993-2000

Year	1993	1994	1995	1996	1997	1998	1999	2000
Percent	13	14	14	14	14	15	15	15

Source: Socialstyrelsen.

times prevent some people from getting the drugs they need.

There is also a possibility that those who do have money to buy the medicine decide not to buy it. Since they have to pay all of the first \$135 or so, they may conclude, relying on a cost-benefit analysis, that they will not benefit enough from buying the prescription drug. If this is the case, the individual has made a choice that has to be respected. Patients may also decide that the medicine may not help in that the doctor did not really understand what was wrong, and they are therefore unwilling to pay for the medicine. Whatever their reasons, people without means can still access the safety net, but the government can not force them to use it. It is possible, and likely, that even in a system offering free prescription drugs, some people may decide not to buy medicine. Nobody can be forced to buy and take medicine, but it is important in Sweden that people who want prescription drugs have access to them, regardless of their financial status.

Since some people admit that they do not buy the prescription drugs they presumably need, one might argue that user fees are unfair and should be scrapped. Socialstyrelsen (2000c) estimates that if there were no user fees in Sweden, demand would increase by 20 percent. The additional cost to the taxpayer would be roughly 3 to 4 billion (some 500 million dollars) a year. The report states that it would be hard to justify such a large increase in costs, based on the additional benefits.

High-cost Protection

The system for user fees for prescription drugs changed a number of times in the 1990s. The main result of these changes has been an increased cost for the consumer. The expenditure on drugs increased rapidly in the 1990s. As a percentage of total health care costs, it increased from 8.4 percent in 1990 to 15.7 in 1997 (Apoteket, 1999). The expense was 10.1 billion crowns (about 1.5 billion

Canadian dollars) in 1990, doubling to 20.1 six years later. Price increases are not the main reason for the increased costs. The main reason is an increase in the use of drugs, which follows from the development of new drugs, which in turn stimulates increased activity in the health care system.

Of the total cost for prescription drugs, the average Swedish patient paid 21.9 percent in 1998 and 23 percent in 1999. After paying 1,800 crowns during a 12-month period, the patient gets a "frikort," a card showing he or she is entitled to free prescription drugs for the rest of the period. In 1998, 10.6 percent of the population had such a card, in 1999 it was up to 11 percent (Socialstyrelsen, 2000). Since the report from Socialstyrelsen shows that people over the age of 65 buy the most drugs (about 5,000 crowns per person in 1999, compared to between 483 crowns and 3,758 crowns for other age groups), it is interesting to see how many senior citizens hold such a card. It turns out that 30.6 percent of men over the age of 65 had a "frikort" in 1997 and 37.4 percent in 1998, compared to 28.6 percent of the women in 1997 and 33.8 percent in 1998. This report shows that roughly 30 percent of senior citizens got free prescription drugs after paying the first 1800 crowns (Can \$270). It also shows that about 70 percent of the pensioners and 90 percent of the overall population pay less than 1,800 crowns a year for prescription drugs. Seventy-five percent of the population pays less than 1,000 crowns per year, or about \$10 a month (Socialstyrelsen, 2000c). Thus, the average person pays less for drugs than they do for coffee. This low cost may be one of the main reasons Swedes accept user fees.

The family doctor reform

The right-wing Stockholm County government implemented this reform and then the left-wing county government scrapped it in late 1994. The right-wing county government implemented it

again when it returned to power in 1998. This was the most ideological reform of all during the 1990s. Whether or not it was, or will be, successful, this reform tackles the question of how doctors should get reimbursed. It is also a reform that gives the patient freedom to choose doctors, rather than being forced to see whoever is on duty at the local primary care centre. This freedom is important to Swedes: a survey by Temo shows that 75 percent of those surveyed believe it is important to have a family doctor (TT-DN October 23, 2001).

A new reform in 1993 called “Husläkarreformen,” or the family doctor reform—together with a new law that gave doctors the right to practice wherever they wanted and a fee-for-service system—increased competition further. People in the Stockholm region received a letter in the mail, advising them to choose a family doctor for their primary health care needs. Before the reform, doctors were paid a salary, which was unaffected by the number of patients they served. The re-

form increased the number of patients attended to by each doctor, to such a great extent that the total costs of physician services rose. Rising costs as well as ideological preferences led the newly elected Social Democratic-led county government to scrap the reform when it came to power in 1994.

The longstanding struggle between the left and the right has seen the left strongly oppose family doctors and the right stressing the individual’s right to choose. After the coalition of conservative parties came into power again in Stockholm after the 1998 election, new attempts were made again to introduce a family doctor reform. As in 1993, one of the problems is the lack of doctors. The reform stipulates that each doctor should have 1,500 patients in his or her catchment area, but in reality the number is closer to 2,300, which has discouraged doctors from accepting the reform (Johan Hjertqvist, Timbro, September 2001 interview).

Private Care in Traditionally “Red” Regions: Current Developments

Private care has traditionally been out of favour in regions where the left wing holds power. However, during the 1990s, some left-wing politicians started to see the benefits of private competition, and some even implemented reforms that led to competition and choice. Below are two headlines, unthinkable only a few years ago, from Swedish newspapers.

Left-wing-governed Dalarna County just got its first primary care centre run by a private company. Another is coming soon (*Landstingsvärlden* 2001, issue 26, p. 9).

The first hospital in left-wing-governed Västmanland County run as a company is coming in the fall of 2001. Bergsslagssjukhuset in Fagersta is to become a company, according to Glenn Andersson, a Social Democrat in the local government (*Landstingsvärlden* 2001, issue 23: 14).

For the past couple of years, there has been an acute shortage in Stockholm of beds for mothers about to give birth. BB Stockholm, a birthing clinic, opened on October 2, 2001, half a year ahead of schedule. Private Praktikertjänst owns 51 percent, and the county-council-owned and -run Danderyd Hospital owns 49 percent of the clinic. BB Stockholm opened in facilities directly adjacent to the existing ones (*Aftonbladet*, October 2, 2001).

Stockholm County and the Stockholm Model

Stockholm is Sweden's largest county. Stockholm County Council oversees the whole of Stockholm County with its 1.8 million inhabitants. The County Council comprises 26 municipalities of varying sizes, from the City of Stockholm itself to rural, sparsely populated municipalities. This region is the hub of the Swedish economy. Of all 21 counties in Sweden, Stockholm has pushed the hardest for changes. Johan Hjertqvist writes:

Stockholm's health care consumers are already in a much stronger position than their fellow Swedes. The consumer focus in the capital city has developed quickly as providers decentralize, and interest in the model is increasing within and beyond Sweden's borders. (*Swedish Healthcare in Transition*, an AIMS health care commentary, August 2001)

Patient choice and availability of services have been the guiding principles behind these changes. A coalition, led by the Conservative Party from 1991 to 1994, started the revolution. Ideologically, the left-wing parties never favoured this kind of revolution. When the Social Democrats came into power in 1994, they attempted to reverse the reform process. As soon as it came into power, the new local government abandoned the family doctor reform implemented by the conservative parties. Since that reform was implemented only at the very end of the right-wing term of government, it was easy to reverse. Other changes, however, like the first privatization of an emergency hospital in Sweden and the privatization of many primary care units, proved harder to reverse.

The main result of the 1994–98 left-wing era was an ideological desire to change everything back to pre-1991 format, coupled with a political reality in which citizens no longer tolerated long

line-ups and inadequate care. A decrease in financial resources made global budgets and huge deficits less tolerable. Much remained the same, therefore, when in 1998 the conservative parties returned to power. After the 1998 fall election, the conservative parties agreed to a common platform called "Focus on Care." According to the platform the parties' goals were to "strengthen health care and its organization, prioritize patients according to the seriousness of their illnesses, offer patients more choices, and increase the influence of employees by allowing many types of employers and greater choice in the day-to-day running of the hospitals" (*www.moder-aterna.net*, as translated by the author).

The platform also contained such other important points as having a more open approach towards private caregivers and reinstating the care guarantee of January 1, 1999, which promised patients treatment within 3 months of seeing a specialist. To control deficits, the health care sector in Stockholm received increased resources to some 4 billion crowns (about Can \$600 million) between 1999 and 2001. Assets, buildings, and activities not part of the core health care mandate have been sold. It is now easier for medical staff to control the service unit they work for, especially in the areas of primary, psychiatric, and geriatric care. In many cases, hospital units run by the staff have avoided the problem of recruiting and retaining personnel, which has plagued most county council and municipality run units (Hjertqvist, 2001).

Below are some highlights (translated by the author) of the right-wing coalition's achievements during its first two years in power (1998–2000), as seen on the Conservative Party's Web site (*www.moderaterna.net*).

- Today, working under contract with the county council, private companies run 60 percent of the primary health care centres in Stockholm County. Many centres are run by nurses or midwives who took over from the county council.
- The privately operated emergency hospital, St. George's, is 10 to 15 percent cheaper to run than other hospitals in Stockholm County.
- Another example of the positive influence of competition and private players is that the number of back surgeries performed in Stockholm County in 2000 is expected to be 20 percent higher than in 1999, but the cost per surgery is expected to be 33 percent lower. The reason for this cost saving is primarily that two private companies now perform the surgeries. More procedures and reduced waiting lists lower the cost for the county council and taxpayers.
- Laboratory services are now also subject to competition, and competitive tenders have resulted in a 30 percent cut in costs, with no change in quality and quantity.

The changes and ideas in Stockholm of the past 10 years have been labelled "the Stockholm Model." More than a single reform, the Stockholm Model is based on firm economical ground, not just ideology. It introduced words like "economy," "budgets," and "results" into the calculation of a clinic's revenue and costs. Before such changes, only global costs were calculated, and there was no revenue. Simply asking the county council for money in the form of global budgets once took care of the income part of the equation. In the new approach, on the other hand, overhead costs are now shown as costs at the clinic level, which has had an impact on the doctors in charge of a clinic's budget. Once unaware of overhead costs, they now try to minimize them to achieve a balanced budget for their units.

The reform eliminated waiting lists and put the patient first. The waiting lists became shorter because of the recession, but also because there was additional health care funding to reduce the line-ups (Hanning, 2000). The "Stockholm Modellen" initiated a discussion about quality as a central goal. It also gave the clinics a chance to take care of and receive revenues from patients outside the hospital catchment area. Before the reform, patients almost always checked into the hospitals closest to where they lived.

Because the Stockholm Model was accepted by those working in the health care sector (Charpentier and Samuelsson, 1999), real changes were possible, such as those at St. George's and other emergency hospitals in the Greater Stockholm region. One major result of the Stockholm Model was that, since patients could choose hospitals, staff had to become more accommodating. If dissatisfied, patients would go to another hospital, and the hospital would lose revenue and, in the long run, jobs.

The model was flawed, however. There were built-in inconsistencies. Patients should have the freedom to choose where to seek treatment. At the same time, no emergency hospital was to be shut down because of this freedom to choose. Another flaw in the model is that, although hospitals are allowed to attract patients from outside their catchment areas, to increase the number of procedures they perform, and to get paid per patient, the total budget for health care remained fixed. An increase in efficiency and procedures meant an increase in the overall health care cost at a time when the public deficit was rapidly increasing. As a result, politicians decided in 1995 to impose a ceiling on health care spending. This decision reversed, in effect, the achievements of the Stockholm Model, and hospitals returned to a less market-based organization. Since the new system compensated hospitals for each procedure they performed, the spending limit worked against the new system to limit compensation for the

number of procedures performed once the ceiling was reached.

Today, the Stockholm Model has become more of a Stockholm Approach, in which constant effort is being made to achieve better health care. According to Johan Hjertqvist of Timbro, the Stockholm Approach

aims to combine a publicly financed system with the demands to reform production and distribution of health care. Important components are the pur-

chaser-provider split, independent hospitals, DRG-points, fee-for-service, decentralization of decisions, units operated by the staff, and a stronger position for the patient regarding rights and information. (From an interview with Johan Hjertqvist, September 2001)

Sections 6 and 7 provide details on how the changes and reforms in Stockholm led to the opening of Sweden's first privately operated primary health care unit and first privately operated emergency hospital. The opinions of those involved will follow.

Experiences from the First Privately Run Primary Care Centre in Greater Stockholm

Below is the story of the first privately run primary care centre in Sweden (summarized and translated by the author) from "Mer sjukvård for mindre pengar Nöjda patienter ger lägre kostnader" (Timbro/CVV, 2000).

In 1987, Erik Björn-Rasmussen started a primary care centre in Vällingby, a suburb of Stockholm. Paid by the county council on a per capita basis, the centre was responsible for providing primary care to the area's 13,000 inhabitants. Rasmussen believed that "if you care about the patients, the costs will be reduced" and that "availability of care must be high." At the time, most people thought that high quality and availability would increase both demand and costs. Waiting lists and waiting rooms would fill up, and a breakdown in services would result. Many other primary care units reduced availability to avoid this perceived problem.

During the centre's first year of operation, the "repeat-business" patients became known to the clinic. The staff collected as much data on these patients as they could. This information was then entered into a

computer journal. With no previous record-keeping upon which to rely, the staff found that many of these patients had undergone the same medical procedure many times before. As a result, the doctors built something the centre's founder called a dependable, personal relationship with these "repeat business" patients. This approach was new in Swedish health care. It included the data collected in the computer system and the attitude of the doctors and nurses. The founder told the staff always to treat these patients extra carefully and to respect their right to contact their doctor at any time.

The result? Instead of increasing, demand actually decreased. Patients were always admitted on the next day or days following the request for a visit, and the waiting room for acute patients was rarely full. After the introduction of better service through shorter waiting periods and pleasant attitudes of the staff towards the patients, the number of patients needing to see a doctor decreased. How was this result possible? Data shows that three percent of the 13,000 people liv-

ing in the area, constituted 30 percent of both scheduled and emergency visits to the doctor.

A study surveyed the centre's patients, including those who, every year for four years, went to the doctor at least once a year. The study revealed that patients who went to the doctor at least five times a year for the first two years changed their behaviour in the next two years. Although they still relied on this medical centre for all their primary care needs, their needs declined and so did overall demand. As the founder puts it, "For obvious reasons, we were not able to count the resources our resource-demanding patients use in the health care system as a whole. Our impression is, however, that considerable re-

sources are used to examine and treat this group." His approach resulted in better service and lower costs. Patients, as well as taxpayers, were happy, a rare combination indeed.

Today, Eric Björn-Rasmussen says that the publicly-owned health care system did not learn anything from his successful enterprise. He claims that his health centres were 35 percent cheaper than the normal county primary care providers, but the county council did not seem to care. In 1993, he closed his three primary health centres because of a new family doctor law that made it impossible to continue (Hjertqvist, 2000).

St. George's and Other Emergency Hospitals in Greater Stockholm

Greater Stockholm has seven emergency hospitals. Capio, a publicly traded company, operates St. George's. Two of the hospitals are companies owned by the county council, and a county council board of directors operates the remaining hospitals in the traditional way. Up to 1993/94, they were all operated in the traditional way by a board of county council politicians using global budgets.

Emergency hospitals are one of society's most complicated service systems. Vague procedures and a lack of clear goals exacerbate inefficiencies in this system. Prevented in part by global budgets, few tools exist to measure hospital efficiency in Sweden. During the 1990s, the financial constraints of the recession forced the development and implementation of tools to control costs. However, any steps taken to contain costs had to ensure that health care remained available to everyone at all times. At both the national and county levels, different reforms emerged, includ-

ing purchaser-provider splits and results-based approaches at both hospitals and clinics.

The road to the privatization of St. George's and other emergency hospitals

One of the most radical health care changes was the re-organization of St. George's. The county councils once owned and operated all the emergency hospitals in Stockholm. In 1994, the conservative Stockholm county government turned St. George's into a company, with the intent of selling it to a public or private company. A coalition led by the Social Democrats, in power between 1994 and 1998, meant a delay in the plan until 1999. The issue of public or private companies running hospitals for profit represents a deep ideological gulf between the left and the right. As soon as the Social Democrats assumed power in late 1994, they announced that St. George's would return to county council ownership and opera-

tion. In the end, the local government bowed to strong opposition from hospital staff and the union and allowed St. George's to remain a company. The main union, Kommunal, which always fights for justice and higher pay for its allegedly underpaid members, reacted positively to the hospital remaining a company. The union and the Social Democrats have a longstanding tradition of supporting each other, so when Kommunal so strongly favoured running the hospital as a company, the regional government gave in to the pressure.

After March 31, 1995, the county council gave the staff at St. George's the option of working somewhere else in the county council-run health care sector. That 96 percent of the employees chose to stay with the company is strong evidence that the president and the board of directors at St. George's AB (Plc) managed to create a feeling of belonging to the company and to make people feel part of the process. Only a handful returned to county council employment.

St. George's will be studied in detail because it was the first emergency hospital to be owned by the county council but operated as a company. It is also the first hospital operated by a private company. The county council still owns the actual hospital buildings, but all the equipment belongs to the hospital and the staff are employed by the hospital. The Stockholm politician Ralph Ledel says,

The agreement between Stockholm County Council and St. George's is very agreeable. The purchaser was able to buy the production of health care services for 30 percent cheaper than the county council would have been able to produce the care itself. (Hjertqvist, 2000)

The Conservative Party initiated the hospital's privatization and its change from a traditional hospital structure to a company structure with a president and a board of directors. Interestingly,

the Social Democrat local governments have in many cases also expressed an interest in trying this approach to running hospitals. St. George's has in fact been so successful that in 2000 the Stockholm County Council turned Huddinge Hospital, Danderyd Hospital, and St. Erik Eye Hospital into companies.

That the conservative parties are now in power (1998–2002) may also be a reason behind the above-mentioned hospitals being turned into, and operated as, companies. The Stockholm County Council runs the other four emergency hospitals in Greater Stockholm: Norrtälje Hospital, Karolinska Hospital, Södertälje Hospital, and Södersjukhuset (South Side Hospital). So far they operate in the traditional way, but plans may yet turn at least Karolinska Hospital and Södersjukhuset into companies.

After St. George's was sold to a private company, the central government quickly passed a temporary new law to forbid emergency hospitals from being owned or operated by private companies. The local Stockholm government is nevertheless going ahead with plans to let hospital staff and an outside party buy St. Erik Eye Hospital, arguing that it is not an emergency hospital. It has also threatened to sue the central government and take it to the European Union Court. According to Kevin Thompson of the union Kommunal, the government will have to turn the temporary law into permanent law, amend it, or decide not to implement it at all by spring 2002.

St. George's Hospital

The success story of St. George's is unique in Sweden. The only privatized hospital, it is also the most efficient in Stockholm. What is the reason for its success? This section aims to explain this.

For hospitals to be cost-efficient, Socialstyrelsen, The National Board of Health and Welfare (*Sjukvården i Sverige*, 1998), estimates that they need to have a minimum of 100,000 catchment

area residents as a patient base, but no more than 350,000 to 400,000, since such large numbers of inhabitants would lead to organizational and logistical problems. The size of St. George's, according to the report, gave it a good chance of being efficient, both before and after its merger with Sabbatsberg's Hospital.

St. George's employs about 1,100 people, which is considered mid-size by European standards and mid-size to large by North American standards, according to Kevin Thompson, the local chairman of the Kommunal union at St. George's. Thompson is an active politician in the Left Party (former Communist Party), and director of the Capiro board (the company that runs St. George's), who has worked at the hospital since 1986. Most of this, and the next, section is based on a September 2001 interview with him.

In the early 1990s, St. George's formed part of a health care unit with St. Erik Hospital and Sabbatsberg's Hospital. Back then, a board of county council politicians operated it, and St. George's ran frequent deficits. An excess capacity in the region's emergency health care hospitals led to the decision to close either Sabbatsberg's Hospital or St. George's Hospital. The union Kommunal was obviously against the closure of St. George's.

Eventually, Sabbatsberg was closed in the summer of 1993, and the 1,400 employees from the two hospitals had to compete for the 1,100 jobs at the surviving hospital, St. George's. Due to the hospital closure, the number of people who would turn primarily to St. George's increased from 150,000 to 300,000, much of the population of downtown Stockholm. During St. George's first year as a company, its number of patients increased by 35 percent, while the number of hours worked only increased by 10 percent (St. George's Annual Report 1994). The hospital reflected an obviously unique situation. The huge

increase in the number of patients in 1994 coincided with the re-organization of the hospital into a company with a market orientation.

In 1993, the conservative local government had started the process of transforming the hospital into a company. At the time, the opposition (the Social Democrats) agreed to the hospital's transformation into a company but strongly opposed turning the hospital into a shareholder-owned company. An American-French company negotiated with the county council about acquiring 50 percent of the hospital. The union talked to unions in England and France where the company also ran hospitals. These unions had had negative experiences with the company. The company eventually pulled out and the county council ended up becoming the owner of St. George's AB (Plc) instead.

Later, a coalition led by the Social Democrats ran Stockholm County. Its intention was to put the hospital back in the hands of the county council politicians. The staff and unions said no to the proposition for two main reasons. First, the staff was so exhausted from the previous change that they had no desire for another disruption. The second major reason was that the staff felt the new hospital organization worked better than the previous one. Employed by a company with better management, they had acquired more influence over their work environment.

At the time, there was a 2.4 billion crown deficit that the county council had to address, and the staff at St. George's felt safest working for a company rather than for the county council politicians. St. George's staff feared that the politicians might close the hospital to reduce the deficit. Their jobs with the independent company, on the other hand, were secure as long as they produced efficient health care in terms of both quality and quantity.

In October of 1993, a president was appointed for St. George's. At the same time, studies and surveys were undertaken to analyze the effectiveness of the hospital's workflows. These initiatives gave the staff a feeling of being part of shaping the "new" hospital's future. One of the changes occurred in the orthopaedic clinic.

This change concerned the method of making rounds. Under the old system, all doctors in each ward went to all beds, together with a nurse, a physiotherapist, and an occupational therapist. Usually only the doctor and the nurse spoke, and often the patient was not involved in the conversation. Under the new system, the doctor alone saw the patient, after discussing the case with the nurse. As a result, the doctor could start seeing patients 30 to 45 minutes earlier each day. This new routine involved 15 to 20 doctors, each meeting one patient every 10 to 15 minutes. The result was very clear: increased efficiency with new patients starting their treatment sooner and spending less time in the waiting room (Öhrming and Sverke, 2000).

Mr. Thompson continues:

In 1994, St. George's became St. George's AB (Plc), opening up the possibility of measuring costs and revenue both hospital-wide as well as at a clinical level. Starting in 1994, the hospital was to be run like any other company, and the county council owner instructed the president not to incur losses.

Back in power in 1998, the conservative parties started to privatize the company. Still funded by taxes, the hospital would now be run by a private provider. When the private company Capio showed interest in running the hospital, the union was naturally suspicious. The county council employed union members under a contract called "Allmänna Bestämmelser" or General Rules. The private companies, on the other hand, have a union contract

called "Privatvårdens avtal" or Private Care Agreement," which stipulates shorter vacations, lower wages, etc.

The union tried to convince Capio to use the more generous agreement, arguing that staff would be very unhappy with lower salaries, etc. With a shortage of medical personnel, the union argued, many would leave the hospital, making it hard to find new employees. Capio agreed and the employees kept the old contract. In 1999, Capio bought the company, including everything except the hospital buildings, which remain county-owned.

Since becoming a company in 1994, the hospital has shown a profit every year, except 1999. That year they showed a loss of 30 million crowns (about 4.5 million Canadian dollars). In that year, county council politicians, who spend little time on the everyday business of operating a hospital, ran the hospital while it was in the process of being sold.

Some researchers have described what happened to the hospital in the 1990s as a period of redefining 1) the organizational structure of health care, 2) the way doctors, nurses and other staff work, and 3) the work-identity of certain groups. (Jacobsson, 1993; Sahlin-Andersson, 1994). According to Jacobsson, the caregivers started in the 1990s to see themselves, their jobs, and the organization in a fundamentally different way, and as a result changes occurred faster than ever before.

St. George's: Strategies and Goals

Before the reforms, most hospitals had no clear goals other than to provide health care, whenever needed, to everyone. The new president of St. George's, together with its staff, set out to define new goals more specific than the old, usual ones. The goals for 1995 included generating a profit of 22 million crowns, reaching 75 percent of the population in central and western Stockholm, in-

creasing client satisfaction, and reducing waiting times for the ER.

Most of these goals could be measured, an unusual step for Swedish hospitals. The board also identified 10 key areas for special attention, including employee productivity, waiting times for ER patients, and patient satisfaction with service. In this way the board managed to combine economic and medical goals, to define clear goals for the hospital and its departments, and to focus on the running of the ER. Often for the first time, the heads of the clinical departments felt connected to the hospital organization and supported the hospital's strategies and goals as more important than the goals of their own units. The new order came as a shock, or at least as a surprise, to many of the staff. One director says,

Well, one could say that we never had any goals for budgets or results. I have never, during my many years as a clinic director, discussed with the director of the hospital what my clinic should contribute to the hospital as a whole. This is the first time specific goals are set up. Once we were told to give the best possible care, for as little money as possible, and everybody was happy. Now they are calculating costs and revenue to formulate goals for each clinic, which is nonsense. So there's a clear difference. (Öhrming and Sverke, 2001, p. 70, as translated by the author)

This quotation clearly shows how hard it is to change the way the hospital works. Medical staff have been through a great number of changes, and many are tired of having to adopt yet another change. Given the staff's sense of exhaustion, it must be considered a success that the hospital implemented fundamental changes with the staff's involvement so that, all things considered, staff feel happier working for the hospital than they did working for the county council.

Emergency Care

St. George's activity plan for 1995 stated that the hospital should be an emergency hospital for the adult population in central Stockholm. It would focus on the needs of patients, patients' relatives, referring doctors, and purchasing boards. Never before was the ER considered worthy of this kind of attention. One doctor describes the way patients used to be treated:

I remember working at another hospital. The district doctors complained that the service quality in the ER was too high and that patients went to the ER instead of going to their primary health care doctor. The result was that we reduced staff to decrease the level of service. When I started out as a doctor there was talk about replacing the hard beds in the ER. But it was decided that the beds should remain uncomfortable because ER is supposed to be an unpleasant place to be in. One should go there only when absolutely necessary. That's the attitude I have encountered throughout my career. (Öhrming and Sverke, 2001, p. 71, as translated by the author)

Studies of St. George's show that 90 percent of the patients coming to the medicine clinic, 70 percent of those coming to the surgical clinic, and 40 percent of those coming to the orthopaedic clinic came through the ER. More skilled doctors and nurses in the ER, and more staff working during peak periods (i.e. evenings and weekends) would result in higher service quality for patients. The hospital increased the number of nurses from 57 to 75 and the number of doctors from 4 to 12 during the daytime, and it increased the doctors from 3 to 6 during the night. In this way patients get better service and, instead of remaining idle during evenings and weekends, x-ray equipment, operating theatres, etc. can be used more efficiently.

Capio: The Largest Private Health Care Company in Sweden

Since Capio is the largest private health care company in Sweden, it may be of interest to learn who they are and how they operate. St. George's is run by Capio, a private company that has been on the Swedish Stock Exchange since October 2000. Major Swedish institutions—which means the banks, the insurance companies, and the general public pension fund “6th AP fonden”—own a large part of the company. The company's goal is to have a return of about 7 percent. The company is not aiming for higher profits because to maintain quality and reserve money to invest, it believes 5 to 7 percent is a viable long-term return. Kevin Thompson, a member of the Capio board of directors, says,

It is important to realize that the health care business does not yield high, fast profits. It is rather a process of a long-term business with steady incomes. Unless the provider understands this, there will be a conflict between quality, the demands of the patients and the county and municipality councils, and the shareholders

(Kevin Thompson, October 2001, personal communication).

The following is a statement from their Web site, *www.capio.se*, as translated by the author:

We offer both in-patient and out-patient care, as well as occupational care. To offer efficient care methods, we have procured expert knowledge in several different areas. By uniting the different areas, we have developed new work methods that respond to individual needs and expectations more effectively. We want to build strong relationships with our patients and customers. It is also of great importance that our colleagues within the publicly-operated health care system regard our care methods favourably and that these methods attract competent personnel to Capio. Capio's hospitals and other units have agreements with public authorities. These agreements mean that all patients are welcome and are given care on equal terms. Our patient fees are the same as those in public health care.

The Views of Patients, Staff, Unions, and Politicians Regarding Recent Changes

Since Swedes, especially supporters of the left, have long been very suspicious of private alternatives, fearing that such alternatives would produce inferior health care services, it is of interest to look closely at the changes to determine how they have affected people. The changes have had a fundamental impact on many people, from nurses, doctors and patients to union leaders and politicians. In this section, I have gathered views from all these groups. This chapter looks at views on health care in general and St. George's Hospital in particular.

Patient and hospital staff surveys

St. George's has proven to be an efficient hospital with excellent quality of care, according to both patients and hospital staff and according to surveys taken in 2001 (Filip Patient, och personalnöjdhet, 2001).

The survey on quality of care was conducted in the spring of 2001. 2,137 patients received the survey, and 1,267 filled it out. This was the third sur-

vey, first used in 1998, conducted at the hospital. Researchers at Uppsala University developed this survey, called the Pyramid Survey, in co-operation with Örebro Regional Hospital. It is based on the QWC (Quality-Work-Competence) method and looks at ten quality criteria. Based on the survey results, each hospital department receives a plan on how to improve quality in the areas in which it received the lowest scores. So far, 60,000 patients have responded to the Pyramid Survey. Survey results get compared with earlier surveys, as well as with surveys from four other hospitals (Norrtälje Hospital, Länsjukhuset in Halmstad, Lindsbergs Lasarett, and Thoraxkliniken at Karolinska Sjukhuset).

St. George's rated the highest among all the hospitals on the criteria of Illness Information and Routines Information. It rated second on Accessibility, Treatment, Care, Physical Environment, Working Environment, and Overall Grading of the quality of care at the specific time of the survey. St. George's placed in the middle on how patients felt hospital staff greeted them and how involved they felt during discussions of their illness and the available treatments.

The patients answered 50 questions in 10 different categories in which improvements could be made. The aim is to measure how patients perceive the quality of care in all clinics at St. George's. The survey results will then lead to attempts to increase service quality in the hospital areas where improvements are needed most.

Compared to the 1999 survey, the 2001 survey measured improvements in the following areas: Information-routines, Accessibility, Physical Environment, and Overall Grade. No other changes occurred in the results between the 1999 and 2001 surveys. Interestingly, 49 percent of the respondents were completely satisfied with the amount of time they had to wait before treatment. The surveyors also asked medical staff some of the questions in the patient survey, with the result that, in all categories, the medical staff underestimated patient satisfaction. For example, 90 percent of the patients were happy with the care they received, whereas the medical staff thought only 70 percent were satisfied.

The personnel survey, also developed at Uppsala University, was conducted in the spring of 2001. The results are listed in table 4.

Table 4: Quality-of-care Survey, 1998 and 2001

	Benchmark (%)	Result, 1998 (%)	Result, 2001 (%)	Improvement
Psychological energy	>70	76	78	yes
Social climate	>70	67	78	yes
Workload	35-40	43	36	yes
Feedback	>65	54	58	yes
Participation	>80	66	73	yes
Learning on the job	>70	66	72	yes
Goal-Quality (Målkvalitet)	>70	62	61	
Leadership	>70	62	67	yes
Efficiency	>65	64	68	yes
Co-workers	>85	79	78	
Work-related exhaustion	<30	46	40	yes
Competence	>80	76	84	yes
Internal communication	>80	76	81	yes

Eleven out of the 13 categories show improvement over the last survey. The overall results show that the 819 employees who responded to the survey are satisfied with their work.

To get a better understanding of how individuals working at the hospital feel about the changes, the next section focuses on the views of 1) a budget-holder who is also the head of a hospital unit, 2) an assistant nurse, who is also the local chairman of the union *Kommunal* at St. George's, and 3) assistant nurse Inger Sandström. The intention is to get a personal perspective on working at St. George's Hospital. These personal responses will complement the more general survey results.

The changing views of medical staff at St. George's

After the changes at St. George's Hospital, its doctors and nurses, rather than feeling helpless in a huge organization, saw themselves as leaders, competitors, and co-workers in a specific, results-oriented unit.

Gunilla Granath, a budget holder at the hospital, says that the leadership is much clearer today. It is possible to speak to the President about problems. Before the changes it was almost impossible to talk to the democratically elected politicians in the county council. She also says that the purchaser-provider split means that now both she and her staff get a much clearer picture of what things cost and how much revenue different procedures generate. The bonus system, now in place, also stimulates her and the rest of the staff to become more efficient. In the old days, global budgets made it impossible to determine how much things actually cost, and of course there was no revenue to consider. Today, most employees are hired on a full-time basis, whereas part-time work was very common when the county council ran the hospital. Since many fought hard to become full-time employees, they are

very pleased with the private employer.
(From a September 2001 interview)

Kevin Thompson, an assistant nurse and the local chairman of the union *Kommunal*, also prefers working for *Capio* over working for the county council. As the local chairman of *Kommunal*, he points out that when people talk about private health care they must distinguish between private-private and public-private. He says that 90 percent of Swedish health care is financed and delivered by the public system, since the public pay taxes and elect the politicians who run the health care units. Only about nine percent of Swedish health care is financed by the public, but run by a private company. The remaining one percent is financed and delivered privately. The 100,000 Swedes with their own private health insurance—almost always provided to high-level executives by their companies—account for that one percent.

Kevin Thompson sees one major problem with private caregivers. Since the purchaser-provider split was introduced in the early 1990s, the Swedish economy has performed dismally. The purchasers, especially the municipal politicians, have at times chosen private providers solely on the basis of the cost of the contracts. Private providers that underbid others by offering health care for the elderly at a very low cost often sacrificed quality to quantity. Since revenue is relatively fixed under the tender and subsequent contract, only costs can be lowered in order to provide less expensive care. Rent is also relatively fixed, so wages are the only variable that can be easily changed. Some private caregivers to the elderly have reduced their staff or work hours, resulting in a few cases of mistreatment of elderly patients. A number of companies have tried to make a quick buck by mistreating the elderly, which has outraged the public.

This mistreatment is likely the number one reason for the debate on profit versus quality of care. Thompson points out that, "it is not who is run-

ning the unit, but how. Several publicly owned units have patients that are being mistreated and personnel who are overworked and unable to influence their work situation." He says that he has to defend his employer to members of his union who are ideologically trapped in old values and times. He finds it irritating that certain people are automatically against private caregivers, not recognizing that some of them are superior employers and that returning to county council employment would not benefit them as members of the union.

He also has strong views on the efficiency of St. George's. Since the hospital is about 12 percent cheaper than the other emergency hospitals, Thompson feels that the company should increase the salaries of the employees, since they are the main reason for the hospital's efficiency.

In an article in the daily newspaper *Dagens Nyheter* ("Skillnaderna blev inte så stora," October 28, 2001) assistant nurse Inger Sandström said she felt strange, a little frightened and, politically, entirely wrong. Now, two years later, she and her colleagues feel that things are not that different from before. There are, however, some differences. Many employees have bought stock options in the company they work for. Monthly budget reports provide a clear financial picture, and staff no longer waste supplies. Before the hospital was privatized, Inger Sandström says, better, more expensive gloves were wasted on simple tasks that did not require them. Now they use cheaper ones. Perhaps such savings will help create a budget surplus to pay for a staff conference. "I see this as a chance to influence how to perform the job," Ms. Sandström says. "I am a part of the chain. This is something assistant nurses are not used to. Now there is a kickoff each fall and a Christmas dinner, which didn't exist when the county council ran the hospital."

A common argument is that health care in private hands is not directly affected by the people,

through the politicians. As an employee and former active union member, Inger Sandström sees another side:

Well, now we are closer to the bosses. I can, if necessary, walk up to the boss and pull his tie and tell him what is wrong. With the county council it was different. How could we affect decisions made in a political way? That was very hard. As a citizen I still feel hesitant towards privatization. This is hard for me. It feels odd to say that it has been a success, working for a company. I still object to the basic idea of private companies running health care.

It seems evident that the ideology shared by many Swedes regarding a strong society is undergoing a structural change. Private health care companies were once viewed as unnecessary, if not evil, but now a growing number of people have first-hand experience working for private caregivers. The people interviewed for this paper all prefer the new employer to the old county council employer, yet they continue to stress the importance of treating people rather than making a profit. Some seem embarrassed to praise the private company they work for, and after praising it, nearly all of them stated that at heart they still believe in a just society in which people do not think of profits. It seems that little by little Swedes have come to accept and appreciate private caregivers, and that quality health care and lower costs are compatible if the right tools are used to increase efficiency. This efficiency can lead to better service for patients and lower taxes for taxpayers.

The views of the three leading unions

A sign of the times is that the three leading representatives of the union (for doctors, nurses, and other medical and non-medical staff) share the views of the Confederation of Swedish Enterprise regarding competition in the health care sector. They agree that the private sector offers a more

stimulating work environment, in which their members enjoy a high degree of participation in both daily work and the decision-making process. In the public sector, this is rare (Erixon, 2000).

The largest union in Scandinavia, Kommunal has 600,000 members, 80 percent of whom are women; most of its members work in the health care sector. One of the main reasons Sweden has been able to provide health care at a relatively low cost is that these union members do not enjoy high salaries and benefits. They include cleaning staff and ambulance drivers, with less medical education than the nurses. They work in hospitals and for municipalities, taking care of the elderly.

Kommunal has discovered that their members who work for private caregivers enjoy good working conditions. For example, they can further their education and take part in making decisions, opportunities never offered to them when the county council employed them. In addition, their managers are nearby and available.

Lars-Åke Almqvist, vice chairman of Kommunal, says, "We are not afraid of private companies in the health care sector... Competition creates the driving forces for development."

Elisabeth Brolin, a health expert at Kommunal, writes:

Our members were sceptical at first about working for a private company. Today, they say that they wouldn't want to go back to work for the county council. They feel that they are close to the boss, they get answers, they have the opportunity to influence the work, and they are allowed greater responsibilities."

She adds that the union believes that politicians cannot give up their democratic responsibilities just because a private company operates a hospital unit. Health care should be publicly financed and ac-

cessible to all according to need, important principles that can never be changed (e-mail to the author, summarized and translated by the author).

Below is an e-mail statement to the author from Eva Fernvall, head of the nurses' union:

The nurses' union believes that health care should be delivered in different forms and by different caregivers, but the union dismisses care in which the primary motive is profit. The main objective should be that stated in the Swedish Health Care Act: "good health care for all, and all treated equally." A publicly financed health care system, not private insurance, is the best way to achieve this objective. However, a good, public health care system, financed by all, demands different care providers and more tax-financed private alternatives. Different methods of health care delivery provide opportunities to compare. By comparing, we learn more about operating health care units and how best to meet the needs of individual patients. When patients have the opportunity to choose from among several forms of care, their role within the health care system strengthens. Ms. Fernvall adds that there are too few choices in the health care sector. Public health care must consider profits, she believes, to increase quality of care for patients. Attracting more capital to health care is also important. It is, however, extremely important that no new monopoly emerges from the few large private caregivers in the health care sector.

The doctors' union, Läkareförbundet, has been working since the 1990s on ideas to increase competition and choice. According to an e-mail to the author from Robert Wahren at Sveriges Läkareförbund, the union played a part in the restructuring of health care in the 1990s. In 1991, the union presented two papers. The one entitled *A New Primary Health Care* discusses the implementation of a new system of family doctors. That paper laid the foundation for the family doctor

reform implemented by the conservative coalition in Stockholm in the early 1990s. The second paper describes how a purchaser-provider split can help facilitate the entry of private players into the health care market. Finally, for the past few years, the union has been involved in a project called “Mångfaldsprojektet” or “the multiple choices project.” aimed at increasing the number of health care providers. Below is an excerpt from the project plan, translated by the author:

Surprisingly little of the discussion on the management and organization of health care addresses the core: the daily work to ensure the sick are taken care of in the best possible way. Stress and sick leaves among doctors and nurses are increasing. Doctors and nurses increasingly move abroad, while others take early retirement. The reason behind these developments is almost always a strong dissatisfaction with the management and organization of health care. The huge dissatisfaction with decreasing real wages in the past 20 years is another factor.

Against this background, it is crucial that the union try to identify the necessary changes for making better use of the medical profession’s skills. SACO, the other health care related unions, and the nurses’ union have expressed an interest in acting together to explore alternative ways of delivering health care.

Introducing more choice in health care requires more than merely overcoming obstacles to private alternatives. Even the hospitals run by county councils would benefit from diversity, the decentralization of responsibility and authority, and local organizational solutions. The union should work for diversity that leads to more private alternatives but also for more diversity within the county council-run units. It is only when we have more employers and alternative ways of delivering health care that our [union] members can forcefully demand more power

and authority to take charge over their own workplaces.

This author finds it interesting that all unions—whether they represent doctors, nurses, or non-medical staff—all agree that private alternatives are essential. From interviewing a number of people in the health care sector, I get the impression that many good ideas from staff are ignored and that staff feel powerless in the old system. Both the doctors’ and nurses’ unions, while actively stressing the importance of diversity and competition, encourage their members to take over county council and municipality-operated health care facilities. When nurses and doctors take over their health care facilities and implement their good ideas, patients will notice the improvement in the level of service and the quality of care. Privatization is, however, unevenly spread throughout the country, since the largest cities have most of the new private health care facilities. Most hospitals and primary care centres remain in the hands of the municipalities and county councils.

The views of the politicians

Budget conscious politicians likely favour increased freedom, availability, competition, and productivity, as well as a focus on the patients’ welfare, all of which make for happy voters. Even politicians with the opposing ideological disposition do little, when in power, to reverse these privatization trends. For insight into the rhetoric of the opposing sides, I have translated and summarized some comments from Moderaterna (the Conservative Party), from Vänsterpartiet (the Left Party, formerly known as the Communist Party), and from Socialdemokraterna (the Social Democrats). The following is a translation by the author of a statement by the county council in Stockholm:

The conservative parties run Stockholm county council. Starting with the principles of the Health Act, the Public Pur-

chaser Act, the Municipality Law, and the Svea Rikes Law (the Swedish Law), the conservative leadership works with the questions and ideas for which voters gave us a mandate. The conservative health care politics conducted by the Stockholm County Council is a threat to the central government, since the differences between the political ideas are clear. While we work for universal health care, financed by all and for all, as well as health guarantees, greater choice, freedom to choose, clear roles, and better leadership, the central government supports policies that lead to longer line-ups and fewer alternatives. We work with fresh ideas, while the county councils run by the Social Democrats are the models for future central government health care policies. (*www.sll.se*)

At the other end of the spectrum stands the Left Party. At *www.vansterpartiet.se* there is an article, translated here by the author, entitled "Health Care as a Market: How Should the Left React?" Starting with the term comrades, the left-wing party clearly shows that it was once called the Communist Party.

During the 1970s, all parties agreed on the principle that health care and schools should be run by the public, i.e. by politicians. "Today the buzzwords are buy-sell (or purchaser-provider split), competition, run by companies, and privatization. This trend in buzzwords started in the 1980s, during which neo-liberal economists, as well as politicians like Ronald Reagan and Margaret Thatcher, inspired the public debate." The overall message was that high taxes reduce growth, which according to the left-wing party was against the prevailing view. "A very important role in the right-wing ideological offensive was played by think tanks like Timbro and SNS, which held seminars and lectures and wrote papers, often of very high quality. The right wing thereby led the ideological debate." Lowered taxes

and cutbacks in the public sector led to increased waiting lists, and it became hard to recruit health care personnel, which was in line with the right wing's goals, since this made it easier to demand alternatives.

Turning the emergency hospital St. George's into a company diminished the role of the politicians, and the goal of a company is to yield a dividend to its shareholders. Its board of directors has to look at the economy before anything else, and this approach will create a conflict at odds with providing good health care to people in great need.

Strangely enough, the staff and union said that being employed by a company rather than the county council was an advantage. The chances of being represented by the board of directors were better than they were in the multi-layered, hard to penetrate, county council bureaucracy. It is important for the Left Party to continue the ideological struggle against the market as well as against the privatization of health care. At the same time, going back to the old top-down bureaucracy is not an alternative.

Of all the parties, one would assume that the Left Party would be the least in favour of private solutions. Even though, ideologically, it strongly opposes profit and private enterprise, the political reality seems to be pulling it in the other direction. It seems to me that the Left Party realizes that the old system did not work and that many people in the health care sector actually prefer working for a private company and favour taking over the health care facility from the county council in the tender process. Since people such as the health care workers form the basis of any left-wing party, the Left Party seems to realize that it cannot hold on to ideology if it is also to hold on to its members.

It only makes sense that, as the world has evolved, politics has changed since Karl Marx'

era. Today, Swedes have more education, own company shares, go on holidays, work eight hours a day or less, and have a lot of spare time. They have ideas and are not satisfied to remain silent. Many want to make an impact. Since the Left Party comes from an era when workers were dispensable, had little or no education, and little opportunity to make their voices heard, it is in my opinion that what worked 100 years ago cannot work today. Ideology has to give way to reality. Even if the politicians dislike the changing times, they cannot ignore them. Ultimately, the voters will decide which parties will survive as time passes and society changes.

This last piece, summarized and translated by the author, is from the major daily newspaper *Dagens Nyheter* (September 30, 2001):

When the wave of privatization started in the 1980s, the Social Democrats stood on the sidelines. They stubbornly said no to everything and had to retreat during the 1980s. Today, the working-class movement still lacks a strategy regarding future welfare. In late May of 2001, the union Kommunal presented a report called *Solidarity and Freedom to Choose in the Welfare State*. Angry with the union for presenting this report, the Prime Minister said it was doing the right wing a favour and conspiring with the enemy. The union felt forced to withdraw the report.

Words and phrases like “profit,” “freedom to choose,” and “private companies” are very controversial when the subject is the welfare state. According to Lars-Åke Almqvist, vice-chairman of Kommunal [the union for many poorly paid women in the public service], the reason for the controversy is the lack of left-wing debate on the future of the welfare state. All parties agree that the welfare state should be financed by taxes and its benefits available to all. No party, not even the Conservative Party, wants the rich to access better health care or schools than those without

means.

For the election in the fall of 2002, the Social Democrats have created a slogan: “This election is about a welfare state for all or for the rich only.” The Conservative Party and several union leaders find this slogan dishonest. During its party congress, the Social Democrat’s wrote that the welfare state should not depend on the stock market and speculation. The vice-president of the largest union, Kommunal, said: “No party or person wants this. The Social Democrats are trying to create a battle with a non-existent opponent. If they want to pick a fight, don’t fight profitable companies.”

The question is how to use the available resources. The county councils have failed to provide efficient health care. Health care is all about organization, not more money. If the welfare state is unable to deliver what the people paying for it expect, they will buy what they want in the marketplace. As long as a small elite do this, there is no political danger, but the day the middle class finds it politically acceptable, then solidarity and the welfare state will be destroyed, and fast. That day, when money can buy health care, workers and presidents will never meet in the same ward, Lars-Åke Almqvist says.

Today Skandia sells insurance that allows people to jump the queue or get treatment in private clinics if they ever need surgery. It is St. George’s Hospital, Sophiahemmet, and Ersta hospital that sell excess capacity to the insurance company. A staff member at Skandia said, “We live off the mistakes of the county council.

The last word in the current debate belongs to those who actually work for private caregivers and experience firsthand the benefits of competition and a more flexible work environment. The unions seem to have listened to their members and have embraced the private caregivers. Even

some local left-wing politicians seem to recognize the advantages of private alternatives. Die-hard ideology still rules the hearts of many leftwing politicians at the national level. Since the movement towards private alternatives started

at a grassroots level, even the politicians at the national level will eventually listen to what the staff and patients in the private health care sector have to say, since ultimately they are voters.

Are Private Caregivers More Efficient? Results from Various Studies

Measuring how well private caregivers perform compared to publicly-owned and -run health care facilities seems complicated. Equally complicated is measuring the impact of competition on both public and private players. A number of studies will nevertheless be presented below. First, however, comes a short explanation of the size and structure of the private health care sector.

Of the total amount spent on health care, Sweden spends 5 to 10 percent on private providers. The private caregivers are found mostly in the primary health care sector. Private care in Sweden usually means care centres run by a private company that are nevertheless publicly funded (Social- och Hälsovårdsnytt i Norden, no 1, 1999. www.shn.dk/1-99/artiklar/8.html). In the traditional top-down system, medical staff often feel unable to influence what they do and when. Their frustration resulted in some primary health care centres being privatized, run and owned by the staff.

Some hospitals are also operated like companies. The Stockholm County Council allowed the privatization of the emergency hospital St. George's in 1999. As a first step towards privatization, the county council turns the hospitals into corporations with a professional board of directors and a president. Two of the major hospitals in Stockholm, Huddinge and Danderyd, have been run like companies since April 2000.

One benefit stemming from competition is the quality of service. This parameter, often overshadowed by efficiency, has proven to be the hardest to measure. Just as consumers consider both cost and quality when buying a product, a market-driven health care system relies heavily on these same aspects. Most studies concentrate on costs, but a study by Svalander and Lindqvist (1998) shows that 45 percent of the patients who chose St. George's did so because of its reputation as an excellent hospital. Only about 20 percent of the patients who chose other Stockholm hospitals did so for the same reason. Since St. George's expenses are 10 to 20 percent lower than those of the hospitals owned by the county council, competition seems to have served patients, the county council, and the taxpayers well. An excellent product delivered at a competitive price is not usually associated with a hospital.

As mentioned above, some studies focus on cost efficiency. Gerdtham et al. (1997) compared county councils that implemented the purchaser-provider split to those county councils that continued to use global budgets. They looked at the following factors and included them in a comprehensive statistical assessment:

- The introduction of internal markets. Their hypothesis was that county councils that implement internal markets are more efficient than the ones that continue to rely on global budgets.

- The age of the population. Health costs are often higher when a large proportion of the patients are elderly.
- Economies of scale. The assumption is that larger units are more economical than smaller ones.
- Alternative health care services. These are the private providers that usually exist even in a monopoly market.
- Financial status. Financially distressed county councils are assumed to be under the most pressure to improve productivity.
- The political majority. The hypothesis is that social democratic governments tend to increase public spending faster than non-socialist governments.

The Gerdtham study shows a potential cost saving of about 13 percent for the county councils with global budgets, of which there remain a large number. The researchers found that the estimated effect of internal markets is statistically significant at the one percent level with a negative sign, indicating that hospital services in county councils with internal markets are more efficient than those with global budgets.

Tambour and Rehnberg (1997) looked at all county councils between 1989 and 1994. They measured technical efficiency and productivity growth. They noted that by the early 1990s, five county councils (Stockholm, Dalarna, Örebro, Bohuslän, and Sörmland) had adopted a comprehensive purchaser-provider split system. Tambour and Rehnberg used data from various official records and looked at performance in short-term hospital care. The results show higher efficiency on average for those county councils that use internal markets compared to those that had global budgets. At the beginning of the study period, the potential output increase was about five percent for both groups. However, the situation changed at the end of the period. For exam-

ple, in 1994 the internal market county councils were close to full efficiency whereas the global budget group had an estimated potential output increase of about 7 percent. Important to notice is that the mean estimates show that both types of county councils had a similar level of efficiency before the internal market period began.

Svalader et al. conducted a third study in 1997, which shows that private primary health care centres run by Praktikertjänst AB are about 20 percent cheaper than those run by municipalities or county councils. Moreover, the salaries for doctors in the privately run units are higher. But due to differences in administration and the use of the nurses' time, the overall cost for the private health care centres remains lower, according to Söderström and Lundbäck (2000).

A fourth study looks at St. George's Hospital (Svalander and Lindqvist 1998). The study was conducted before the hospital became privately operated but after it was turned into a county council owned company. The study does not mention the difference between profit and non-profit health care, since for the period of the study the hospital had no profit-making goal. However, it does reveal something about the differences between independent health care facilities with a board of directors and a president and the county council run units. The study shows that St. George's is 10 to 20 percent more efficient than the hospitals run by the county councils.

Both the third and fourth studies introduce controls for determining the amount of care and money needed for different procedures. In this way, a hospital that handles difficult and expensive procedures more often than other hospitals will not seem to be less efficient because of the higher cost. A weighted average of the procedures ensures that average costs for average procedures are used. These studies indicate that private care is better, but more studies are necessary before a definite conclusion can be drawn.

Future Needs: Will There Be Enough Medical Staff?

In Sweden, as in many other countries, some problems of the health care system relate to the medical staff. In Sweden, many doctors and nurses are getting old and will soon retire. Many move to Norway to get away from the stress and to get a higher salary. As more Swedes get older and require more care, the shortage of medical staff must be addressed.

Between 1993 and 1998, the number of people working in the Swedish health care system fell from 379,000 to 310,000. A reduction in the number of staff with less education, those involved primarily in taking care of patients, accounted for most of this reduction.

Table 5 shows the average length of stay in in-patient care.

The number of health care employees declined, but so too did the number of days patients stayed in hospital. In 1990, the average length of stay was 18 days, and in 1998, 6.6 days. Two major reasons explain the decrease. First, when the economy deteriorated, hospitals had to close wards and lay off assistant nurses and other hospital staff. And second, new and more efficient methods of treating several illnesses were introduced. Day surgery for cataract patients is one example. The treatment of ulcers with medication instead of surgery is another.

With the Ädel reform, part of the cost of health care has also been delegated to the municipal

level. With the old system, some patients would occupy a hospital bed for years, long after they should have been transferred. The Ädel reform changed this. Within three days of the patient being treated and considered well enough to leave the hospital, the municipality takes over responsibility for the patient. The hospital charges the municipality a high fee if it does not assume responsibility for the patient. Most municipalities try hard to return patients to their own homes and provide daily after-care.

Since the number of days patients stay in the hospital fell sharply in the 1990s—due to the Ädel reform, day surgery, and medical advances—the reduction of staff may be a natural result of reduced “bed days,” since the staff that was laid off mainly took care of patients. Technological progress, therefore, helps to reduce the problem of the medical staff shortage. However, doctors and nurses are in short supply in many counties. Low wages and a stressful job are two of the reasons. The average starting wage for a doctor is 38,900 crowns per month, which is about 70,000 Canadian dollars per year or less than 60,000 PPP adjusted dollars (OECD 2001). The average salary per month is 42,100 crowns. For the average nurse, wages start at 19,500 and the average salary is 20,700 crowns per month (*Landstingsvärlden* issue 26, 2001, p. 5).

Working as a nurse in a Swedish hospital in the 1970s and the first part of the 1980s was a much easier task than it is today. The expansion of the

Table 5: Average Length of Stay in In-patient Care (in Days)

	1960	1970	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998
Canada	11.1	11.5	13.1	13.8	13.0	12.7	12.6			10.7	10.7	8.4	8.2
Sweden	31.8	27.2	23.2	21.2	18.0	16.8	10.1	9.4	8.1	7.8	7.5	6.6	6.6

Source: OECD, *Health Data* 2001.

public sector during the 1970s resulted in more nurses and money in the health care system. Sweden had a large number of nurses per capita, 10.7 per 1,000 inhabitants in 1996, according to the OECD. In addition, there was also a large number of support staff, making the beds, etc. Partly because of the recession in the early 1990s, cuts were made throughout the public sector. Even though the number of nurses and doctors actually increased during the 1990s, the number of support staff fell dramatically (Anell and Persson, 1996). This in turn led to a substantial workload increase for the nurses, who had to perform duties like making beds. Since wages did not increase with the workload, nurses became increasingly dissatisfied. The nurses who had spent years in training only to see their duties reduced to making beds were especially dissatisfied.

Even though, compared to nurses in other countries, Swedish nurses have been underpaid for many years by about 20 percent, their workload in the past was not very heavy, which compensated somewhat for the lower wages (Werkö and Enkvist, 2000). The heavier workload of the 1990s, combined with continued low wages for the hospital sector, made it hard to retain staff and also to train and recruit new nurses and doctors.

Doctors and nurses with foreign degrees: a way to help fill the gap

To make up for the shortage of medical staff through retirement and fewer students in the medical schools, many counties have turned to doctors and nurses with a foreign degree. Some counties have encouraged foreign doctors and nurses to live and work in Sweden. Other counties have worked on upgrading the skills of those immigrants living in Sweden who possess a foreign degree that does not qualify them to work as doctors or nurses in Sweden.

In 1995, 995 doctors received licenses to practice (Socialstyrelsen, 2001, no. 2001-125-34). Of those, 234, or 23.5 percent, had a foreign degree. By 2000, the number of doctors with foreign degrees had risen to 36 percent. A main reason for the increase is that many county councils actively recruit in Poland, Germany, and Spain. For nurses, the number of foreign degree holders increased from 8.5 percent in 1995 to 14 percent in 2000. Of the dentists who received licenses in 1995, 3.4 had a foreign degree. In 2000, the number rose dramatically to 20.2 percent. Through specially designed educational programs, these foreign doctors and nurses can quickly acquire the skills necessary to work in the Swedish health care system (*Landstingsvärlden* 2001, issue 23, p. 14).

How to attract and retain medical staff

Discussions with medical staff and union employees reveal two major determinants that will decide whether the future will have enough medical staff. The major problems seem to be salary and responsibility. For many years, hospital staff were paid according to parameters they were unable to change. Paid according to age or number of years of service, an employee has little incentive to work hard. In the past few years, nurses have started receiving salaries based on, among other things, competence. If they work hard and are ambitious, they get more money.

Since this reward system is closely related to responsibility, the challenge is to increase employee responsibilities and then reward them with higher salaries when they perform well. Such a system will likely result in a sufficient number of medical staff for the health care system. With an aging population and a growing demand for health care, the price for failing to attract and retain personnel will be very high. So far, it appears that private health care companies that reward individual performance when deciding salaries

have the advantage when it comes to attracting and retaining medical staff.

The publicly operated health care sector has a lot to learn about revenue, costs, individual salaries,

efficiency, and so on from the private sector. The coming years will determine if the publicly operated health care facilities will be able to stand up to the private newcomers.

Conclusions

The Swedish health care sector expanded rapidly in the 1960s and 1970s. In the 1980s, the nation experienced budget deficits and problems with increasingly long waiting lists. It became evident that global budgets and a lack of incentives to be efficient caused problems that required attention. Although the health care system continues to be publicly financed, the views on who should provide the health care is shifting in favour of private caregivers. This development started when patients became outraged by poor medical treatment and long line-ups, and when hospital staff grew tired of low wages and their lack of influence over working conditions. In addition, taxpayers who face the highest taxes in the world were not impressed with the growing cost of health care and the possibility of tax increases to cover these costs. In the early 1990s, a major re-structuring of the system was overdue. This report focuses on Greater Stockholm where most of the initiatives to increase patient choice, accessibility, and competition began.

The Patient Choice and Care Guarantee was introduced in 1992. This guarantee promises patients treatment within three months of being diagnosed and the right to go to another hospital, even in another county, if they fail to receive elective care at the hospital of their choice within that time frame. At the same time, as a guarantee of prompt treatment for procedures with long waiting periods, the central government granted the county councils extra money. Between 1992 and 1993, waiting lists ceased to be a political issue when they were reduced by 22 percent.

The purchaser-provider split

Traditionally, almost all care in Sweden was purchased and provided by the public health care system. Global budgets were eventually deemed cost inefficient. The belief grew that competition would lead to decreased costs and increased efficiency. Of all health care reforms, the purchaser-provider split increased efficiency the most. Some county councils implemented it in the early 1990s. A process was introduced in which both the traditional public providers, as well as the private ones, competed for contracts. Often the cheapest bid was accepted, and care was provided at a lower cost. In the beginning, the media reported the mistreatment of elderly patients, which led to a public outcry. As the purchaser became increasingly sophisticated, however, contracts began to include measurements of quality.

Effects of the reforms

These reforms led to increased competition and led to Sweden's first privately operated primary health care centre and first privately operated emergency hospital. These health care facilities became more efficient than the ones operated by the county councils and municipalities. Various studies show that costs are 10 to 30 percent lower in the privately run units. Given greater responsibilities, often higher wages, and in some cases options and profit sharing, the staff also feel happier working for a private caregiver.

Patients are also often happier being treated as customers who can influence decisions on their treatment. The unions all support private health care, realizing that it provides greater opportunities for their members. The politicians have embraced private alternatives in many municipalities and counties. Many left-wing politicians on the national level, however, are still against private solutions. They fail to understand how these health care facilities function and the positive impact they often have on patients and staff. When the Social Democrats on the national level declared their opposition to private health care, the Stockholm County Social Democrats were appalled. Afraid to lose votes because of the rhetoric from central government politicians, the Stockholm County Social Democrats realize that voters demand private alternatives. Eventually, even the central government Social Democrats might one day embrace private alternatives: the evidence from those involved with private caregivers is that they provide an excellent complement to the publicly provided health care units.

Lessons for Canada

Since Canada struggles with the same problems as Sweden—without having dealt with them yet—it can learn a couple of things from the Swedish experience. For a country that wants a publicly funded health care system but lacks sufficient funds to sustain such a system based on

global budgets, the most important initiative is to introduce competition. A purchaser-provider split, in which both public and private health care providers can bid, is an important first step.

Measuring costs and revenue with the help of DRG points, or other similar systems, is pivotal if increased efficiency is to be achieved. With global budgets, neither hospital staff nor politicians are fully aware of the costs for different procedures, making it hard to decide on strategies to increase efficiency. Increasing responsibility and salaries for medical staff, along with profit-sharing and options, are additional ways to involve staff in the work of increasing efficiency. These tools have been successfully implemented at St. George's Hospital in Stockholm.

In Sweden, the changes started with a recession and a public uproar. People were fed up with waiting in line for years for surgery, and finally local politicians understood the needs of the public as well as the needs of dissatisfied hospital staff. This has been something of a grassroots revolution, where medical staff and patients have seen the benefits of change. Local politicians and taxpayers have also benefited from efficient health care facilities. Many politicians on the national level also embrace private health care. When society as a whole recognizes the benefits of mixing private and public approaches, society will change, and the politicians who are against private alternatives will have to change too.

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