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Perspective

Structural patterns in Swedish health policy: a 30-year perspective

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Abstract: This perspective reviews key institutional and organizational patterns in Swedish health care over the last 30 years, probing the roots of several complicated policy questions that concern present-day Swedish decision-makers. It explores in particular the ongoing structural tension between stability, on the one hand, and the necessary levels of innovation and dynamism demanded by the current period of major clinical, technological, economic, social and supranational (EU) change. Where useful, the article compares Swedish developments with those in the other three European Nordic countries as well as other northern European health systems. Sweden's health sector evolution can provide valuable insight for other countries into the complexity involved in re-thinking tradeoffs between policies that emphasize stability as against those that encourage innovation in health sector governance and provision.

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Introduction

Nearly every health system in Western Europe is currently under pressure to re-think its future strategy and health policy direction. In varying degree, national policymakers find themselves faced with slowing public sector revenues and continuing high unemployment rates, both of which are increasingly understood as the long-term consequences of three well-known structural factors: the consolidation of the electronic industrial revolution, the accompanying economic globalization that has brought over 2 billion new workers into the global workforce, and much of Western Europe's continued high rates of corporate and personal taxation (Alesina and Giavazzi, 2008; King, 2010, 2013). This combination of malign economic forces, coupled with a rapidly increasing

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number of elderly citizens who no longer work but require extensive clinical and custodial services, has left national policymakers in the midst of a prolonged period of low/no economic growth, little new public revenue, growing service needs, and, ultimately, little choice but to seek more effective and more efficient ways to meet their health systems' core objectives (Saltman and Cahn, 2013).

In this new environment, national ministries of health (and finance) are constantly weighing new avenues to meet access, quality, safety, and efficiency standards that themselves keep increasing, reflecting rising international standards of care and with them rising service expectations from citizens and patients. Equity remains essential politically but must now be balanced against financial and managerial efficiency. Choice has become increasingly prominent in tax-funded health systems but must be balanced against both provider efficiency and system effectiveness. Stability of institutional structures and routines remains a critical dimension for regional and local policymakers, yet there is continuing pressure for structural as well as clinical innovation. Lastly, financial security for patients and citizens continues to be a political imperative but must be balanced against strong and growing demands from the same groups for the dynamism of increasing standards and better working patterns.

Most difficult of all is that these shifts in focus and strategy must be accomplished with the same or, increasingly, fewer financial resources and personnel. The dilemmas of how to set and steer a realistic course in this new environment, of how to be a 'good steward' when the structural and institutional goalposts keep moving, now inevitably require policymakers to re-visit and re-assess a wide range of previously settled policy issues.

One useful avenue for exploring how this difficult combination of increasing service demands and growing fiscal pressure has affected policymaking is to step back from current policy deliberations and take a broader longer-term perspective. In recent years, health system analysts have suggested that various strains of historical institutionalism can be helpful in understanding past patterns and predicting future directions in developed country health care systems (Oliver and Mossialos, 2005). Through its emphasis on the long process of building up organizational infrastructure, this school of thought has highlighted the importance of previous political and economic decisions in framing the context for current policymaking options. When this institutional perspective is extended to a cultural anthropological perspective that incorporates the importance of social norms as ingrained in national culture (Saltman and Bergman, 2005), analysts potentially can detail the range of factors that steer and/or constrain a particular country's future health sector decision making.

This article examines key institutional and organizational patterns in Swedish health care over the last 30 years. It probes the roots of several complicated policy questions that concern present-day Swedish decision makers, in particular the ongoing structural tension between stability (a good thing) and the innovation and dynamism in institutional arrangements needed in the current period of major

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clinical, technological, economic, social, and supranational (EU) change. In addition, where useful, the article will compare developments inside the Swedish system with those in the other three European Nordic countries (Denmark, Norway and Finland) as well as other health systems elsewhere in northern Europe.

The Swedish experience with institutional reform can be seen as providing useful knowledge for policymakers in other countries and contexts as well as to Swedish decision makers. Sweden's health sector evolution illustrates the complexity involved in re-thinking tradeoffs between policies that emphasize stability as against those that encourage innovation in health sector governance and provision. Sweden's reform history also flags up the increased resilience of provider organizations to health sector change when local political actors play a significant role in institutional management.

While different national health systems have their own history and institutional configuration, other systems also are seeking to assess the mix of advantages and disadvantages that may accompany a new balance between stasis and innovation in their health sectors. That some health systems have moved sooner than Sweden in implementing reform does not change the broader value of information about the motivations of key organizations and actors during the relatively slower Swedish experience of sectoral reform.

This review begins with a discussion of five core structural patterns that can be observed over the past 3 decades. It then draws on past institutional experience to highlight several issues that Swedish policymakers will likely find themselves forced to address going forward.

Two caveats should be noted. The first is that this assessment of patterns looks exclusively at the provider side of the Swedish health system. As such, it does not reflect issues concerned with the raising of health care revenues in Sweden. A major consideration in this approach is that funding for well over 80% of all health care services continues to be obtained through public taxation and/or mandatory social insurances, and that there has been little interest inside Sweden in changing that public funding process. The second caveat is that this review focuses predominantly on structural policy issues, rather than on clinical management questions. It thus looks at macro policy questions in past policy patterns rather than at their meso or micro level management dimensions.

Five health system patterns

The resilience of the county councils

The history of the county councils extends back to 1862, when they were given responsibility by the national government to run hospitals for all citizens paid for through public funds (Serner, 1980). Over time, the counties have considerably increased their role as the main provider of care in Sweden. During the 1960s and 1970s, the counties took over responsibility from the state for seamen's hospitals,

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mental hospitals, and university hospitals, and in 1971 with the seven Crown Reform the counties became the main provider of primary care services as well. In 1983 the Dagmar reform channeled the flow of national health insurance funds – used to reimburse both public and private outpatient doctor visits – directly through the counties, giving county councils control over the contracting payment process with the small number of Swedish private general practitioners (GPs) and office-based specialists.

The only provider area where county control over public provision was weakened during this period came with the ADEL Reform of 1992, which took away nursing homes from the counties and gave them to the municipalities – to facilitate closer cooperation with municipally-run old age homes and home care and thus better coordinate services for the elderly (Johansson, 1997).

During the 1980s, the counties also were a major source of operating contracts for the two small not-for-profit private hospitals in Sweden (Carlanderska in Goteborg and Sophiahemmet in Stockholm), which were used to reduce public hospital waiting lists. The introduction in1992 of the first care guarantee (for 12 procedures) followed by the full care guarantee in 2005 similarly served to encourage the counties to contract with these two private institutions. Since 2007 with the onset of the Vardval Reform allowing patient choice of private as well as public primary care centers, the counties recently have contracted with substantial numbers of new private for-profit and not-for-profit primary care providers (Anell, 2011a).

Beyond this small number of private care contracts, however, the counties have maintained a strong grip on the delivery of most inpatient and outpatient services in Sweden. As one sign of this resilience, the counties have successfully deflected a number of political proposals to either eliminate the county system entirely or to forcibly consolidate the counties into a new level of fewer, larger 'regional' governments. In the 1980s, the Moderate Party believed that county councils were an additional and expensive level of public administration, and many members wanted to eliminate them (Mollstedt, 1983). When a Moderate-Party-headed coalition came to national power in 1990–1994, however, the coalition agreement did not include this type of major structural change.

A different, more subtle effort at changing the structure of health sector governance was included in the national government's 'ansvarskommittee' report (report of the parliamentary commission on governmental structure) which in 2007 recommended that the then-21 separate county councils be combined into six to eight larger regions (SOU, 2007). The recommendation called for mandatory process to create these regional bodies similar to the voluntary process that was then already underway in Western Sweden with the combination of four separate counties into the new Vastra Gotaland Region (VGR). This proposed reform was not attractive to the existing county councils for a variety of reasons, some noble – preserving local level democracy – and some political – preserving existing political positions for party functionaries. Thus in this instance as well,

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the ultimate decision by the national government not to require mergers but rather to 'encourage' voluntary combinations can also be seen as reinforcing the strong institutional position of the current county council governance structure.

Instead of pushing for mandatory mergers into a new regional structure of public health system governance, the Swedish Ministry of Health (Socialdepartementet) chose to concentrate its efforts on creating functional pressure to improve clinical quality, as well as on efforts to introduce a degree of clinical consolidation of certain highly specialized services (Saltman and Vrangbaek, 2009). Starting in 2006, the Ministry began publishing relative performance data of all counties tied to a series of clinical outcome measures (Anell *et al.*, 2012). These 'open comparisons' became the topic of much debate in and beyond the health care system, serving to highlight the less-well-performing counties and to put pressure for improvement on the elected political officials who headed those counties. The Ministry also stepped up its use of financial incentives – e.g. targeted direct payments – to convince adjoining counties to combine efforts on clinically advanced and expensive services such as pediatric eye oncology (Saltman and Vrangbaek, 2009). By such measures, the Ministry sought to generate a degree of *de facto* consolidation in certain clinical services while at the same time – by increasing volume in the remaining services – helping improve the quality of care that the counties delivered.

In comparison with the Swedish experience of continued county control over health service provision and also over the raising of most public revenues for health care, in two of the other three European Nordic countries the national government imposed regional consolidation on county or county-level governments. In major structural reforms put in place in 2002 in Norway (from 19 counties to 5 now 4 regions) and in 2007 in Denmark (from 14 counties to 5 regions), new regional administrations are no longer allowed to levy taxes to raise health care funds. Instead they have been made fully dependent on the national government – and the national budget – for nearly all their operating as well as their capital revenues (Olejez *et al.*, 2012; Ringard *et al.*, 2013). This change is in contrast to the Swedish situation, where Swedish counties (as well as the newly established VGR regional level government) continue to raise more than two-thirds of their operating revenue through county-level fixed-rate tax rates of ~14% on inhabitants' income (Anell *et al.*, 2012). Moreover, in the Norwegian case, members of the four regional councils are not elected but rather appointed directly by the national government.

Similarly, in Finland, where nationally determined federations of municipalities have formally owned, operated, and partly funded primary care, central hospital, and university hospital districts (Vuorenkoski *et al.*, 2008) the national government has recently begun negotiating a new governance structure that has fewer, larger municipalities (already reduced from 450 to 370, expected to be reduced further). More importantly, if current political agreements between key political parties stand, Finland will fold the current 20 central hospital districts into the

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existing five university hospital regions, with a new arrangement for financing health care that could include direct state payments to the five regional governments – in effect eliminating the financial role of the municipality (Voipio-Pulkki, 2013; Jonsson, 2014). If some version of this Finnish reform does in fact take place, then the Swedish health system would become the only one in the four European Nordic countries to still have in place a fully decentralized model of health system governance in which locally elected governments also have the right to levy taxes (Saltman *et al.*, 2012).

One could also compare the current Swedish picture with recent changes in the tax-funded health system in England, where contracting authority for elective hospital services has gone through four different types of primary care contracting agencies since 1991: fundholding GPs, Primary Care Groups, Primary Care Trusts, and now (in April 2013) Clinical Commissioning Groups. Public funding in England remains a national function, as now occurs also in Norway and Denmark (and perhaps Finland in the near future). In Ireland's tax-funded health system, the five regional health boards were consolidated in 2003 into a single national administrative agency (Department of Finance, 2003).

This context of major institutional change in nearly all other tax-funded health systems in Northern Europe serves to underline the stability – or the rigidity – of the Swedish county council arrangement, and the resilience of the counties in the face of strong fiscal and clinical pressures to consolidate and to surrender greater power to the national government. To be certain, the counties themselves have considerably changed the way they manage themselves internally over this 30-year period of time (Andersson, 2014). There also are now three larger consolidated regional bodies (VRG, Skane and Stockholm), reducing the number of county governments from 26 to 21. Lastly, the debate as to whether centralized decision making is more efficient than decentralized decision making is far from self-evident (Saltman and Bankauskaite, 2006). The conclusion remains, however, that the basic governance structure in the Swedish health systems remains in 2014 very similar to that of the early 1980s.

The slow growth of diversity among service providers

A second long-running pattern in the Swedish health care system has been the slow expansion of the provider pool, from almost exclusively publicly owned and operated hospitals and public health centers in the early 1980s, to a bit more diversely managed (hospitals) and/or substantially more diversely owned (primary care and home and long-term care) service delivery structure in this second decade of the 21st century. Diversity in this context means a wide range of non-public sector approaches to capitalizing and/or managing health services: semi-autonomous 'public companies'; private not-for-profit religious or worker cooperative based organizations; small local as well as large corporate for-profit companies; and private, stock-market-based or venture capital based investor owned providers.

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This process of slow change has been fairly consistent over the past 3 decades. It also has been uneven in its impact, with considerably more diversity of provision apparent in some counties (Stockholm) while little structural or organizational change in others.

In the *hospital sector*, the initial impetus to diversity was the introduction in the late 1980s and early 1990s of a purchaser-provider split, similar to that first adopted in England in April 1991 (Robinson and LeGrand, 1994). This essentially involved a re-configuration inside the public sector of hospital management, such that budgeting and paying decisions were made by a separate arm of the county from the arm that was responsible for managing the day-to-day operations of the (still very much publicly owned) hospitals. These purchaser-provider splits were introduced in counties such as Stockholm and Dalarna, each of which was said to have its own 'model' of reform (Bruce and Jonsson, 1996). Typically these models featured splitting up at least the elective inpatient component of each hospital's budget to a sub-county 'district board' responsible for running the primary health centers inside that district and then for contracting for needed specialist services from one or more hospitals in that county. Moreover, in Stockholm, several of the bigger public hospitals were re-structured into 'offentligbolaget' (public corporations), in which all shares were owned by the county council, allowing the hospital to be managed as a semi-autonomous organization inside the public sector (Saltman *et al*., 2011a). Although this new management tool was seen in Sweden as attractive in the early 1990s, by the end of that decade interest began to fade as county decision makers re-asserted their authority through a more traditional hierarchical system of top-down political management.

As noted earlier, a second type of diversity, contracting for elective procedures between the counties and Sweden's two private not-for-profit hospitals (Carlanderska in Stockholm and Sophiahemmet in Stockholm), grew up in the 1980s, particularly for relatively new procedures for elderly patients (CABG, total hip replacement) for which the public sector had long waiting lists. In the 1990s, as those waiting lists declined (largely due to more effective public hospital management), the number of these contracts also declined. While a few contracts continue to be written, this second source of diversity in provision of publicly funded hospital services has largely faded as well.

A third avenue of hospital diversity was the establishment of small privately operated clinics in Sweden's largest cities. In the early 1990s, a number of these facilities were established, typically taking patients who could pay privately either through separate privately purchased insurance or out of pocket. Again, much as in the first two instances above, this form of diversity has now largely gone out of business and disappeared from view.

The fourth – last – avenue for diversity of hospital services in Sweden was to contract out the management of a publicly owned hospital to a for-profit hospital management company. This model was adopted in Stockholm County in 1995 for one hospital, Saint Gorans, which was contracted out to Capio, a relationship

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which has continued on a five-year-rolling-contract basis up to the present. Although detractors (and also advocates) persist in terming this 'privatization', the hospital buildings are still owned by a Stockholm County owned 'offentligbolaget' and thus the hospital has not been sold off (the central requirement for privatization to take place). While this example of private management is largely considered a success inside Stockholm County, similar contracting out efforts were banned via national legislation in 1998 by the previous Social Democratic government (a ban since repealed), and there have been no further examples elsewhere in Sweden. Of the four types of hospital diversity examined, then, one can now observe only vestigial remains rather than vibrant alternative and/or competing models to the public sector.

This brief history of diversity in the Swedish hospital sector appears to reflect two central patterns. The first is that there has been a series of efforts by a number of different health sector actors to find innovative ways to diversify the provision of at least some hospital services in Sweden. The second pattern is that these efforts, whether within or outside the walls of the county council system, have had considerable difficulty sustaining themselves over time. Both patterns lend credence to the overall characterization of 'slow growth' in the heading for this section.

This pattern of slow change in the hospital sector in Sweden can be contrasted with the fundamental structural shift in hospital governance that occurred during this same period in England and Norway. In April 1991, England began the process of transforming its hospitals into semi-autonomous public institutions. Starting with 57 hospitals, by 1997 half of all English hospitals (about 600 out of 1200) had been re-structured as 'self-governing trusts', each reporting to its own government-appointed board of trustees (Edwards, 2011). In 2000, the sitting Labour Government decided to transform all English hospitals into self-governing trusts, and then, unhappy with the limited degree of semi-autonomy in this model, introduced an even more independent model of public sector hospital governance in 2003 by encouraging hospitals to transform themselves into Foundation Trusts, each of which had its own board of governors and a further degree of managerial freedom (Edwards, 2011). During these same years, Norway developed a somewhat parallel policy approach, in 2002 taking over direct national ownership and funding of all public hospitals and reconfiguring them into 'state enterprises', which like the English hospitals had semi-autonomous management (Martinussen and Magnussen, 2009; Ringard *et al.*, 2013).

The historical pattern of development in the Swedish *primary care sector* resembled that of the hospital sector from the 1980s up until the implementation of the Vardval reform in 2007. In 1983, the first privately owned clinic – Citi-Akuten – was established in downtown Stockholm. Patients could get first contact care from a walk-in clinic without having a prior appointment, with that service paid for by the county council's public funds. This represented a major

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shift from the approach of public primary health centers, which required a telephone call between 9 and 10 am (only) followed by an appointment to the clinic (not to a specific doctor) which might not be available for up to seven days. In contrast to this frozen public health center framework in the early 1980s, in Sweden in 2014 there are now a variety of private walk-in primary care and travel vaccination clinics, owned by Citi-Akuten and others, in most of Sweden's larger cities, with at least some having their services paid for by public county council funds.

A second early initiative during the 1980s was 'Qvarters Akuten', a local (Vasastan in Stockholm) primary health center that sought to match the patient-centeredness and flexibility of Citi-Akuten (Ohrming, 1990).

A third major initiative to make primary health services more accessible and more acceptable to patients also occurred in Stockholm County in 1990. Individuals were given the right to sign up (they had to register for services at only one primary health center) at a primary health center different from the one to which they had been assigned. Previously, where you lived determined where you were entitled to receive primary care. When a patient called a primary care clinic, the first thing they were asked was 'To which health center do you belong?' That language – indicating that the patient belonged to the health center, rather than that the patient had chosen to receive their care there – changed a bit in 1990 in Stockholm when individuals were allowed to sign up at any health center they liked, perhaps one closer to where they worked rather than the one where they lived. Since health centers only saw patients during normal working hours, at least the new system allowed patients to receive care close to where they worked, rather than as before requiring them to travel back to where they lived. Under the new arrangement, the health center received its public funding as a monthly capitation payment for each signed up patient – 300 SEK for those under 65, 600 SEK for those over 65. This connection of patient choice to health center funding resulted in the clinics welcoming new patients rather than resisting them as extra work (Bruce and Jonsson, 1996).

A fourth initiative to introduce provider diversity in the primary care sector began in 1991, when the incoming right-of-center government sought to introduce the 'Huslakare' or 'house doctor' reform. The Minister of Health, Bo Konberg, introduced legislation in the national parliament that would allow patients to put their names on a list for a specific primary care doctor inside a public primary health center, and then to make appointments to see specifically that doctor. This effort to create what would have been, in effect, a private GP structure inside the confines of the publicly run primary health centers, was passed by Parliament, and was adopted by some counties (Vastmanland, Ostergotland for two). There was resistance from some counties, however, and in 1994 the reform was repealed shortly before the national election (Harrison and Calltorp, 2000). Some counties did continue the Huslakare model, however, under their own managerial discretion (Vastmanland, for one) for some years thereafter.

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Although discussion of the need to strengthen primary care continued after the termination of the Huslakare legislation, there was little agreement on how to do so. In 2007 and 2008, a more thoroughgoing, longer lasting organizational approach was taken. Three counties (Halland, Vastmanland, and Stockholm) shifted from the existing publicly provided model to one in which more private provision became possible through county contracting out of services to various types of non-public providers, combined with increased patient choice. Subsequently, the national government passed legislation to put in place this Vardval (Care Choice) Reform, which from 2010 required all counties to adopt a mixed public/private primary care arrangement (Anell, 2011a).

The Vardval initiative has taken root and has now generated significant change in how primary care is delivered in Sweden. The new structure encouraged a substantial number of private sector entrants, ranging from previously publicly employed medical staff who left public service to set up their own companies, to larger privately capitalized firms including (somewhat controversially) so-called 'risk-capital' or venture capital firms with the expressed intent of selling off their investments within five years (Calltorp, 2013). Moreover, in an important measure of how Swedish citizens value diversity and choice among providers, by 2012 patients sought out private providers for 50% of all primary care visits in Sweden (Anell, 2011b).

As the above review suggests, based on the development of the Vardval model, first contact primary care is the only clinical medical area where Sweden currently has a more diverse, broadly competitive public-private environment for the delivery of health care services. One also can point to increasing diversity of long term care and home care provision – largely similar to the type of activity seen now in first contact primary care (Fagerstrom and Willman, 2012). Thus while Swedish primary care in the 1980s was characterized by nearly exclusive public control over both financing and delivery, the recent adoption of Vardval in primary care has now generated considerable diversity in the area of primary health care generally.

On an international level during this period, there was considerable change in Norway, where in 2003 a majority of physicians who previously had been employed at municipal public health centers became private GPs, reimbursed by public funds (Ringard *et al.*, 2013). Similarly Finland continues to have mixed public-private arrangements in primary health care. Public primary care physicians frequently work privately in the afternoon, often seeing the same patients and in turn partly paid for this private service by a separate second publicly funded source (KELA, National Social Insurance). Finland also has some diversification in the delivery of home care services, with new private contractors coming into view, although most nursing home care continues to be provided through inpatient wards attached to public primary care centers, and arrangement which the Finns call 'Primary Care Hospitals' (Vuorenkoski *et al.*, 2008; Genet *et al.*, 2012). Denmark continues to have mostly private GPs, although under the new 2007

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health reform these private GPs are required to contract with municipalities to provide more preventive services (Olejaz *et al.*, 2012). Recent shifts in Sweden toward a more mixed public-private provision of primary care and primary health care services, then, generally resembles the structural approach currently seen elsewhere in the Nordic Region.

The slow strengthening of patient choice

In the early 1980s, the Swedish publicly funded health system afforded few opportunities to patients to choose their provider facility or their doctor. When stirrings of interest were raised, the response of the planners in the county councils would be 'we already planned for where you should go – we would have to pay twice if you chose to go somewhere else'. As already detailed above, for primary care services patients were assigned to a facility based on the number and street of residence (assignments were listed at the back of the local telephone book). For hospital care, each facility had a catchment area, and patients were assigned based on the planners' preferred balance between institutions (e.g. not necessarily the closest facility). As also detailed above, the arrival of Citi-Akuten in 1983 in Stockholm represented the first breech of this patient assignment process, since patients from anywhere in the city (or beyond) could receive care there.

The movement for patient choice of provider facility (or 'valfrihet') developed slowly from this point. Choice was of interest to patients for several reasons. One glaring concern was the length of the queues for elective procedures in Swedish public hospitals. In the mid-1980s, some procedures for elderly patients (total hip replacement, coronary artery bypass grafts, corneal lense transplants) had waiting lists up to two years long. Faced with these waiting times, some patients wanted the opportunity to go to hospitals in other counties with shorter lists. A related point was that allowing patients to choose another institution, if those patients brought adequate funding for their procedures with them, could introduce a measure of 'public competition' into the publicly operated system (Saltman and von Otter, 1987), and that, by so doing, could create incentives for public hospitals to be not only more efficient but also more patient centered (Saltman, 1992).

Choice of primary health center and, for pregnant women, of delivering hospital, was built into the 'Stockholm Model' introduced in 1990 (Bruce and Jonsson, 1996). In 1991, the program for the annual congress of the Federation of County Councils included a commitment to establish valfrihet for both primary care and hospital services (Landstingsforbundet, 1991). This commitment remained more official than actual, however, and in many counties was never publicized or made widely available. At the primary care level, in 1991 the national government's Huslakare legislation required counties to allow patient choice of their primary care doctor inside the publicly operated health centers. This too, however, was no longer operating in most counties after the program's repeal in 1994. Only with the arrival in primary care of the three Vardval pilot

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county programs in 2007 and 2008 did patient selection of their publicly paid and/or employed primary care provider become widespread and, seemingly, permanent.

In addition to the Vardval legislation, two recent legal actions appear to be placing patient choice of provider facility on more solid legal ground. One is the 2005 introduction of a 'care guarantee' by the county councils (through the Federation of municipalities and county councils, or SALAR). While this agreement only promises that elective procedures will be received within 180 days of the first patient contact with the health system, it does provide that patients can elect to receive care in a hospital in a different county – paid for by their home county – after this deadline is reached (Anell *et al.*, 2012). The second measure is national legislation currently under consideration in the national parliament which would establish in Sweden a 'Patient's Bill of Rights' (Winblad, 2014).

Finally, the issue of patient choice has come under increasing scrutiny from the European Union. The European Court of Justice in Luxembourg, in a long-running series of opinions that began in 1998, has ruled that access to 'timely' care means that EU citizens who are required to wait beyond certain deadlines for needed care can take themselves – without permission from their home system – to another country for care, and that the home health system is required to pay for that out-of-country care (Palm and Glinos, 2010).

Taken together, the developments around patient choice in the Swedish public system suggest two broad patterns. The first is that choice of provider facility, over time, has become increasingly important in how the Swedish public system is being managed. Choice in primary care has been more prominent, and choice of elective hospital facility has started to make itself visible (e.g. the care guarantee and the ECJ directives). While this process has largely been driven by citizens and national politicians, and acquiesced to rather reluctantly by county council managers, when one looks back over this 30-year period choice nonetheless has become an increasingly integral part of patient options within the public system. In this regard, there are strong similarities with how the process of choice of public hospital has evolved in Norway and Denmark as well (Winblad and Ringard, 2009). At the primary care level, Danes have long had choice among their private GPs (except for Copenhagen's reliance on public health centers in the 1980s) which also has been true in Norway since the 2003 reforms (Olejaz *et al.*, 2012; Ringard *et al.*, 2013).

The second pattern apparent in the evolution of choice within the Swedish public system is, curiously, what this process has not included, namely choice of physician for elective procedures within hospitals. There has been considerable discussion of this latter issue concerning primary care – it is seen as linked to both good continuity of care, especially for the chronically ill elderly, and to improved patient compliance with pharmaceutical and other physician mandated regimens. However there has been little to no discussion of this issue regarding elective hospital procedures – even those that are life-threatening, such as open heart surgery. Traditionally, when pressed, Swedish patients like their political leaders

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will say "I trust our doctors, they are all qualified". To date, regarding hospital inpatient procedures, that viewpoint remains common.

Continued public capital for hospitals

One of the more interesting developments in several other tax-funded health systems across Europe has been the concept of the public-private partnership, particularly the Private Finance Initiative (PFI) in England for funding the construction and equipping expensive new hospitals (Rechel *et al.*, 2009). At one recent point, there were over 100 PFI hospital construction projects underway in England. While these projects have their detractors, largely based on concerns that the new facilities lock public funders into paying annual rent for 30 years even as medical technology and treatment patterns continue to change (Atun and McKee, 2005), there has been general agreement among the implementing political groups that this PPP strategy is the quickest and most efficient way to raise capital for new facilities without overburdening an already overburdened public sector tax structure (Ferriman, 1999).

When one looks at the Swedish public system, however, thus far there has only been one major PPP funded hospital – the new Karolinska university hospital in Stockholm (Stockholm County, 2013). Even though the financial position of the county councils has not been good recently (in the early 1980s, most had a positive balance of some hundreds of thousands of Swedish crowns; today most operate with a deficit), this process of reliance upon outside private capital for necessary new construction has not taken hold. Moreover, in terms of hospital building generally, beyond remodeling of the existing two not-for-profit facilities, no new for-profit or not-for-profit hospitals have been built in Sweden over this 30-year period. All new capital for large institutional construction continues to come from the public tax base.

When one compares with Denmark and Norway, one finds that a number of small private hospitals have been built in both countries (Vrangbaek, 2012). In Finland, beyond one relatively large private hospital (Mehilainen) which has been in operation throughout this 30-year period, there have been several smaller facilities that have been funded with private capital – in particular the 20 bed 'heart hospital' in Kuopio in the 1990s. While these private facilities receive substantial funding from private patients using a mix of private commercial insurance, in Finland KELA public social insurance, and personal funds, these private commercial hospitals also have been keen to attract public contracts and funding. However in all four countries, with the exception of Mehilainen in Helsinki, most of these facilities have been quite small handling only elective procedures. In England, there has been substantial expansion in the private hospital sector, both not-for-profit such as BUPA and for-profit as well, as NHS patients since 2007 have been given the choice of receiving elective care in private as well as public facilities.

Overall, the pattern in Sweden continues to be one of little apparent interest among private funders in investing in new hospital facilities. That this pattern has been consistent over the 30-year period, at a time of considerable change in other

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tax-funded health systems, raises several interesting policy questions. One might be why private for-profit capital in Sweden, while it is very interested in investing in primary health care centers, has had almost no interest in investing in the hospital sector. This even though the public sector in Sweden has now reduced its number of inpatient beds to a level below that of most other Northern European countries, leading one group of Swedish health experts to call for an expansion of hospital capacity (Roos *et al.*, 2014). A second, related question concerns the apparent difficulty of raising not-for-profit or community-based capital for new hospitals in Sweden. Both questions are valuable as insights into the way in which diversity of providers has encountered obstacles to date in developing.

Slow progress with integrated/coordinated care across the health/social interface

There is increasing pressure on health systems across the developed world to link inpatient and outpatient services to a broad range of primary health care and social care services, with the stated goal of creating a 'seamless web' of appropriately targeted and delivered services for patients generally and for the elderly in particular (Mor *et al.*, 2014). This pressure has been generated in equal parts by a rapid increase in the number of chronically ill elderly and by the resource constraints that publicly funded health care systems currently face.

Efforts to construct appropriately integrated programs in Sweden date back to the 'vardprogrammet' framework developed by the joint county council/national government research organization SPRI in the early 1980s. There also were efforts at the county council level to put in place joint health/social committees and other working mechanisms that went under the general heading of 'forandringsprocess' (change process).

While both of these programs had some measure of success, the most visible and important shift took place in 1992 with the onset of the nationally mandated "Adelreform" (elderly care reform). This reform shifted public nursing homes from the county to the municipal level of government, in effect conjoining nursing homes, old age homes, and home care all within the responsibility – and the single public budget – of the 289 municipal governments (Johansson, 1997). While coordination among these three levels of direct elderly care services improved, relationships with primary care and other clinical care services – all of which were still at the county level – required sometimes difficult cross-organization and cross-budget efforts, as well as cross-focus (social vs health) collaboration. Recently several private for-profit companies and public sector county pilots have shown somewhat better outcomes, but they remain hampered by the structural splits between health and social as well as county and municipal responsibilities (Fagerstrom and Willman, 2012). Thus while there has been increasing diversity of providers in this sector (as noted earlier), the full service and financial benefits of new innovative approaches have yet to be widely felt.

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Looking internationally, considerable attention has been paid to a variety of different examples of innovative health/social interface mechanisms. One general approach has been to re-organize the way that both health and social care delivery are organized and paid. In the Netherlands, private for-profit companies like Cordaan employ personnel across the interface, and have contracts with the country's dominant (social health insurance funded) private health insurers that pays Cordaan tied to client outcomes (Saltman *et al.*, 2011a). This is a quite opposite funding strategy from that employed in the Swedish public sector, which pays salaries to personnel for time worked not client outcomes. A similarly integrated delivery-based strategy has been adopted inside the (nationally funded) US Veterans Administration health system, It is based on an integrated electronic record across the entire health/social interface, and appears to more effectively coordinate health and social care (Oliver, 2007).

A second type of innovative initiative is a new management tool in England and The Netherlands that gives home-bound elderly a (publicly funded) personal budget combining home care and social services, allowing the individual to select their own caregiver (often from a mix of pre-qualified private as well as public providers) and also the mix of different services they prefer (Hutchinson, 2012). In England, the patient can also add personal funds to that budget, 'topping up' to provide additional services. In both countries, this model has become very popular with many elderly, since it allows them to control the quality and volume of the services they receive and who they receive them from, and its range is expanding.

A third model focuses on new ways to manage chronically ill elderly, who often make up the most expensive segment of the home-bound elderly population. The initiative involves giving incentive payments to GPs to more closely follow their chronically ill patients. In Denmark, GPs receive 7700 DKK (~$1200.) for a full workup on a diabetes patient, and 2200 DKK (~$400.) for providing annual checkups to that patient. Early results in a 2009 evaluation showed a small but important improvement in the number of adequately controlled patients (Sundhedstyrelsen, 2009).

Although each of these three models is tailored to fit a different health system context and culture, they all represent efforts to develop new and more cost-effective ways of organizing and paying for better outcomes for the growing numbers of elderly individual, and all three different approaches would represent quite a break with current practice in the Swedish public health system.

Assessing the patterns

This broad portrait of long-term trends leads toward a range of different observations about the present configuration of Swedish health policy and also about its current capacity to meet emerging health sector challenges. When one draws together all five of these structural and institutional patterns, they form quite an interesting picture of Swedish health policy over this 30-year period:

(1) The resilience of the county councils
(2) The slow growth of diversity among service providers

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(3) The slow strengthening of patient choice
(4) Continued public capital for hospitals
(5) Slow progress with integrated/coordinated care across the health/social interface

On the one hand, viewed positively, this mix of patterns and trends describes a health system that has undergone considerable change over the past 30 years, and that is continuing to change in the current period. Beyond the major long-term reforms instituted by the central government (Adelreform in 1992; Vardval in 2010), there also has been an increase in the diversity of service providers in primary health care and long-term care, as well as a substantial increase in the level of patient choice of provider. In other areas of health policy, however, there appears to have been more stability than change.

As often noted above, a key dimension of health sector change in Sweden over this 30-year period has been its slow and deliberate character. This approach is broadly appropriate for a generally successful health care system that largely meets the clinical needs of its citizenry, and which is broadly satisfied with its level of performance and outcomes. It also is appropriate for a system that views the process of care and service development as itself slow and incremental in nature. In many ways, it reflects the values and expectations of Swedish society in mid-20th century, when medical care involved mostly settled science, population demographics were largely stable, and the Swedish economy was strong and vibrant.

Looked at from a less sanguine perspective, however, precisely this institutional and organizational stability can be interpreted as more of a liability than an asset. Rather than stability, the process of slow change can be viewed as more static than stable – as reflecting an inertial inability to overcome a range of difficult structural impediments that prevent needed change to service patterns and delivery mechanisms. From this perspective, moreover, the 'slow change' still evident in the current Swedish system may well be insufficient to respond to the growing range of demands created by a newly emerging historical period of rapid technological change in the science of medicine, a larger number of chronically ill elderly in the overall population (itself partly the positive result of past medical advances, e.g. the development of statins to treat high cholesterol levels and of CABG surgery to repair clogged arteries, etc.), and the potentially prolonged weakness of not just the Swedish but European economies generally (King, 2010, 2013).

Going forward, one might contrast the slow stately process of county council led governance with the types of new challenges that will array themselves before the Swedish health system over the next several years. Among the more difficult issues will likely be the following:

A. How to improve services/personnel/facilities if economic growth stays low and public sector funding remains limited?
B. How to attract professional staff if salaries can only go up based on productivity (no new money)?

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C. How to respond to a likely emerging Cross-Nordic competition for tertiary hospital services (e.g. Sahlgrenska in Gothenburg competing with Rikshospitalet in Oslo and Rigshospitalet in Copenhagen)?
D. How to effectively shift and pay for prevention programs run by municipalities (as already underway in Denmark and Norway)?
E. How to serve more chronically ill elderly needing flexible, personal, targeted, cross-sectoral care?
F. How to cover costs of providing human-genome-based personalized testing, pharmaceuticals, and the accompanying medical support services?
G. How to meet internet-driven patient demands for services delivered at the highest international standard of care?
H. How to develop a parallel infrastructure for E-Health services (both staff and facilities)?

In Sweden as elsewhere in Europe, the standard policymakers' response to these (and other) emerging health sector challenges is to call for a more flexible and more efficient structure of service delivery, and to find innovative new ways to design and organize the care process. Moreover, in the Swedish context, the explicit political expectation is that such challenges can (and for values reasons must) be met within the context of the existing tax-driven system of health care financing. The scope and scale of these new challenges, however, suggests that the past process of slow change will be insufficient. Some other way of working and delivering health services will be needed, whether that means more diversity, more choice, more non-public capital investment, and/or more integration of health/social and county/municipal arrangements. In essence, however one may interpret past efforts toward change in the Swedish health sector, the challenges of the future will almost certainly require substantially greater and more extensive change to the traditional public system of service provision than has thus far occurred.

The types of new structural arrangements that Swedish policymakers will likely need to consider are difficult to implement in any health system, and certainly in one as stable/static as the Swedish system has been over this past 3 decades. Potential policy options might well include the following:

- Modify/re-design health sector governance away from county councils toward fewer, larger regional councils (as in other Nordic countries) with a consequently larger, more centralized role for the national government. The sitting Minister of Health and Social Affairs, Goran Hagglund, has been quoted recently wondering if what was needed was a 'state-directed' health care system.
- Modify payment/salary incentives for publicly employed health sector staff to incorporate major changes such as individual pay-for-performance and/or individual bonuses.
- Re-structure existing county owned hospitals into state-owned enterprises, reducing existing union-based work rules and shifting permanent public employees to fixed term employment contracts linked to institutional and individual performance.

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- Separate hospital management from direct political control, restricting elected politicians to decisions regarding strategic issues.

Just to raise these questions about possible innovative strategies and solutions is to confront how complicated any of them are in the current Swedish policy context, how unattractive they are to many of the key power brokers in the Swedish political environment, and how difficult any of them would be to achieve even if they could in fact somehow be implemented. These reforms would be substantially more far-reaching than the re-configuring of national regulatory agencies proposed by the final report of a 2012 national investigatory commission (SOU, 2012), whose suggestion to combine 12 separate agencies into four has been itself viewed by many as too contentious to implement.

In turn, then, the experience of this 2012 state commission suggests the degree to which the Swedish system going forward may well have much the same framework of organizational and institutional structure in the future as it has had in the recent past. If this is in fact occurs, it will come as no surprise to those who hold to the historical institutionalist theories noted in the Introduction. Such an outcome would, however, from a health system performance and outcomes perspective, and thus from a patient perspective, come with at least as many structural liabilities as advantages.

Why it is that the other three Nordic countries have adopted more thoroughgoing institutional change than has Sweden is a question that will likely hover over Swedish health policy debates going forward. Some might point to Sweden's lack of immediate financial difficulties in funding the present structures, others to the ideological configuration of existing political alliances and coalitions, and still others to the general level of overall satisfaction with health service delivery that Swedes usually display in surveys and questionnaires. However one views the sources of this stability and/or stasis, current ongoing processes of change internationally in health care standards and technology as well as globally in the world economy will inevitably drive future reform in the Swedish health system. What form these structural changes will take, however, and the ease with which they will be put in place, has yet to be determined.

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