

INTERNATIONAL HEALTH CARE MODELS: SWEDEN

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1. Introduction

The Swedish health care system and its evolution during the last twenty years may be of considerable interest in the context of future Canadian health care reform, for several reasons. Although Sweden is not a large country (its population of less than 9 million is smaller than Ontario's alone), it has a highly decentralized and heterogenous (in some respects) health care system, with major operational autonomy lodged in more than 20 regional authorities, the county councils. Sweden's experience may therefore be of considerable interest to provinces that are proceeding with, or contemplating, a move toward increasing decentralization of the management of their health care systems. At another level, a study of the interplay between the county councils and Sweden's national government may contain useful lessons in assessing the methods we use in Canada to regulate federal-provincial relations in health care.

An additional reason why the Swedish experience is interesting is that Sweden, along with the U.K., the Netherlands, and New Zealand, was one of the countries in which serious experimentation was undertaken with the principles of managed competition and internal markets that have been central to the international debate about health system reform since the late 1980s. The model of managed competition in a system of publicly funded health care is based on the idea that health services will be delivered to the population not by a single organization (such as the U.K. National Health Service), but by a number of *independent*

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providers who compete with each other for patients and funding. This of course is how health care is delivered in Canada. Consequently, the information that was generated by the Swedish experiments with managed competition could be of considerable interest to provincial decision-makers as they grapple with questions regarding the methods that should be used to pay for the services of hospitals, doctors, and other providers. (For example, the experience with contracting out of certain forms of surgery in the city of Stockholm may be relevant to the issue of what constitutes appropriate forms of public funding of private surgery clinics, an issue that has recently been debated in Alberta.) In part because the Swedish system is so decentralized, the experiments generated information about a wide range of possible approaches to system management.

The rest of the paper is organized as follows. In Section 2, the system of financing of health services is considered, with special reference to the mix of public and private funding, and the role of user charges. The section also reviews the legislation governing citizen's access to care, and briefly compares the costs and performance indicators of the Swedish system with those of other countries. Section 3 describes the decentralized system that is used to manage health care resources, and the tools that have been used during the 1980s and, especially, the 1990s, when the experiments with internal markets, managed competition, and a purchaser-provider split were introduced and subsequently modified. Section 4 first discusses the mechanism through which political accountability is created through a system of elected county councils, and the methods that are used to make county councils accountable to the national government. It then briefly considers the issue of provider accountability to patients. Section 5, finally, contains some concluding comments.

2. Financing and the right to care

Share of the public sector

The share of total health expenditure that is publicly funded has traditionally been very high in Sweden (and in the other Scandinavian countries). In 1980, the public share was over 90%. By the late 1990s, it had fallen to about 83%, but this figure, too, is higher than in most major countries other than the United Kingdom. As in the U.K., the large public share in Sweden primarily reflects that fact that coverage in the public plan is quite broad. In particular, in addition to hospital and physician services, it also covers the cost of most pharmaceuticals, a substantial part of dental care, and care of the elderly in nursing homes. This broad coverage is consistent with Sweden's position as having one of the most comprehensive social welfare systems in the world. One noteworthy element is a plan under which individuals receive income replacement through the social insurance system if they have to take time off work due to illness. Another health-related element of the social insurance system that has become very costly in recent years has been the financing of early retirement for those with chronic health problems. Although the costs of these programs are not included in the cost of the health care system as conventionally defined, they are large components of the cost of the social welfare system more broadly.

The privately funded component of health care costs, some 17% in the late 1990s, is almost entirely made up of patient fees and co-payments for items that are included in the public plan. Although it is legal to offer private insurance that covers the same benefits as in the public plan (contrary to what is the case in Canada), the number of person with private insurance is very

small (much lower than in the U.K.), and private insurance pays for only a very small fraction of total health care costs. While the reasons for this are not entirely clear, part of the explanation probably is that publicly employed doctors in Sweden are not allowed to practice privately on a part-time basis, as they are in the United Kingdom, and that almost all doctors that practice privately on a full-time basis do so within the public system: Their services are paid for through public insurance. Thus the market for private insurance is small simply because the availability of health services outside of the public system is limited.

The right to health care

Formally, all persons in Sweden, regardless of their ability to pay, and regardless of where they live, are entitled to all "necessary" health care as a matter of right, and a general statement to this effect is part of national legislation. Implementation of this principle, however, takes place in a highly decentralized system in which most kinds of care provision is funded and managed by some 25 local bodies, *county councils*. On average, each one includes around 330,000 persons, but they range in size from some 1.6 million (the city of Stockholm) to less than 100,000. The county councils are responsible for provision of acute-care hospital services, primary care, and (since 1998) pharmaceuticals. Long-term care for the elderly is organized on a different basis, with responsibility for both funding and management resting on municipalities, the level of government below the county councils. The usual explanation for this arrangement is the need to integrate the provision of long-term care with other services that are provided by the municipalities, such as social assistance and home care.

As will be further described below, most of the important decisions regarding funding and management of the health care system are made at the county council level but, as in

Canada, the system is constantly changing and the national government plays a significant role in setting the boundaries for the degree of local autonomy.

A good example of the nature of the legal and administrative interaction between the national government and the county councils is the so-called "care guarantee" that was introduced in 1992. Originally, the guarantee concerned maximum waiting times for certain types of elective surgery for which there were long waiting lists. However, these waiting lists have largely disappeared, as a result of various measures by county councils to shorten them (including contracting out of certain kinds of surgery, and incentive-based funding mechanisms for hospitals and surgeons). At present, the guarantee specifies the maximum waiting time before a person will be seen by a doctor in primary care (eight days, although of course patients are seen by other personnel, such as a nurse, before that), or to see a specialist (three months). These guarantees exist as a result of agreements struck between the national government, on the one hand, and the Federation of County Councils, on the other.

Sources of public-sector revenue

Most of the public sector's share of health care costs are covered out of general tax revenue. However, an important feature of the system is that the county councils (as well as the municipalities) raise most of their revenue through income taxes of their own. The tax base on which this revenue is raised is the same as for the national income tax, and both the county council and municipal income taxes are levied as a flat rate on each person's taxable income. (In contrast, the national income tax is progressive.) In addition, county councils also receive certain grants from the national government. Essentially, these grants are population-based, but with certain adjustment for the population's socio-economic status and other factors. Although they

are important sources of revenue, in the late 1990s the national government's contribution was, on average, less than 10% of the county councils' total revenue, though additional amounts were transferred through the social insurance system.

In principle, each county council is free to set its own flat rate, at a level that is sufficient to cover its expenditure (after allowing for national government grants). However, during the severe public-finance crisis that Sweden went through in the late 1980s and early 1990s, the national government unilaterally froze county council tax rates for a time. At present, more flexibility is allowed, but the system still contains incentives on county councils to exercise restraint (those county councils that raise additional revenue by raising their flat-rate percentage suffer a reduction in the national government grant equal to 50% of the additional revenue they raise themselves (Mossialos and Le Grand 1999b, p. 109).

While most of the cost of care is paid for by the county councils and municipalities, certain components, notably the public sector's share of dental care for adults, is paid for through the national social insurance system, which in turn is financed through a system of payroll taxes. Until recent years, the role of social insurance was larger than it is today. For example, payment to privately practicing physicians (that is, those that are not employed by the county councils), as well as the public sector's share of the cost of pharmaceuticals, were made directly to the providers from the social insurance system. However, since the late 1990s, most of these costs are now born by the county councils, following agreements providing for increased cash transfers from the central government.

User fees

By Canadian standards, user fees in Sweden are relatively high. For hospital stays, a fee

of SEK 80 per day (about C\$ 12) is charged. For primary-care consultations with nurses and doctors, the fees vary by county council: Each one is free to set its own fee level. However, they are relatively high, ranging from about C\$ 15 to C\$ 20 for visits to primary care doctors, and up to twice that for visits to hospital-based physicians or doctors that practice privately. While county councils can set their own outpatient fee levels, patient fees are subject to a stop-loss provision that is stipulated by the national government; it specifies that the maximum patient fees in any twelve-month period be no more than SEK 900 in the aggregate. In addition, although the Swedish system covers part of the cost of pharmaceuticals, patients pay a substantial portion of this cost. Specifically, in each twelve-month period the patient has to pay the first SEK 900 (about C\$ 135) of drug cost out-of-pocket, and part of any additional cost up to a maximum of SEK 1800 per twelve-month period. Together, therefore, patient fees and pharmaceutical co-payments may add up to as much as about C\$ 400 per twelve-month period. The potential impact of these relatively large amounts is moderated through special provisions for persons with low income, however, and persons under age 20 are exempt from patient fees.

Swedish health care costs in international perspective

Around 1980, Sweden devoted as much as 9.4% of GDP to health care. According to the most recent OECD statistics, this was a larger number than in any other country in the world, including the United States, at that time. The statistics also show that around that time, close to 10% of the Swedish labour force was in the health care sector. This was much larger than the corresponding statistic for other major countries. For example, it was almost twice as high as the percentage in the U.K.

Since 1980, Sweden has taken a variety of measures to contain health care costs. By

1990, the percentage of GDP devoted to health care had fallen to to some 8.8%. By that time, the figure in a number of other countries, including Canada and, of course, the U.S. was as high or higher. Although the Swedish economy continued to grow very slowly during the 1990s, health care spending grew even more slowly, so that by 1998 the percentage of GDP had fallen to 8.4. The share of employed labour working in health care has fallen even more dramatically; the latest figure in the OECD statistics is 7.7%. While this represents a substantial reduction from the 1980 figure of 10%, it still high relative to many OECD countries (for example, it is estimated at only 4.5% in the U.K. and the figure for Canada in the mid-1990s is given in the statistics as 5.5%). It should, however, be kept in mind that Sweden has a very old population and some other countries that also do (for example, Germany) now has as much health employment compared to the total as Sweden.

Although Sweden's per capita GDP, some decades ago, was near the top in international comparisons, Swedish economic growth in the last two decades has been extremely slow, so that in real terms, the 8.4% share of GDP now translates into a figure of only \$ 1746 in U.S. Purchasing Power Parity dollars (OECD 2000). The corresponding figures for Canada and the U.S. are \$ 2312 and \$4200. The only major European country with lower estimated per capita spending is the U.K. at around \$ 1460.

In spite of the relatively low health care spending, the simplest indicators of population health put Sweden near the top. For example, infant mortality is somewhat lower than in Canada (3.6 and 5.5 per 1000 live births, respectively, in 1997), and male and female life expectancies are about the same as for Canada (about 72 and 82 years, respectively, in 1997).

With respect to other aspects of health status and quality of care, the picture is less

certain. Some years ago, there were long waiting lists for certain kinds of elective surgery, but as noted above, by the mid-1990s, those had by and large disappeared. Another issue that at one time caused considerable controversy and concern was the lack of patient choice with respect to provider that was inherent in the way the system then was organized. Again, this issue has to a considerable extent been addressed, and Swedish patients now are able to freely choose their family doctor, and in which hospital to have certain forms of elective surgery. Moreover, following the reforms that were tried during the 1990s, there is now considerably more emphasis on attempts to raise the quality of care, and systematic attempts are made to measure the quality by keeping track of interventions and outcomes for a wide range of disease conditions. However, there is no consensus regarding the quality picture. For example, in the mid-1990s, a parliamentary committee undertaking a major study of the health system's organization concluded that a projected gap would exist in the year 2000 between the resources that would be "needed" (taking into account the aging population) and those that would be available, of about 8% (Arvidsson and Jönsson 1997, p. 38). Statistics from the end of the century now show that in real terms, health care resources actually fell by some 10% in real terms during the 1990s, and one school of thought in Sweden interprets this as meaning that such a gap now has come into existence. Not surprisingly, however, there is another school that interprets the reduction in real resources as evidence that the measures that were tried used during the 1980s and 1990s to improve the efficiency of the health care system did in fact have the intended effect, so that the reduced resource use simply reflects the system's ability to provide high-quality care at lower cost than before. The debate continues.

Management and devolution

Decentralized management

As discussed above, funding of health care in Sweden is a shared responsibility between the national government and the county councils, with the latter carrying most of the cost through the tax revenue they raise themselves. With respect to the management of the system of health services production, the role of the county councils is even more dominant. Formally, all but a small number of hospitals are owned by the county councils; the county councils also own the primary-care centres where most Swedes receive their primary care. Most doctors, both those practicing in hospitals and those working in primary-care centres, are salaried employees of the county councils. Most other personnel in the system are county council employees as well. Not surprisingly, therefore, the county council is the largest single employer in many Swedish communities, and many councils' chief executive officers manage more resources than CEOs in all but the largest private firms.

As described in the previous section, the national government contributes to health care funding in two ways: Through direct grants to the county councils, and through the money that flows through the social insurance system to fund certain specific providers. The most important ones in the latter category are privately practicing doctors, and pharmacies. (Another large component is dental care for adults, but it will not be further discussed here.) In the past, the county councils were not directly involved in managing those services that were funded through social insurance. However, through reforms in the 1980s and 1990s, their role in these areas has been strengthened as well, and a large share of the social insurance funds now flow to the county councils rather than directly to providers, as discussed below.

Although most doctors in Sweden are salaried employees, somewhat less than 10%

continue to practice privately, and are paid through a system of negotiated fee for service. Prior to the mid-1980s, privately practicing doctors were free to practice anywhere, and were paid directly through social insurance. Since 1985, however, the funds to pay private practitioners are transferred to the county councils on a per capita basis, and privately practicing doctors have to have a contract with the council in the county where they practice. To keep costs down, such contracts may cap total payments or the number of visits for which reimbursement will be made. Thus the system is no longer open-ended: The county councils have control over the total amounts paid. (For a brief period during the family doctor reform of the mid-1990s [see below], the system *was* effectively open-ended. However, since 1995 the county councils have once again been able to control total spending.)

The subsidy component of the cost of pharmaceuticals continued to be paid through social insurance up until the late 1990s, but since 1998 this cost is also paid by the county councils. In return, the county councils receive additional grants negotiated with the central government. Thus by the end of the 1990s, the decentralization of management responsibility for the health care system that had begun in the early 1980s, was close to being completed.

While day-to-day management is highly decentralized, national legislation nevertheless continues to impose certain restrictions on what the county councils can do. Beyond the general language dealing with equal access without regard to ability to pay or residence, there are national rules specifying maximum waiting times for care (referred to in the previous section), and rules regarding stop-loss provisions for patient co-payments, the freedom to choose a family doctor, and so on, are national in scope. Thus in general, the picture is one in which management has been substantially decentralized, but with government at the national level

retaining a high degree of control over some of the health care system's most important features. This control is both in the form of explicit statutes (like the Canada Health Act), or in the form of agreements negotiated between the national government and the Federation of County Councils. (In the Appendix, I briefly compare the contents of the 1982 Health and Medical Services Act with the five principles of the Canada Health Act.)

From the viewpoint of the Canadian experience with devolved federal-provincial jurisdiction over health care, an obvious question concerns what instruments are used by the central government to enforce the national rules, and how disputes between the central government and the county councils are settled. The somewhat surprising answer seems to be that this issue has been largely irrelevant in Sweden, because the system has not generated any major tension between the two levels of government.

The difference between Canada and Sweden in this regard may, to some extent, be due to factors such as differences in population size and homogeneity, or to fundamental differences in the systems of government, rather than to the way the health care system is organized. However, it is also possible that there are features of the Swedish system of divided jurisdiction that are conducive to a smoother relationship between the two levels of government than Canada has had.

Management tools: the 1980s

Around 1980, Sweden devoted a larger proportion of GDP (9.4%) to health care than any other country in the world, as noted above. At about that time, it was also becoming clear that Sweden was facing a public-finance crisis of major proportions, a crisis that would last for many years to come. Serious concern with cost containment in health care can be dated back to that

time. Since the major responsibility for managing the system had already been transferred to the county councils by that time, the burden of implementing cost reductions fell largely on them, and most of the approaches to cost containment that subsequently were adopted originated with the county councils. As also noted above, cost containment has been relatively successful in the sense that by the end of the 1990s, Sweden spent about 8.4% of its GDP on health, a full percentage point less than twenty years earlier.

During the 1980s, the principal tool for cost containment was simply budgetary planning under which the county councils attempted to impose global budgets on particular districts within the county. In turn, the districts tried to stay within their aggregate constraint by establishing global budgets for units such as primary care centres and hospital departments within the district.

While the global budget system had considerable success in reducing the rate of expenditure growth, it did not lead to a major change in resource allocation in the system. Often, budgets were established based on historical cost. In some counties, the flexibility of local decision-makers was also limited by other constraints, such as rules against personnel layoffs during times of high unemployment. Thus, while expenditure growth slowed, there was little evidence that the system was becoming more efficient. Instead, it appeared to many that the success of cost containment to a large extent had come simply through a reduction in the level and quality of services received by the population, and especially during the latter half of the 1980s, increasingly long waiting lists for certain types of care became an important political issue that ultimately led to national government intervention.

While the use of global budgets may not have contributed directly to improved

efficiency, it has been argued that they may have done so indirectly, by constituting the first step toward more effective forms of decentralized management, and the use of managed competition and internal markets during the 1990s (Anell 1999, p. 705). In particular, establishing global budgets at the district level made it possible to compare the per capita cost of care in different districts, and contributed to the subsequent trend toward the principle of population-based health care funding. Also to the extent that costs in some districts were higher than elsewhere because care was delivered to residents of other districts, the global budget system contributed to discussions that made such transactions explicit, and thus contributed to laying the groundwork for explicit inter-district negotiations about contracted care.

The 1990s: Internal markets and managed competition

The lengthening waiting lists contributed to growing public dissatisfaction with the health care system in Sweden in the 1980s. Various polls suggested that there were other contributing factors as well. People sometimes complained about the way they were treated by the personnel they encountered in the system, and often voiced a desire to have more "influence" over the care they received. In particular, many citizens wanted more freedom to choose their health care provider. In the Swedish system as it existed during the 1980s, there was little freedom of choice in this regard. Access to private doctors was largely limited to those living in large cities, so that for most people, the only source of primary care was a publicly operated centre. Even if you lived in a place where there was more than one primary-care centre, you were only allowed to go to the one serving the population of the area in which you were a resident. In the centre, you were treated by a nurse or the doctor on duty, who might or might not be your "regular" doctor. Similarly, people needing hospital care could only receive it in the hospital

serving their area of residence.

As a result of these problems, political decision-makers began paying increasing attention to proposals by economists to introduce elements of reform in the Swedish health care system. The reforms were intended not only to make the system more efficient (raising the quality of care while continuing to contain costs), but also to respond to the public's desire for more freedom to choose their health care providers. Although in some ways, these objectives are complementary, in others they are in conflict, as will be further discussed below.

The fact that Sweden became "an important pioneer of market-oriented reform in publicly funded health care systems" (Harrison and Calltorp 2000, p. 219) in part reflected a change in the political climate (the social democratic party had lost the election of 1991 to a non-socialist coalition), but in part can be seen as the result of the general openness in Sweden to ideas originating in the academic debate. In the late 1980, Richard Saltman and his Swedish co-worker Casten von Otter (1987) published a proposal for "public competition" in Sweden, and the Swedish Institute of Health Economics published a working paper on the Swedish system by Alain Enthoven, the economist whose work provided the model for both the Clinton plan for universal health care in the U.S. and the Dekker-Simmons plan for health care reform in the Netherlands. Work commissioned by the Federation of County Councils in 1991 provided sympathetic discussion of different models of public competition, and the U.K. model of health care reform through a purchaser-provider split was well known in Sweden (Federation of County Councils, 1991).

The purchaser-provider split in Sweden

The fundamental concept behind the idea of a purchaser-provider split in a system of

publicly provided health services is that of an explicit *contract* between the agency that pays for a defined population's health services (the purchaser) and those that provide these services (hospitals, primary care centres, privately practicing doctors). The contract with a provider specifies what services (of a specific quality, say) that are to be rendered to what population, and perhaps sets a limit to the quantity. It also specifies what the provider will be paid, and on what basis (for example, per procedure). However, the contract does not specify *how* the services are to be produced: This is left up to the provider to decide. A fundamental principle of a meaningful purchaser-provider split is that the providers will *only* be paid the amounts specified in the contracts it holds. Any deficits that are incurred should be the providers' responsibility or at least (if they end up being covered by the funding agency) should result in some form of future sanctions. Under managed competition, the purchasers should also be free to choose among competing providers in contracting for their population's care.

Unlike the case for the U.K., there is no national legislation in Sweden that mandates a purchaser-provider split. However, most county councils did, over the first half of the 1990s, move some distance in the direction of such a system. The exact model varied. In Dalarna county, the split was accomplished by essentially giving purchasing authority to primary-care centres which received population-based funding to cover the cost for all types of care for the population in their catchment area. (This was reminiscent of the U.K. system of fundholding, with the centres acting as fundholders: Like U.K. fundholders, the centres had to negotiate with hospitals for secondary care for its patients.) In other counties, a single purchasing agency was given responsibility to negotiate with all providers in the county.

As in the U.K., the experience with the purchaser-provider split in Sweden has been

mixed. In some counties, there has been little change *de facto* even though the split has been formally introduced. There has often been little competition, as purchasing agencies simply sign contracts with the same hospitals that have always provided given types of care. When there is a single purchasing agency, each hospital may be given a "block contract" which simply specifies that it will provide the same types of services as it always has, in return for a lump-sum grant that may be set on the basis of its historical cost. In practice, purchasing agencies may also, indirectly, allow providers to incur deficits by simply increasing next year's block grant by enough to cover them. Thus in those counties where there was an absence of political will to make the system effective, ways can be found to design a system that formally qualifies as a purchaser-provider split, but makes little or no difference in practice.

In some counties where the purchasing function was decentralized (as in Dalarna county, and the city of Stockholm) the split was potentially more effective, but other problems arose. According to Harrison and Calltorp (2000, p. 228), the negotiations between local funding agencies and hospital caused confusion and high administrative costs, and the purchasing function was subsequently centralized again. In the city of Stockholm, although the evidence suggests that there was a substantial increase in hospital productivity, aggregate costs for hospital services rose because the volume of services increased and payment was on the basis of a fixed sum per treatment performed (Arvidsson and Jönsson 1997, pp. 53-4). To counteract this problem, the system in Stockholm was also re-centralized and modified in other ways.

In spite of these problems, the prevailing view seems to be that even though some of the more radical experiments have been abandoned (in Dalarna and the city of Stockholm), the purchaser-provider split will remain as an important principle in the Swedish system, at least in

the sense that funding agencies and producers will "increasingly conduct their transactions through contracts that specify mutual entitlements and obligations" (Arvidsson and Jönsson 1997, pp. 55-6; author's translation).

The Swedish experience with a purchaser-provider split may be of considerable interest to provincial and regional decision-makers in the Canadian health care system. The essential features of a purchaser-provider split is an arms-length relationship between those who finance health care, on the one hand, and those who manage the organizations that actually provide health services (hospitals, primary-care centres, physician practices), on the other. In Sweden (as in the United Kingdom), such a relationship had to be created through a "split" since the funding and management functions had not previously been separated. In Canada, no "split" would be necessary since hospitals and physician practices already are independently managed private organizations. However, although the funding and management functions already are separated, the methods that have been used in the past to allocate health care funds to providers have not been based on explicit considerations of cost-effectiveness. (Physicians are paid by provincial insurance plans on the basis of a fee for service, while hospitals have been funded on the basis of negotiated global budgets, with little explicit consideration of productivity.) Introduction of some type of contract-based funding mechanisms may be an interesting alternative, especially if management of the system will increasingly be devolved to regional authorities below the provincial level with population-based funding.

Patient choice and care guarantees

The perceived public dissatisfaction with the lack of freedom to choose one's health care provider was addressed in two major reforms; both were supported by national legislation. The

second, the family doctor reform, is discussed in the next section. In this section, the reform referred to in English as the "patient choice and care guarantees" (henceforth PCCG) is described.

The PCCG reform was directed specifically at hospital care. Its cornerstone was the provision that patients requiring surgery or other hospital treatment would have the right to freely choose the hospital in which they would receive treatment. (Recall that under the earlier system in Sweden, patients requiring hospital treatment could only receive it in the hospital to which they were assigned; that is, the hospital serving the area in which the patient resided.) In addition, the PCCG specified that "money would follow the patient". That is, if a patient elected to receive care in a hospital other than the one to which he or she was originally assigned, a specified sum of money would be transferred from the budget of the latter to that of the former.

The PCCG reform was not only intended to address the general public dissatisfaction with the lack of patient choice of provider, but also the problem of waiting times for certain forms of surgery. (Other things equal, patients are obviously likely to choose treatment in a hospital with a shorter waiting time, if they have the option.) To further address this objective, the national government provided the county councils with additional funding specifically intended to shorten waiting times. In some cases, the county councils passed these funds on to only those hospitals that were able to guarantee that patients would be treated within a specified period of time.

In absolute terms, the PCCG reform led only to a relatively small reallocation of health care funds. Even so, it has generally been considered a major success. For one thing, it appears to have been responsible for a substantial reduction in waiting times for important kinds of

elective surgery, to the point where, by the end of 1993, waiting lists had "ceased to be a political issue" (Harrison and Calltorp 2000, p. 223). The public at large also appears to have put considerable value on the increased freedom of choice that it offered. In addition, many observers claim that it produced a major change in the way patients scheduled for surgery were treated, as an incentive was created for each hospital to attract patients from other ones, or to prevent patients from going elsewhere. Although the specific measures aimed at eliminating waiting lists for certain kinds of elective surgery have been discontinued, patients still have the right to choose among hospitals, and as discussed above, maximum waiting time guarantees have been introduced for consultations with primary care doctors and specialists.

The family doctor reform

While the patient choice and care guarantee reform was successful, the other reform that aimed at expanding patient choice, the family doctor reform, was not.

The central element of the family doctor reform was to introduce a right for patients to choose a specific primary-care doctor as their family doctor, and to guarantee that this doctor would henceforth become the patient's regular physician. This right was intended as a response to public dissatisfaction with the fact that those who received treatment in primary care centres could not count on being seen by the same doctor on successive occasions. In addition, of course, establishing a regular doctor-patient relationship can be seen as a way of improving the quality of care, since diagnosis and treatment are likely to be better when the doctor knows the patient well.

Another objective was to raise the productivity of primary-care doctors by making their income more directly dependent on the number of patients that had chosen them as their family doctor. Introducing an element of competition among doctors for patients was also seen as a way

of making doctors pay more attention to patients' desire to be treated more like "valued customers", rather than impersonally. It was envisaged that this would be accomplished by including elements of capitation or fee for service in the physician's remuneration, although county councils retained the authority to negotiate the system of remuneration for the primary care doctors that were employed in the primary care centres.

In addition to serving these objectives, the family doctor reform also was intended to strengthen the role of privately practicing physicians in primary care. It did this by introducing a provision under which the county councils were obliged to allow doctors to establish themselves as privately practicing primary care providers, and specified the way such doctors would be paid (through a mix of capitation and fee for service). These provisions were part of the reform at the insistence of the Moderate party, the largest one in the non-socialist coalition that had come to power in 1991, after an election that in part had been fought on the proposals regarding a family doctor reform.

The family doctor system went into effect at the beginning of 1994. It did not take long for problems with it to become apparent. Because the terms on which doctors could establish private practice were relatively generous, a substantial number did so, and the cost of paying private doctors quickly became a significant part of overall health expenditures in some counties. Although the intention, presumably, had been that the additional cost of privately produced care would be substantially offset by reductions in the cost of care provided through primary care centres, this did not happen, in part because Swedish labour legislation at the time made it difficult for the county councils to lay off those doctors that ended up with few patients. (Some county councils also continued to pay primary care centre physicians on the basis of salary.)

In the election that followed the introduction of the reform, the Social Democratic party was returned to power, and the government quickly moved to undo a number of the changes that had been introduced. In particular, the system of giving doctors the right to establish publicly funded private practices was repealed, after having been in force for less than two years.

While the family doctor reform has generally been regarded as a failure, certain elements of it remain. Although counties now have regained the right to organize their system of primary care without the restrictions of the family doctor reform, most have elected to continue the system under which patients have the right to choose a family doctor, and some of the newly established private practices continue in existence, although under more restrictive contracts with the county councils. While many counties have returned to a system of purely salaried doctors in the primary care clinics, others have retained an element of capitation.

Accountability

Political accountability

The most important decisions that influence the health services provided to communities and individuals in Sweden are made at the county council level. The mechanism through which the county council leaders are accountable to the population they serve is through elections that take place at the same time as parliamentary elections. At the bureaucratic level, each county has a chief executive officer who reports to the council through the political leaders. The most important political leadership is exercised by individuals analogous to cabinet ministers, chosen from among the elected council members. Although the county councils have certain other responsibilities, by far their most important function is to run the health care system, so that the county council elections can, to a large extent, be seen as being about health care issues.

Although it may be argued that this system should ensure a high level of accountability, in practice it has weaknesses. In Sweden, elections at different levels are largely based on a system of proportional representation in which the number of representatives from each official party is calculated according to the party's share of the popular vote. The individuals representing each party are chosen from lists established by the party. Given this system, representatives of providers' interest groups can count on a high probability of being elected by becoming active in the internal work of a party, so as to secure themselves a place high on a list; in many counties, this virtually guarantees that they will be elected. As a result, the interests of existing providers may end up playing a more important role than those of the public at large when the county councils allocate funds or bargain with doctors and hospitals about contracts.

While county councils have a very high degree of autonomy, they do of course face restrictions imposed by national laws, and county council politicians are accountable to the national parliament for following these laws. Even though health care issues often play a prominent role in national politics, enforcing county council compliance does not appear to have posed a major problem in Sweden. In a number of cases, agreements regarding implementation of new laws have been negotiated between the national government and the Federation of County Councils, a body with a substantial secretariat that is the repository of much of the best health policy expertise in Sweden, and the source of a considerable amount of literature on Swedish health policy. It also is the repository of detailed statistical information and annual reports on all aspects of costs and health services provision in individual counties.

As in other areas of social policy, the Swedish government devotes considerable resources to research and knowledge dissemination in support of the health care system. It

finances the Swedish Council of Technology Assessment, and, through the National Board of Health and Welfare, conducts work on continuous quality improvement "covering the full range of health services in a continuous target-oriented development process focusing on the people for whom health services are intended" (Swedish Institute 1999, p. 15). It also maintains "national health care quality registers" in which information on treatment measures and health outcomes are systematically collected for some 50 separate illness categories, and diagnostic and treatment guidelines are being developed for a number of categories. Much of this work takes place in cooperation with the county councils.

Accountability to patients

While the system for ensuring accountability at the political level seems to function reasonably well, the mechanisms for holding providers accountable to individual patients have traditionally been regarded as relatively weak in Sweden. To some degree, the ability of patients to choose among providers ensures some degree of accountability if providers' incomes depend on how many patients they serve. Although such incentives now exist to some extent, they are relatively recent and may not be particularly strong. Litigation to hold providers accountable for faults or negligence in treatment is rare, but there is a National Board of Health and Welfare that can impose disciplinary measures, including removal of individuals from professional registers. There is also legislation that provides for compensation for patients that have suffered injuries during treatment, but such cases are decided in a process that does not involve the issue of fault or negligence.

Conclusion

There are features of the Swedish health care system that, given current values, rule it out

as a comprehensive model for a reformed Canadian system. For example, there are user fees for physician visits at levels that would clearly be considered unacceptable in Canada, and until recently, there were tight restrictions on patients' right to choose their health care providers. To the Canadian medical profession, a system of mainly salaried doctors would seem unattractive, to say the least.

In certain other respects, however, the Swedish case is an interesting one to study. For one thing, Sweden has a very old population. The latest available OECD statistics show the share that is over age 65 at 17%; during the late 1980s it was as high as 18%. These figures are higher than for any other OECD country, and are equivalent to levels that Canada will not reach until some 15 years from now, according to Statistics Canada projections. It is remarkable that in spite of this burden of ageing, and with aggregate resources limited by very low growth rates in per capita income, the Swedish system has functioned well enough to maintain the country's position near the top of tables ranking countries by mortality indicators. As the saying used to go, how do the Swede's do it?

The Swedish case is also an interesting one from the viewpoint of those who believe in the potential usefulness of increased decentralization of managerial authority to the regional level as an element of future health care reform in Canada: As is clear from the discussion in the preceding sections, Sweden has operated a highly decentralized and varied system for the last twenty years. Of particular interest, of course, is the experience that has been generated by the active use of various versions of the purchaser-provider split model of contract-based care, with some degree of managed competition. As noted above, this experience may be helpful in considering innovations in the methods used by provincial or regional decision-makers

responsible for allocating funds among hospitals and other providers.

The Swedish experience with the "family doctor reform" may also be relevant from the viewpoint of considering alternative approaches to primary care reform in Canada. As I interpret it, the Swedish experience illustrates two important principles regarding how a well-functioning primary care system should be designed.

First, patients attach a high value to being able to choose a specific physician as their regular primary care provider. A system in which primary care is supplied in clinics or hospital emergency departments by whatever doctor happens to be on duty when the patient comes in, is not a good one. Neither is a rostering system in which patients are automatically assigned to a specific doctor or primary care centre, for example, on the basis of where they reside.

Second, a decentralized system in which primary care is funded on a different basis than hospital and other services is unlikely to function well. For example, a system in which privately practicing fee-for-service physicians are funded independently of the regional health care budgets (as they currently are in some Canadian provinces, and as they were in some parts of Sweden in the mid-1990s) is unlikely to yield an efficient integration between primary care and other inputs such as hospital services and pharmaceuticals. On the other hand, if primary care is to be funded out of regional budgets, regional authorities must have the right to negotiate contracts with primary-care physicians in order to retain effective control of total cost.

In designing a system of primary care, therefore, there is a degree of tension between the desirability of freedom of choice and the need for cost control. For example, a system in which primary-care doctors are paid on the basis of fee for service and patients can go to any doctor at any time is not compatible with effective cost control. Thus design of a well functioning system

will require some degree of compromise between the two objectives, such as, for example, a system of capitation and rostering (which facilitates cost control) in which freedom of choice is retained in the sense that patients have the opportunity, at specified times, to choose the doctor on whose roster they appear.

Finally, as was noted above, Sweden's experience with a system of divided central and local jurisdiction over health care appears to have functioned well. From the viewpoint of system design, the Swedish model of accomplishing a high degree of political accountability through regionally elected representatives whose main responsibility is the management of health care and who have their own tax base, may be interesting for Canadian provinces; Saskatchewan already appears to be moving in this direction. Moreover, the formula-based system of central government contributions to funding local health care costs does not seem to have given rise to anywhere near the degree of controversy as the methods used for federal-provincial cost sharing in Canada. Again, a closer study of the way the Swedish system works in this respect may yield helpful lessons.

Appendix: Sweden's Health and Medical Services Act and the principles of the Canada Health Act

The main legal statute that governs Sweden's health care system is the 1982 Health and Medical Services Act (henceforth HMSA). While it has been amended in many ways since it was originally passed, the main provisions regarding the division of jurisdiction between the central government and the county councils remain as they were originally written.

A direct comparison with the five principles of the Canada Health Act

(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 and explicit than the CHA, in several respects. For example, a Canadian critic could argue that the absence of explicit language prescribing comprehensiveness and universality in the HMSA render it a less effective instrument for the Swedish central government to enforce these properties in the Swedish system. However, in paras 2 and 3 in 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" (this and other translations in this Appendix is the author's), and that the care provided shall be "of good quality". It can be argued that these provisions, and others that refer to the patients' right to information about their health conditions and available treatment methods, as well as their right to choose which one to choose which "scientifically accepted and proven" treatment alternative to choose when more than one exists, are at least as specific as the CHA provisions regarding comprehensiveness and universality. (An interesting aspect of the HMSA is that it explicitly specifies [para 6] 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.)

Para 2 in the HMSA also specifies that in order to qualify as "good", health care has to be "easily accessible". However, as noted in the paper, 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. (Para 26 specifies the "stop-loss provision" that stipulates that no one will have to pay more than SEK 900 per twelve-month period in user fees for hospital and medical care, or more than SEK 80 per day for hospital care. The stop-loss provisions for

pharmaceutical costs are contained in a separate act.)

A form of "portability" is indirectly assured by requiring each county council to provide care to non-residents that need "immediate care" (i.e., in emergencies), and county councils are also allowed to negotiate agreements to provide each others' residents non-emergency care.

There are no provisions, finally, requiring "public administration". The significance of this difference between the HMSA and the CHA, however, is unclear since there is little agreement in Canada regarding exactly what it is that Canadian provinces are not allowed to do as a result of this provision in the CHA. On the whole, therefore, one may argue that the only substantial (as opposed to terminological) difference of any significance between the HMSA and the CHA is that the former allows user fees up to certain levels.

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