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Swedish Healthcare in Transition

AN AIMS HEALTH CARE COMMENTARY
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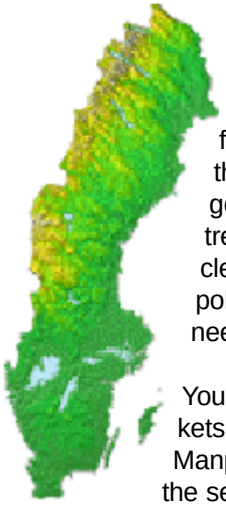
THE PURCHASER-PROVIDER SPLIT

From public monopolies to market services



By Johan Hjertqvist

For 500 years Sweden has been a uniform and centralized country. Today it is on the road to pluralism and stronger regional governments. Often the leader of new trends in Europe, Swedes are making it clear to their politicians that they want public policies which cater better to individual needs and preferences.

You can notice this change in the labour markets. Collective bargaining is in retreat, and Manpower, a temporary-help agency, is now the second-largest employer in Stockholm. In the education industry, privately operated schools are doubling their market share every year (though from a low base), and competitors who offer e-learning solutions for workplace education are booming. Signs of change are also apparent in the health-care industry: privatized hospitals, clinics and medical practices of all kinds; increasing numbers of private insurance companies; Internet-based patient information and a profusion of well documented opinions in favour of free choice, competition and diversity.

Underlying this change of opinion is the success of public policy experiments that have embraced the principles of competition and choice. In 1992-94, the Greater Council of Stockholm launched a number of competitive initiatives whose success is now apparent. Competition in public transportation in the metropolitan area has reduced taxpayer costs by 600 million Swedish Kronor ($95 million), or roughly 25 percent. In one blow, with competitive contracting, the Greater Council reduced the yearly cost of ambulance service in the Stockholm region by 15 percent. In all areas service quality has increased noticeably.

The results in health care have been just as startling. For example, privatized nursing homes have reduced costs by 20-30 percent. Or again, a recent evaluation has shown that private medical specialists are more efficient than their colleagues in public service. They focus on "with-patient time", which results in more patient value. Publicly employed doctors, in contrast, have more staff, spend more of their time on paperwork and ask for 10-15 percent higher budgets to provide the same treatment levels.

By 1994, when the centre-right regional coalition lost the election, 100 small and medium-size health-care contractors had been established, all of which had previously worked within the public system. All except one remain active. The change in government slowed, but did not stop, the process. In 1998, the centre-right grouping returned to power, and they picked up new steam. They have wide public support in the urban areas, including that of the largest health-care unions, and plan to turn most of primary care into contracted services, an irreversible major step.

Right now, about another 100 health-care units are in the process of leaving public ownership to become private companies. The Greater Council lends significant support in the form of free training and start-up consultants. In general, the new contractors run local health-care stations, GP group practices, treatment centres for mothers and infants, laboratories and psychiatric out-of-hospital clinics. When (and if) the Council completes this transformation, private GPs and other contractors will deliver around 40 percent of all health-care services, and about 80 percent of all primary health-care in the metropolitan area.

This series of newsletters on Swedish Health Care in Transition is a joint project of **AIMS**, Atlantic Canada's public policy think tank, and the **Frontier Centre for Public Policy** (FCPP). FCPP is a Winnipeg-based think tank that examines news policy ideas for the eastern prairies region of Canada. AIMS wishes to thank FCPP, and its President, Peter Holle, for making this initiative possible.

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In 1999, a private company, Capio Ltd., bought one of Stockholm's largest hospitals, the St. George, from the Greater Council. Since the early 1990s, Capio has run a hospital in Gothenburg as well as X-ray clinics, laboratory services and other "infrastructure". The St. George operates at a cost level 10-15 percent below its most efficient public counterpart in Stockholm, the South Hospital. Compared with the average of public hospitals, the margin is 15-20 percent. According to Greater Council evaluations, the St. George is well known for implementing new, efficient organizational structures and treatments.

This success portends similar changes for the remaining six emergency hospitals in the Stockholm region. Two have already been turned into commercially viable, and thus saleable, corporations; two others are slated to follow next year. The remaining three are candidates for marketization. In other words, while the sale of all of Stockholm's hospitals seems imminent, the strategy is to give the public hospitals a chance to prove their efficiency before any new moves are made.

REFORM OR EVOLUTION?

Swedes still have strong egalitarian convictions. In particular, they believe that good health care should be available to everyone, that incomes must not decide the level or quality of treatment and that basic care should be financed by public authorities. Indeed, good health care is considered intrinsic to democracy. In Sweden, as in Canada, the deficiencies of the American health-care system are frequently used to divert and confuse the debate over reform. More and more, Swedes are looking for a more flexible welfare state, but not the end of the welfare society.

Nevertheless, the Swedish system will continue to see reform. Or, more correctly, changes. The word "reform" might suggest a well planned transition, decreed by Parliament and managed by the civil service. But as national politics drift away from traditional welfare-state thinking, regional and local parliaments will gain more power, opening up a broader pattern of experimentation. Mounting demand for services will be met increasingly by insurance companies and private care-providers, particularly in local markets in the major cities and more populated areas. Rather than a top-down, nationwide series of reforms, we are witnessing an evolution, a "bubbling up" of localized solutions, a decentralized and spontaneous "marketization" of the sector.

THE DEMOGRAPHIC TIME BOMB

What are the forces driving this evolution? Sweden leads the general European trend towards aging populations. In the year 2020, four out of ten Swedes will be over the age of 65. That means not only that demand for health services and geriatric care will increase, but also that the productive workforce and the tax base will shrink correspondingly. Rising individual demand for greater choice, higher quality, more information and second opinions will compound the challenge. This will push costs even higher.

These trends are manifesting themselves in almost every developed country. In other European countries - as is already the case in the United States - people are putting such a high priority on being well and maintaining the quality of their lives that they are becoming more willing to use their own money for health care and services for seniors. They no longer trust politicians to use tax money to satisfy their needs; they are sophisticated enough to want to be in control themselves.

In post-war Sweden, tax increases made the welfare state work. Over the longer term this trend proved unsustainable. To meet European Union requirements and global competition during the coming years, Sweden has had no choice but to reduce its high tax levels.

LIKELY TO SURVIVE?

Sweden's present health-care structure cannot meet the challenge of being part of a lower-tax environment. Health-care consumers want a customer focus, no waiting lists and highly motivated service providers. This type of service is best delivered by small, independently operated enterprises, particularly employee-owned firms.

Competition between these entrepreneurs, and between them and government health-care units, will expose bad operating practices and neglected opportunities. Allowing entrepreneurs to compete for public contracts will create an environment conducive to improved problem solving, new approaches and budget discipline. There is considerable experiential evidence that competitive organizations tend to concentrate on customer satisfaction and productivity. This entrepreneurial difference will give them an edge in solving problems (like waiting lists) over public units, which operate in an environment in which there is only a vague focus on outputs.

Many health-care procedures in Sweden involve the participation of the country's overlapping bureaucracies. Responsibility for social welfare services is spread among several regional and local authorities, which often co-operate badly. However, people no longer accept being pushed back and forth or enduring delays in treatment caused by administrative inertia. Service entrepreneurs have the tools to solve these severe problems.

A TORPEDO

The Swedish health-care sector is suffering increasingly severe recruitment difficulties, due to both low birth rates and a poor image as a place to work. The system is harmed by weak leadership, low pay and the lack of possibilities for advancement. Dramatic organizational changes are needed to satisfy and motivate employees, especially young people who sympathize with the ethos of public health care but find the working conditions unattractive.

In Sweden, private health-care entrepreneurs generally tend to treat their employees better. Many nurses have lost their illusions about public employment and have started their own

enterprises. They have benefited from public-private competition. Since private companies began competing with public units, wages in the health-care sector have risen at three times the earlier rate. Today, very few people - most notably including trade unionists - believe that public monopolies pay higher salaries. Like a torpedo launched out of the blue, competition has blown a hole in the hull of the old system.

The National Union of Nurses, with 120, 000 members, actively supports nurses who want to leave public employment and emulate the success of their colleagues who started new careers as contractors in the early 90s. The union runs a special company to promote new ideas and activities in this field.

The chairwoman of the Union, Eva Fernvall, has become an articulate advocate of radical change. "Let the market take over health care!" a headline has quoted her as saying. She makes the case for more patient focus, flatter organizational structures, stronger incentives for workers and increased numbers of producers and employers. On November 25th, 1997 Dagens Nyheter, Sweden's largest daily, published a discussion of ideas that Fernvall had co-authored with other opinion leaders-including the chairmen or CEOs of the National Union of Doctors, four other health-care unions, a large private health-care company and the Union of Swedish Industry. She wrote the following points:

• "From different points of view we have come to the conclusion that a completely different, more independent organization than the present one can offer very large gains for Swedish welfare - a better function of health care with the same or lower costs."

• "Today, in many fields there are uncertain mechanisms for decision-making within sometimes-conflicting hierarchies. The system suffers from petty political interference. Operations therefore ought to be led by professional, non-political management."

• "Of course there would be enormous stimulus to those working within the health care field to be valued for how they perform, where they themselves -- under independent conditions and professional responsibility -- have at their disposal methods to deliver good quality of health care."

• "When it comes to organization, it cannot be very complicated for the Greater Councils to get rid of most of the parts of the ownership of hospitals and other health-care institutions. There are great numbers of new owners ready to take over if the price and terms are correct."

• "Co-operation and confrontation between enlightened buyers and sellers can be made a developing force in the system's details as well as its whole. In today's society the old [health-care] model no longer works. Now there is a need for flexibility, entrepreneurship and new channels to let loose the complexity of demand and supply, held back for decades…."

Since then, Fernvall has had occasion to repeat her message. "Health-care pluralism" is today the official standpoint of the nurses' unions. She is supported in her stand by most other health-care unions.

Looked at from the aspect of nurses' salaries, the Fernvall arguments are based on solid ground. Between 1995 and 1999, publicly employed nurses increased their salaries by 26 percent, second only to civil engineers. This gain is three times greater than what was won during the previous period, when private alternatives were still weak. The trigger turned out to be the individual competence factor: employers now have the freedom to reward initiative and responsibility. This development becomes possible only when increasing numbers of employers compete for nurses and other staff.

During the old greater council monopoly, very little happened. It turned out to be impossible to raise salaries through central negotiations, Fernvall said in an interview earlier this year. How you performed was of no significance. A wider salary range for differing skill levels is the key. Today, she maintains, the 20 percent spread between the highest and lowest nurses' pay is still far too narrow. It must, she writes grow to at least 50 percent to promote individual competence.

It's clear that competition from the independent contractors has simultaneously bid up nurses' wages across the system and raised the quality of care. This explains the attraction markets exert on Sweden's health-care unions even though they are opposed by virtually every union in the field in most Western countries.

SWEDEN 2010

Sweden's future health-care system is developing fast. Many do not like the new arrangements or the side effects of the emerging welfare-services market, but a growing number of people will not be satisfied with anything less.

The trend is towards ongoing reform of the old system, rather than towards a complete rebuilding from the ground up. There will be no "grand master plan" imposed by Parliament. Instead, there will be a large number of small- or medium-scale changes in shifting tempo dispersed around the country. I suggest that the transition will run along the following lines in two distinct regions:

1. Urban Areas

• Policies and solutions will become less homogeneous. In the bigger urban areas, income, education and political trends will favour provider pluralism and - incrementally - additional financing (private insurance).

• Hospitals now owned by the regional authorities will turn into publicly traded companies; this measure will increase productivity and budget control.

• Private providers will expand as successive sectors (e.g., nursing homes, public dentistry) are forced to compete.

• Public and private producers will build alliances. International companies will enter the market and operate hospitals that were once publicly owned.

2. Rural Areas

• In more traditionalist parts of the country, generally those with sparser, older and less well educated populations, you

will not see much change.
• The regional and local governments will hesitate to contract out services.
• These areas will also attract fewer entrepreneurs (who, of course, prefer environments where competition is welcomed).
• Patients will still be willing to stand in line for treatment.
• The aggressive consumer will have hardly any impact on the northern parts of Sweden.

PATIENT VOUCHERS IN A DECENTRALIZED MARKETPLACE

Efficiency will rapidly become the single most important driving factor. Not from a narrow budget perspective, but from a value-for-money and quality-of-life viewpoint, "How can I best use my (tax) money to improve my health and quality of life?" will become an increasingly common question among young people as private pension funds and other savings grow at high rates.

The political system will lose much of its power (not without controversy, of course). Fewer citizens, as sophisticated consumers, will trust elected bodies to solve the problems of the individual through collective measures. With better education and higher levels of "social competence", people will feel comfortable creating their own solutions within the publicly financed system.

The ever more apparent potential for dramatic improvements will keep up the pressure for change. The combination of pharmaceutical and technological advancements is already opening new possibilities every day. It's doubtful that the system will withstand the pressure for better, albeit more costly, service by saying "no" to individual needs. When patients ask for the latest treatment, the financial aspect will become crucial.

In ten years' time, basic health care will still be financed by taxes, but many services will be for sale in the out-of-pocket or private insurance markets. Regional authorities will be responsible for most of the hospitals, but private contractors will operate from within these facilities.

In large parts of the country, primary health care will be privately owned and operated but publicly paid for through "patient vouchers". In general, networking will be the predominant approach; i.e., combinations of public and private suppliers will be seen in many fields.

Throughout Sweden, the focus will centre on customer satisfaction in a system that measures and guarantees quality outputs, including evidence-based routines and best-practice treatments. Working conditions within the care services will improve noticeably, thanks to stronger owners, better management, expanding career opportunities and the efforts of manpower companies.

Care will no longer be looked upon as a basically political question, but as a matter between well-informed consumers and their partners in the healthcare field.

Johan Hjertqvist,

AIMS Activities on ...*Health Care*

Recent Publications

Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System offers a guide to Canadians and their policymakers in thinking through the roots of medicare's current difficulties, and a toolkit for resolving those difficulties as they intensify in the years to come. This publication won the Sir Antony Fisher Prize for excellence in think tank publications. Operating in the Dark can be found on the AIMS website at www.aims.ca (requires Adobe Acrobat Reader).

Recent Events

On Tuesday, 25 September 2001, over 100 people attended a lunch with **Johan Hvertquist** in the Bluenose Room at the Delta Halifax in Halifax NS. Johan provided an insightful discussion of the challenges and opportunities being discovered in Sweden as they move forward with health reform.

To Watch For

AIMS website to add a new **Health Policy Page** in October 2001. AIMS new Health Policy Page will soon become a must-read for those interested in being informed participants in the ongoing debate on securing health care in Canada.

Working papers on **health policy issues** to be released in coming months. Beginning in October AIMS will begin releasing a series of working papers on various issues within the health care field.