The health care revolution in Stockholm

Johan Hjertqvist

THE HEALTH CARE REVOLUTION IN STOCKHOLM

A short personal introduction to change

Timbro Health Care Unit

TIMBRO
HÄLSA

JACKET PHOTO: Stefan Borgius/Pressens Bild
COVER DESIGN AND TYPOGRAPHY: Charlotte Häggblad
TYPESETTING: Ateljé Typsnittet L&R AB
PRINTING: Elanders Gotab, 2002
ISBN: 91-7566-526-3
http://health.timbro.se/
www.timbro.se
tel +46 (0)8 587 898 00
fax +46 (0)8 587 898 50

CONTENTS

1.

A WORD OF WELCOME

WELCOME TO THE WORLD of the new health care. Or at least a small part of it – the Stockholm County Council in Sweden. Here you can find one of the most ambitious and interesting attempts to transform public health care from an old-style, politically administrated monopoly to the consumer-related, incentive-driven network of tomorrow.

Though politically very controversial in parts, this process of change, which began in the early 1990s, follows the pragmatic Swedish culture of service distribution reform helping Swedish industry to stay competitive, as well as de-regulating public monopolies in energy, telecom, pension funding etc. This short – and no doubt personally coloured – introduction is written from this long-range systems perspective, which to my mind is a far more relevant view than the day-to-day fragmented picture you get from party politics and Swedish mass media.

Sweden, a well-reputed (not to say overrated) welfare state, has attracted international interest in social reform ever since the 1930's. For 50 years the name of the game was expanding political and administrative power. Now the opposite goes – increasing the freedom of consumers, employees and entrepreneurs, thereby reshaping the strategy of welfare service distribution. Here the Stock-

holm region is ahead of other parts of Sweden.

When reading this short piece, please bear in mind that there is no cut-and-dried "Stockholm model" (even if this phrase is still often used). Nor does "reform" evoke the appropriate associations: there is no clear beginning and no end to this process. It is more accurate to speak of ongoing change by many small steps, a cultural revolution or maybe a strategy for implanting modern incentives into a public structure, because – and this is very important – the health care system of the Stockholm County Council remains publicly funded, with open and equal access to every inhabitant, though the Council contracts many privately owned operators to deliver the services on equal conditions with the publicly owned providers.

The purpose of health care remains the same, but the tools for delivering the outcome are starting to change. Clearly, then, health care is not an island unto itself but a part of the mainland, which to me is encouraging rather than confusing.

Again, welcome to Stockholm and the landscape of the new health care!

Johan Hjertqvist
Director
The Timbro Health Unit

2.

WHY SO MUCH INTEREST?

Increasing numbers of foreign visitors are touching down in Stockholm. They are British politicians, think-tank people from the Netherlands or Canada, lobbyists from Norway or Australia, hospital managers from Denmark and Russia, journalists from Germany and Japan. And so on.

They are all looking for health care reform. But why all this interest in Stockholm?

The answer to this question also serves to explain the characteristics of the Stockholm transition process.

What, as I see it, both surprises and thrills foreign observers is the way in which an unwieldy, old-fashioned and politically managed system can start changing its course. Sweden's reputation of being a genuine welfare state is still sending signals of credibility and goodwill. If the Swedes decide to reform their health care system, they must have good reasons for doing so... And the way they do it must safe-guard solidarity, equality and all the other fine Swedish values. This is an example of Swedish modernisation using tools of pragmatic co-operation between public and private initiatives.

THIS IS WHY

To me, this is the – somewhat simplified – outside picture causing so many people to visit Stockholm in search of experience and inspiration.

What do they find? What is "the backbone" of the health care reform movement in the metropolitan region of Sweden? I will start by giving you these elements, and then proceed to the process which started a little more than ten years ago leading to the present situation.

NO MASTER PLAN

"The backbone" of the Stockholm Transition is not the outcome of thick master plans or strategy seminars but rather an ideological guideline implemented by intuition and even pure coincidence. There are few very specific goals but a number of strategies and tools, moving the process ahead:

- Incentives which address the need for productivity. Instead of central or global budgets, hospitals are paid if and when they deliver. Not until then. A DRG (Diagnosis Related Groups) system puts a "price tag" on every treatment, thus providing a system for negotiations between purchaser and providers.
- Market-oriented approaches. Competition for public contracts is open to great numbers of private, as well as public, providers. The idea is to create an internal service market, increasing the quality outcome to competitive price levels. You can add an entrepreneurial dimension as many new producers emerge from this process.

- All hospitals are turned into limited council-owned companies, creating an opening for a more entrepreneurial approach; and benchmarking – witness one emergency hospital which was sold to the Capio Group, a big private services producer. More accurately, this was a transfer of competence and equipment – the key elements of modern health care – but the buildings remained in the Council's hands, rented by the new owner.
- A division between purchasers and providers, clarifying the responsibilities of each party (and ensuring that the politicians leave the production side alone).
- Publicly employed personnel getting active legal and educational support to start their own companies, which can take over the operation of primary care clinics and other contracted facilities.
- A rapid expansion of the Stockholm Council's consumer information – supporting active consumer behaviour and choice [www.vardguiden.nu] – which is said to be "state of the art worldwide."

These, you can say, are the hallmarks of the Stockholm Transition. If you want to, you might add an even more thrilling dimension: the invention of the health care of tomorrow. If the development in Stockholm really shows such an ambition or is merely just another confused attempt at face-lifting the old system is for the reader to judge. My opinion will be made clear soon enough.

One fundamental restriction on the Stockholm Transition must be stressed: the tax funding of the County health care system will remain in the foreseeable future. International observers often ask how poor inhabitants are treated in this system. Will they have the

same access? Or will they have to pay extra for some services?

In Sweden everybody is affiliated to the publicly funded system (the exception might be illegal refugees staying in Sweden). There is no entrance test. You cannot be denied access or excluded from the system. Even if you do not pay a penny in taxes you are entitled to services. So regardless of income, profession, sex, age, health status etc. you have the same rights. You pay a patient's fee (10–25 USD) cash when visiting the services. Again, everybody does. If you are on welfare you will get help to pay this money.

On the other hand you cannot buy a better access. As long as you use the publicly funded health care you must accept the same waiting lists. Whether you turn to a privately owned contractor or to a Council facility does not matter; they follow the same rules. In-hospital medication is covered by public means. You will get the same kind of bed and food as other patients; you cannot upgrade by paying some extras. If such things are important to you, you had better use a completely private provider (sure, they exist, even in Sweden) but then you must pay the full cost yourself.

To the patient the system is quite simple; automatically an open and equal access, co-payment known in advance, no extras. It is all very nice – at least if it proves sustainable. The Stockholm Transition does not aim to change this fundamental fact, but to strengthen the credibility by improving access and outcome with the help of a new logic of incentives and logistics.

Of course, you can go into more detail regarding the process of change. But my ambition in this very short, personal introduction is to give you the broad picture and to convey the need for new thinking. Accordingly, I will confine myself to structures and strategies.

Add trade union support for change and a mounting battle for health care policy dominance between the national government and its regional counterparts, and the odds are you will find a rather interesting brew...

So, how did it all start? What about the process up till now? And of course – the outcome?

3.

HOW DID IT ALL START?

In the late 1980s, frustrated council politicians in the Stockholm County Council felt a need to reform the governance of the system. Or, more correctly, they found it a matter of life and death to regain control over hospitals that were delivering less and less but costing more and more.

The health-care situation at the time could be described as follows:

After three decades of rapid growth, the Swedish economy was slowing down. But the publicly funded systems were used to ever-increasing funding. With good reason, you might say: Between 1971 and 1990 council taxes rose by 60 per cent, with the lion's share of taxation revenue going on health care spending. But for every extra injection of tax money, waiting lists grew longer and longer.

Since the central budget system rewarded the least efficient clinics, where the longest waiting lists were to be found, much more creativity was dedicated to funding manipulation than to increased productivity. Sounds familiar?

WEAK POLITICIANS, STRONG BUREAUCRATS

Cynicism was wide-spread. A key explanation was the weak political management, a child of the shifting Council majorities. More or

less by tradition, every regional election brought a new majority to power. Among hospital managers and staff bureaucrats the saying went : "Politicians come and go but we remain." Guess who felt like those in power?

For two terms, 1976–82, Sweden had a non-socialist national government, its first in 44 years. Mentally the change opened new windows. In 1983, for the first time ever, a private provider (the doctors' co-op Praktikertjänst) was contracted by the Council to run a new kind of primary health care unit in central Stockholm. The idea was to improve access for people working in the City by offering a treatment to people who could just drop in from the street.

A SLAP IN THE FACE

The establishment was furious! A profit-making private company exposing public inefficiency in this humiliating way! This act was a slap in the face of solidarity! Parliament must forbid it! But when it became clear that the patients loved this new City-Akuten, the criticism faded away. To the political parties in the Council the signal from the citizens was clear: Improve access, regardless of who is doing the job!

By the end of the 1980s the time was ripe for more radical action. An informal coalition of Moderates (the Moderate Party, i.e. the market liberal/conservative party of Sweden) and Social Democrats in Stockholm – both parties strongly dissatisfied over the lack of real power for the elected bodies – started to introduce health care reforms. Here the inspiration from 1983 was significant.

A NEW PRICE MECHANISM

In 1990, literally overnight, a DRG system, inspired by the US, was introduced – by a Social Democrat Council majority! (DRG = Diagnosis Related Groups, a system measuring the resources necessary for a great number of treatments. In the Stockholm purchaser-provider system the DRGs set the price-tag for many of the contracted services and are a tool for the distribution of funding.)

Out went central or global budgets and in came a compensation system, where the hospitals were paid according to what they really delivered, not according to what the budget said they were supposed to produce. Close on 500 "products" were defined by the DRG price list, and prices were gradually reduced to reflect the appropriate level of compensation.

A CHANGE OF MENTALITY

The outcome of this reform was at least twofold. The mentality of hospital managers changed dramatically. And so did the productivity figures. In the first year of the new reimbursement system, productivity in the Stockholm hospitals grew by 19 per cent!

The DRG-system provided a new way of planning and paying for additional care. But that was not enough to create a market environment, to break up the traditional bureaucratic way of acting. To achieve this you need a great number of providers, which were not at hand from the beginning. This question needed to be tackled.

But now, anyhow, the ball was in play. Change was on the agenda. When a Centre-Right coalition won the Council election for the years 1992–94 there was a mandate for reform.

4.

THE PROCESS – INTUITION RATHER THAN MASTER PLANS

Aiming high from the start, the new Council majority declared, in its political platform, that a "radical renewal of the public sector" was at hand. Led by the Moderate Party, the coalition brothers – Liberals, Christian Democrats and the Centre Party – went for radical action. Elements in this policy were patients' freedom of choice, provider pluralism, and a strong increase in co-operation between public and private health care. Cutting down the long waiting lists for treatment was a main task.

The technique was competition for Council contracts as stated in the Public Procurement Act. "Competition" was written on the wall. Selling two emergency hospitals to private interests was a part of the plan.

"THE BERLIN WALL"

Mr Ralph Lédel, Commissioner for Finance and since 1991 the leader of the Centre-Right Coalition, has compared the impact of this policy shift to "the fall of the Berlin wall". New tools were introduced. A competition programme was launched, managed by a special staff implementing competition among producers, and also supporting council employees wishing to take over public operations.

Other radical steps taken 1991–94 were voucher systems for children's dental care and maternity care. Among the GPs the old fee-for-service was released by a capitation system. You might say that these measures delivered what the majority platform had promised, severely shaking the traditional perception of how health care services ought to be delivered. In the national government the same four-party coalition opened for an inter-action with the regional level in several county councils, but only in Stockholm could you really speak of a radical reform agenda. It is true that by introducing for the first time a treatment-guarantee of three months (from referral to actual treatment) the Centre-Right national government reduced the long waiting lists but this was generally not enough to change the organisation of health care in the Councils.

A PRIVATE HOSPITAL?

All these steps were important, but the single most challenging step, that of turning the St Goran hospital into a limited company, was taken in 1994, shortly before the elections.

How could a single, formal step cause such effects?

First, the idea of using the mechanisms of the business world in public health care was extremely provoking to traditional values. To the critics there was a great gulf fixed between health care – guided by such buzz-words as equality, fairness and solidarity – and the brutal commercial society, known for greed, profit, and competition. These barriers must remain, otherwise the purpose of health care would be at risk; that, ten years ago, was the general attitude.

Secondly, the St Goran staff quickly took advantage of the new opportunities of increased local power and freedom to create an ef-

ficient organisation (and better incentives for the employees). The staff stood up for the new company.

When, a couple of months later, the Social Democrats won the Council majority, the new leader, Mr Bosse Ringholm (today the Minister for Finance in the national government), visited the hospital to bring the good news of de-enterprising the St Goran, returning the hospital to the fold of the Council's traditional values.

HANDS OFF!

Seldom has a political gift been less appreciated. Mr Ringholm was seen off by the employees with a flea in his ear: Don't mess with our hospital enterprise!

So there was no change of regime, and after the next shift of political power (in the Stockholm region the majority changes whenever there is an opportunity) in 1998, Mr Lédel made haste to finalise the process by selling the hospital. In 1999 there was a new owner, the Capio Group, a listed Swedish health care provider, also active in many European countries. As the Council retained the ownership of the hospital buildings, you might say that Capio bought "the software" – the strong brand, the competence, the equipment and the infrastructure. You cannot sell staff, but a large majority of the employees accepted the new manager.

Thirdly, the agreement between the Council and the new owner stipulated a procurement process regarding the whole of emergency health care, in practice necessitating large-scale competition for contracts. The Public Procurement Act does the same. Most EU members do not require the competition technique in public health care, but in Sweden this is the case as soon as a council wants to con-

tract a privately owned provider on a larger scale. The practical outcome could be described like this: to public bodies eager to enhance provider pluralism, an invitation to tender could let loose a competitive process. On the other hand, councils afraid of the results of a tendering process found an argument for not rocking the boat.

A BLOW TORCH

Last but not least, the St Goran became a strong bench-mark from the word Go.

Before the birth of the company in 1994, there was a strong increase of productivity, as another hospital in the neighbourhood of the St Goran was closed down, putting strong pressure on the remaining hospital to incorporate the many patients. Thanks to a 40 per cent productivity increase this tough assignment was successfully accomplished, giving the St Goran an excellent start. Since then this hospital turns out every year to be 10–15 per cent more efficient than the other emergency hospitals (assessed from the DRG-based compensation, which makes the services of the St Goran the "cheapest" by far). Stating this is not the same as saying that the Stockholm health care system as a whole automatically gains from the S:t Goran contract, as the volumes settled there do not necessarily reflect the optimal balance of services between all providers. Long-term agreements might complicate and delay change. There is a need for dynamic contracts allowing adaptation over time.

TOO STRONG A CASE?

The owner's, i.e. the County Council majority's, idea was a system shake-out. The outcome is powerful, illustrating the potential of competition, decentralisation and business strategy building in public services. The result was so striking that in 2000 the national Social Democrat government had to counter-act it by declaring a moratorium on further transitions of ownership of emergency health care units to for-profit players.

So the St Goran is still the sole emergency hospital in private hands. Without the ban you would today find three or four more privatised hospitals with emergency capacity in Stockholm and in a couple of other counties.

ON BEHALF OF THE PUBLIC

It should perhaps be emphasised that the St Goran operates within the public system under the same rules as hospitals owned by the Council (except that its superior price efficiency includes a profit margin). The St Goran has the same mix of public patients, and as yet no evaluation has found signs of "cream-skimming."

The management is not allowed to turn away complicated cases. Only one per cent of the patients are paid for by insurance companies. You might think that I am making too much of this single xample. But it has undoubtedly not only become a symbol of the Stockholm transition but is also a strategic key factor for modernising the health care system. To international observers the St Goran evidently has a strong attraction.

But of course there are more steps to take into account when analysing the Stockholm Transition.

A PURCHASER–PROVIDER SPLIT

Since 1999, purchasers and providers are separated. This split was made so that the politicians could focus on representing the citizens simply by formulating visions for health care policy. In withdrawing from the production side, the politicians wanted to signal that finding the practical solutions as well as handling the given budget was a professional manager's business.

The Council's new strategy meant treating every producer equally, opening up the system to large-scale competition. The privately owned providers already knew how to operate in this system. But the council-run competitors did not.

HOSPITAL ENTERPRISES

To act as a player in the marketplace you need to have the appropriate mindset. By transforming the six publicly owned emergency hospitals into limited companies, though still controlled by the council, the Centre-Right regional government wanted to combine decentralisation with businesslike thinking. Professional company boards and management could act independently within a distinctive framework.

This approach was formulated in 1998, when the Moderate-led coalition returned to power in the metropolitan area (this time without the Centre Party, which was wiped out in Stockholm). After a four-year period of Social Democratic rule which neither advanced nor revoked the reforms, the coalition was ready for a big step forward: private contractors were invited to take over the operation of every publicly owned health-care facility outside the emergency hospitals. That was a radical leap.

BACK ON TRACK

The Ralph Lédel coalition could by then look back on a successful reorganisation of Stockholm's health-care policy.

Competition in the contracting process, with roots in the early 1990s, had significantly reduced the costs of several services, such as laboratory work, X-ray treatment, and the ambulance service. In fact many of these first tender agreements resulted in cost reductions of between 10 and 40 per cent. Some of the reductions proved sustainable, while others rather showed that large companies – and public hospitals – knew how to manipulate prices. Quickly changing the culture of the health care organisation, competition proved instrumental in opening new mental windows and focuses. Though the reality after each new wave of tenders often meant co-operation rather than hostility between former competitors, the technique forced each player to analyse strong and weak points, thereby laying good foundations for improvement.

ENTREPRENEURS

New providers entered the market, adding pluralism to the group of service producers. The majority of the private ones have only been recently established – most of the companies were founded during the 1990s. Stockholm has a large proportion of former public sector employees who were actively encouraged by the Council to take over primary health clinics and mother-and-child care units.

Becoming an entrepreneur is an attractive opportunity for public employees today. According to a large poll in the spring of 2002, one out of three nurses can imagine doing so. Other evaluations clearly show that "co-worker owners" are very satisfied with having taken

this step, experiencing a freedom to shape their own future. All the more than 100 new providers from the early 90s (except one!) are still in business.

GROWING CONTRACTED SHARE

Another outcome was a rapidly increasing number of primary care suppliers operated by private contractors, some big ones and a large number of small players. Today 50 per cent of primary care turnover is operated by private contractors. That represents roughly 50 primary health care units out of a total of 120 in the region. Looking at total health-care production in the metropolitan area (primary, emergency, geriatric and psychiatric care together), the share delivered by contractors was 27 per cent in April 2002 – compared to an average of no more than seven per cent for the country as a whole.

UNIQUE TRADE UNION STANDING

I told you how the employees at the St Goran defended their reshaped hospital. To the astonishment of foreign observers, the health-care trade unions have supported the reforms behind the Stockholm Transition. This standing has no doubt made it much more complicated for the Left to attack the change. When trade union officials representing not only doctors and nurses but also junior nurses, organised by the Swedish TUC, praise reform, the scope for attack is rather limited. From the trade union point of view this is rational behaviour: for the first time, health-care workers have access to alternatives to public employment.

Evidently the Stockholm unions have a very different opinion of the constructive strategies for the future compared to their union

colleagues in for example the UK or in Canada (and in some parts of Sweden, as well . . .). But all over the country attitudes are slowly changing.

In a "referendum" during the beginning of 2002 a majority of the members of the largest Swedish union – Kommunal (the Municipal Workers' Union), with close links to the Social Democrat Party – made it clear that they accept private contractors operating within the publicly funded welfare system. This is an historic event. The doctors' and nurses' unions have long favoured a provider-pluralism system, and the nurses' chair, Ms Eva Fernvall, is one of the most important advocates of change.

As a part of the pragmatic Swedish tradition, Kommunal organises employees hired by public as well as private employers. All agreements are more or less the same. This constructive policy eliminates many tensions and supports change.

BETTER CONDITIONS

By using this new freedom to "vote with their feet", all categories of personnel have improved their working conditions substantially faster than in other parts of Sweden. Between 1996 and 1998, nurses received a salary increase of 17 per cent – more than twice as much as they had received before. (Raising the general pay level is a necessary step in the recruitment and retention of health-care personnel.) During 2001, staff salaries in Stockholm increased by an average of 8 per cent, due to a combination of personnel shortages and competition for the available manpower.

A number of surveys have shown that private producers have a good record in terms of employee satisfaction. Private middle man-

agement is considered more competent and approachable. The employees professedly understand and share the goals of the enterprise (which is by no means always the situation in publicly operated units).

PRIVATE PROVIDERS APPRECIATED

In addition, according to frequent polls the consumers rank privately run parts of the health-care higher than their public alternatives. These providers are said to adapt better to consumer conditions in finding new ways to tackle problems. When the staff take over publicly managed units, consumers generally give the new operators better points than before.

At national level too, you will find support for privately owned providers. According to the Care Barometer public polling system, Swedes in general are more satisfied with the way they are treated by the private family doctor or specialist than by publicly managed primary health care. And the Social Democrat Minister of Health, Mr Lars Engqvist, makes the need clear for more private entrepreneurs in primary care...

MORE EFFICIENT TOO

According to researchers at the Stockholm School of Economics, county councils implementing a purchaser-provider split have increased the efficiency of their health care systems by an average of 13 per cent compared with "unreformed" councils. Evaluations show the structural steps taken in the early 90s inflected the upward trend in costs for a number of years. Gradually, though, this positive outcome disappeared as the slack within the organisation was taken

up. The moral is that you must move ahead all the time, because yesterday's victories will soon be history. There must be a coherent system for nurturing and enlarging successful reform steps. Without this awareness you risk the sad pattern of "two steps forward and one back."

In the Stockholm County Council, all the reform moves made between 1991 and 1998 were gradually accepted by the Social Democrats, who implemented competition and privately owned providers as elements of their own policies. When in power they did not speed up the transformation process. But on the other hand they did not try to stop it. Instead they had to lean heavily on contractors to cut the growing waiting lists before the 1998 election. The private producers had become too strong a force to ignore.

A HARDER CLIMATE

But the period between 1998 and 2002 has been somewhat different, filled with tough polemics on "the system change", suggesting that the Moderates have a hidden agenda to also privatise the funding of health care. According to the critics, the proposed introduction of a compulsory health care insurance format is only the first step towards inviting purely private capital, thus breaking the principles of equal access.

This kind of fighting between the Moderates and the Social Democrats will go on whatever the outcome of the general elections in September 2002. Both sides want to tell the world (and not least the campaign workers) that there is a great gulf fixed between their positions. I see more of a convergence, with the Moderates dropping their traditional negative attitude to public spending and the

Social Democrats step by step if not welcoming then at least accepting private contractors and market mechanisms. They all cluster in the middle, forced into doing so by middle-class health care consumers demanding reasonable access and quality in health care – whatever the state of the parties and whoever the provider.

SHORTER WAITING LISTS

The most outstanding achievement among all these reform steps concerns the patient's access to medical services.

In Stockholm the waiting time for an examination or treatment is much shorter than in other parts of Sweden. Things in Stockholm have rapidly improved since 1998, when long waiting lists were again threatening real access. The most striking contrast is to be found in a comparison with the least reformed Swedish county councils, i.e. where power is in the hands of Leftist "traditionalists."

The waiting time figures uploaded to public Internet information systems (<www.lf.se> and <www.vardguiden.nu>), though far from perfect, speak for themselves.

A 90 DAYS GUARANTEE

Every Swedish county council today generally "guarantees" citizens treatment within three months. But only in Stockholm can a patient generally rely on the substance of this commitment. In large parts of Sweden the three-months-limit is a bad joke. The guarantee might be called a kind of insurance. If public health care cannot deliver, the Council buys services from contracted providers to increase the access. Even so, you must be active yourself to be sure of treatment within the appropriate time. In this way in 2001, four thousand

Stockholm patients reduced the waiting time to three months.

Outside the metropolitan area you must often wait for a year to have a hearing device (four weeks in Stockholm), up to two years for plastic knee surgery (two–ten weeks) and ten months for hernia surgery (two–four weeks). We are not, of course, talking about emergency cases, but about patients supposed to be able to wait for some time. Some voluntarily, but many others at the cost of prolonged sick leave, pain, and a reduced quality of life.

It is worth stressing that Stockholm offers better access for the same – or sometimes lower – tax money cost per capita as underachieving councils. The tax level in Stockholm is the second lowest among the counties of Sweden (but, as you will see from my remark on page 45, things are more complicated than they seem).

The number of privately owned providers is still increasing, adding to the care capacity – one important explanation why access has improved. During the last ten years, 150 new health care companies have been born in the Stockholm region. Another 50 will be operative before the September elections, sky-rocketing the importance of contractors. The bigger the scale the more critical it is to get the most out of these new care givers. Each of them may be more productive than they were during the Council regime, attending to the task with energy and good ideas. Nevertheless there are signs that, once having secured their signed 3–5 year-contracts, some entrepreneurs prefer to run their own race, allowing little cooperation with other actors and showing no ambition to adapt to change. However understandable this is from the individual provider's standpoint, the total outcome of the provider pluralism reform could be harmed.

You may have noticed my criticism regarding the lack of analysis from the political management of the Council. My impression is that Mr Lédel & Co are not very familiar with the challenges involved in the operation of a large, publicly financed network of privately owned providers compared with the producer monopoly of yesterday. Most likely this is a critical condition.

THE POLITICIANS PULL OUT

By 1999 the purchaser-provider split was (almost) fulfilled. There are still a few elected politicians engaged on the service production side, but the idea is to pull them out in 2003, as the continuing decentralisation of power reaches every health care unit still operated by the Council. If so, the p-p model will be distinctive, with politicians representing the citizens on the purchaser side by formulating the demand and evaluating the outcome but leaving the production matters and organisation to the professionals. This, at any rate is what the textbook says...

A MORE SUBTLE REALITY

But the latest term of office in the Stockholm County Council also illustrates how complex the process of change can be in this new health care environment. Rules and reality do not always marry well.

The (purchaser side) politician can no longer point out the solution and order the relevant measure. The providers react to proposals regarding compensation or invitations to tender, and no longer to old-style bullying or administrative edicts. When Council officials try to make them deliver extra treatments within the agreed compensation formula, the professional boards of the hospital

enterprises refer to their contracts, declaring a well-defined balance of power. The purchasers must today pay for the extra delivery they yesterday could have for free (or at least within the rather vaquely defined contract). There are no free lunches and no free health services...

For attacking bad working conditions (questioning recruitment and quality of services), the tool is to help the personnel to start their own companies rather than relying on the traditional top-down, low-impact action. And the over-all aim of cost control shows up in quite a different light when a large number of providers in the health care network all try to increase their income by increasing their output. Today there is no lack of capacity in the metropolitan region, except money to buy bigger volumes.

Nice principles and values are put to the test when they come under pressure. Let me give you one example:

A CHECK OF PRINCIPLES

During 2001 a capacity crisis emerged in maternity services all over the Stockholm region. In the most acute phase some mothers had to travel hundreds of kilometres to give birth.

The situation caused an outcry and no doubt gave bad publicity to the Council majority, who were otherwise, and with good reason, bragging about the generally good access to health care. So something had to be done – and fast.

The elected councillor for this sector (there are three full-time central County politicians on the purchaser side of health care) tried to order hospital mangers to open new clinics or to let entrepreneurs into the hospitals, bringing in new capacity.

THAT WAS YESTERDAY'S POLITICS.

The managers safeguarded their new independence as company CEOs. They asked for the assignment (to solve the delivery care problem) but wanted to find the practical solutions themselves. So there was a clash between good intentions violating the new power-sharing principles and managers respecting the high principles set down by the Council by opposing the same politicians...

THE NEXT BIG STEP?

The Council majority wants to address these system questions by launching another large-scale competition drive, i.e. inviting providers to bid for service contracts in large parts of emergency health care. The idea is to give the purchaser-provider system a new edge by forcing the provider staffs to make the outcomes vision clear, to build the next generation of the compensation systems and to force a breakthrough for assessment strategies and methods.

But for two years now the launch of this process has been delayed, today deferring the start of this potential multi-billion SEK competition till 2003 (yes, you are right, *after* the coming council elections, raising the stakes as the Social Democrats campaign on stopping the whole emergency contracting affair after an election victory).

To make the dish even spicier – regarding the moratorium on for-profit actors in emergency care – will there be a place for them in this competition? If you exclude these actors, confining the bidding to the public hospitals – what kind of race will this be? Will it do any good?

TOO MUCH GUNG-HO!

In my view the present problems are due to the lack of preparations in the earlier steps of the Transition. There have been a lot of gung-ho! attitudes and a belief that "the market" will provide answers to the many complicated questions.

Launching visions of change is fine, setting the strategic goals is even better, but being assured that the systems of checks and balances work is absolutely essential. Now there is an instant need to handle matters which have been neglected for many years. Mr Lédel may well get the credit for the general system change, but he must also carry the responsibility for the happy-go-lucky attitude which is putting great values at risk.

Maybe the emergency competition project will – if performed – turn out to be the gadget to bring all these necessary ingredients into a tasty pâté. That could even be the strongest reason for pushing this big step ahead. In my writing on this process (my second report was published in November 2001) I cover a large number of aspects, describing the emergency care approach as a high-risk business.

Why it is, in any case, of great importance to proceed you will find out in the next chapter.

5.

THE NEW SWEDISH REVOLUTION

Anyone following the debate on health care, not only in Stockholm but also at national level, is easily confused. And wonder at it!

Party political polemics deal with matters of health care organisation and technique; you find the most animated quarrels on subjects like competition, contracting, compensation systems, whether a certain rural hospital must close down or not, etc. At the same time most politicians declare again and again that they ought to steer clear of these kinds of questions, leaving the production-organisation details to the professionals.

The political parties are almost totally neglecting what must be their original, democratic assignment – visions, goals, and outcome – and thereby leave a vacuum. Now Nature, as we all know, abhors a vacuum. If there is any thrilling and provoking discussion at all on the future of health care in Sweden, I am sorry to say the politicians are not contributing to it, but individual professionals, scientists, economists and some think-tank people are.

A LACK OF LEADERSHIP

Discussing the wrong topics undoubtedly stifles the creativity of elected bodies. Instead the 150-year-old antagonism between "capital" and "justice" still dominates the way Left and Right set the wel-

fare policy agenda. But if you refuse to remove the historical blinkers you will never notice how the landscape changes. This explains why today there is no political leadership in Swedish health care.

What if the health care policy debate were a forum for handling the new challenges instead of controlling positions of power by attacking any alternative explanation? Then we might respond to this kind of intellectual analysis, asking for reasons, denouncing prejudice and stupidity:

Sweden has a reputation for housing big, successful, international companies. They were generally founded more than 100 years ago on a competitive idea, and have since been growing thanks to their adaptability. Keen to import new ideas in management and workplace organisation, they are still important in global business. Today several of them have merged or changed owners, a living illustration of how nationality as a production factor fades away. But they are still strong brands, delivering good value to the customers.

WHAT IS BEHIND THE IKEA SUCCESS?

Can anyone imagine AstraZeneca, Ericsson, Volvo or late successors like IKEA or H&M surviving without building motivation and rewarding conditions for their employees?

These increasingly knowledge-driven conglomerates have, quite simply, been listening to what the markets have asked for and delivered a competitive outcome. Aside from a few neo-Marxist relapses into class struggle rhetoric, Swedish politicians have applauded devices like co-determination, self-governing work units, profit-sharing, outsourcing, etc. as modern, appropriate solutions. By taking many such small steps the organisations have been successful in

meeting the demands of customers, employees and owners.

Lets us then make the parallel to the health care sector – another large-scale knowledge industry.

ANOTHER WORLD

Here you meet quite a different world.

In this vast structure, where 60 per cent of the staff have at least one academic degree, you might expect a similar pragmatic attitude towards rational incentives and modernisation to prevail. There are of course a number of institutional limitations to importing true business conditions: the still very strong political view of health care as a funding burden, eating the welfare state from inside, calling for strong budget policy restrictions. The lack of market and consumer reactions feeding the business society with invaluable information. The weak, obscure owner, unfamiliar with decisive, longstanding action and straight talk but eager to monopolise the insufficient funding. And of course the political environment, where every challenge or problem must be made operational on party lines and rational solutions are far from always welcomed.

Running a most sophisticated and complex knowledge business under these circumstances is not easy. To be frank – it is impossible.

At the risk of being naïve, what we see happening now in the Stockholm County Council might be the reshaping of health care policies and organisation to fit the standards of modern society. Or to put it another way: to move quickly from the criteria of the 19th century administrative philosophy to a dynamic, incentives-driven network.

GOING MODERN

You can translate the action which has been going on since the early 90s like this (I know there are critics who have quite opposite interpretations):

By replacing the global budget system with a compensation scheme based on productivity, the County Council of Stockholm took a big step in the direction of modernisation: paying for delivery rather than promises, putting a premium on outcome (more services) instead of impotent plans. The DRG price list opened up a competitive environment where the benchmark was evident.

The invitation-to-tender strategy (an element of the national legislation) created the instrument with which to analyse and compare all kinds of health care operations. Were they well managed? Every potential contestant could estimate the chances.

The transformation of emergency hospitals into council-owned enterprises is still highly controversial in Stockholm. Seriously, do not ask me why. Public ownership – though highly inefficiently executed – seems to be the life-bouy to many Left politicians. The process marks another step towards modern, pragmatic conditions: relying on the professional structure to do the job, within the framework of political democracy.

WOULD FLORENCE BELIEVE THIS?

Florence Nightingale never argued about her compensation package. But her successors do. The County Councils must implement new strategies to recruit and develop staff, a new work organisation being one of the most critical needs. Here you must offer employees a freedom of choice – suddenly a reality when the provider plu-

ralism approach makes hundreds of employers compete for doctors and nurses. Taking over a council-operated health care facility is another option for the staff, quickly breaking away from the single-employer history of monopoly and lack of modern incentives.

When, according to a fresh poll, one of two young Swedish doctors says she or he will never accept working for a county council (by far the most frequent employer), the public health care is in deep trouble. Reflecting the shift of values, these young doctors state that they want to work only part-time, giving priority to families, hobbies and leisure time. And when working they no doubt prefer a private provider to the public ones. Add to this that since the work force in Sweden (as well as the whole of EU) is diminishing, recruitment and co-worker motivation is a key element.

With such perspectives you need a strong medicine to cure health care. Anything less than the kind of peaceful revolution of culture and systems taking place in Stockholm will be useless.

6.

THE OUTCOME: A MATTER OF PERSPECTIVES

Are the reformers in Stockholm successful? Or are they fakes? Is this the health care of tomorrow – or just a little more of yesterday's medicine?

You cannot find a good answer until you decide what the preferred outcome of health care is to be. That is the key question.

Let us examine some alternatives.

IS IT ALL ABOUT BUDGETARY DISCIPLINE?

Do you belong to the believers in "econometrics?" Do not be ashamed – you are not alone at all. To many of you the most important outcome is the budget figures and budgetary discipline. Did the organisation tally? Is there maybe even a little surplus? Are costs developing according to plan? If this is your perspective I am afraid you will not like the Stockholm reform process.

First, there is a lack of figures and other kinds of statistics (though things are improving in this respect). That annoys me too.

During the 90s there have been cost overruns almost every year in Stockholm (and Swedish) health care. Costs are rising at a gross rate of 7 per cent a year, last year (2001) by no less than 9 per cent in the metropolitan region. But the figures seldom tell you the reason why. And what is worse, they say even less about the relevance

of the outcome. Did the balanced budget really provide better maternity care? Was there an enhancement of integration between emergency and geriatric care? Could you bring down the number of personnel falling ill due to workplace conditions? Etc.

Far too long now we have relied on budget figures to tell us the truth and provide us with tools for moving health care forward. That was seldom very useful, even in the systems of yesterday, and it will definitely be no use in the future.

HOW ABOUT EFFICIENCY?

Or do you prefer the "efficiency school?" Then Stockholm might be something for you. That is, if you agree to the definition of efficiency.

Here you might find some interesting facts about outcomes, such as the continuing improvement in public health conditions, understood as the remaining life span. Here the improvement is more significant than in other parts of Sweden, the remaining life span increasing faster than in any other county. The same goes for infant mortality (already among the lowest in the world but still improving). Or the average length of stay in hospital – which is still getting shorter though not at the same dramatic speed as during the first half of the 90s.

Since the frequency of complications is also falling, you might draw the conclusion that the health care system is capable of delivering good treatment outcomes with less time input. The use of pharmaceuticals in Stockholm is comparatively low as well, compared with the national average.

And as we have already seen, access to services is far better than

in most other councils, though the per capita costs of health care in Stockholm are average. Short waiting lists have been achieved, evidently not by excessive use of resources but by other means – maybe the flexible capacity resulting from the number of entrepreneurs in the network or a productivity-supporting compensation formula?

Putting it more accurately, as long as the evaluation tools are weak, the translation of efficiency will be questioned. So if your goal is efficiency, Stockholm still often lacks the whole chain, from vision and goals to the follow-up technique, which will allow hard statements regarding efficiency.

A HOT POTATO

The cost situation – or rather the funding policy – of the Stockholm County Council – is a hot potato in Swedish politics. The national equality tradition requires economically better-off parts of Sweden to send some of their tax income to their poorer cousins. This goes for county councils as well as municipalities. But the Stockholm region is by far the biggest contributor, transferring more money to many councils than the national government. The Centre-Right Council leadership strongly opposes the government's redistribution of tax money in this way, by under-balancing the total Council budget. The rapidly growing deficit will necessitate a regional tax rise, whatever the election outcome.

This under-balancing tactics – an "un-Swedish" act of public disobedience – infuriates the government – as well as the Council auditors – accentuating still further the controversy between Moderates and Social Democrats. But as the Council relies on the capital market rather than on the taxpayers to finance health care, you can-

not speak of a lack of health care resources, though the financial policy risks spreading the image of a health care provision in crisis, thereby confusing employees as well as the public.

NEW INCENTIVES

But efficiency also goes for the change of incentives and other mechanisms. When the leaders of the Stockholm Council introduced the DRG system at the very beginning of the 90s, the aim was to boost the efficiency of key services in order to get rid of tiresome waiting lists. Suddenly the old success formula was of no value to the hospital managers: pointing to long waiting lists as an argument for another budget increase was no longer a good idea. Instead the name of the game was to attract purchasers willing to pay for a higher number of treatments, thus increasing patients' access.

Central/global budgets give staffs a tool to reduce costs when the economy gets tough. That means cutting down on activity, closing down units, postponing treatments. If, on the other hand, you are paid a fixed price for every item delivered, it is natural to attack budget deficits by increasing your income, i.e. your production. You think about how to increase quality, lower prices, improving access, in other words how to become more competitive – a 180 degree turnabout compared to yesterday's mentality.

That opens the way to efficiency – if your ambition is to make people healthier, which in my view is a reasonable goal for care organisations! But if on the contrary you express your aim as keeping the costs at par, then this kind of innovation is just confusing. The global budget culture at least gave the illusion of total cost control . . .

EVIDENCE BASE

But again, as you can see from my examples, in Stockholm there are more good examples and inspiration than hard evidence. As a result of the preparations for the grand-scale acute and emergency competition, there will probably be more evidence on efficiency. Or let us put it this way: there must be a rapid development of evidence-based medicine to meet the expectations. The competition preparations include a large project in this respect, which, according to the stated aims, will significantly strengthen the link between outcome and evaluation. Says Dr Kaj Lindvall, head of this project: "We cannot fail – regardless of the general impact of the competition for emergency care in the next few years, there will be a breakthrough for the awareness of evidence-based medicine."

CONSUMER SATISFACTION?

Maybe you would prefer looking at consumer satisfaction as a measure of the degree of efficiency? Fine – in the world of growing consumer power that will probably be the smartest and most relevant way of assessing outcome – but hardly the easiest one.

Consumers will look upon health care as one of many sets of services. Their judgement will be based on how quickly and competently demand can be dealt with. In order to succeed, health-care organisations must implement incentives which drive and develop new and sophisticated services. They will certainly not succeed just by abandoning bureaucratic principles in favour of consumer-market influence.

We can identify such a process in the Stockholm region. The core change is the introduction of rational incentives to improve perfor-

mance, not only in economic terms but also in services to the consumer, in market information, and in conditions for employees. This means that the monopoly must be abandoned in favour of pluralism, starting with the production side.

LISTEN TO THE CONSUMER

There are a number of ways for consumers in Stockholm to make judgements: polls and inquiries, where they can express their expectations and impressions from visits to a health care unit. They can lodge formal complaints through different channels. The law requires certain kinds of malpractice to be reported to the authorities by the employees, in order to provide the informed consumer with – sometimes – alarming statistics.

And they can use the freedom of choice to "vote with their feet" by replacing a certain GP, a primary care unit, or a hospital with another which will deliver better value. Having today a choice between a large number of providers, you can really exercise that power. Supporting this ambition, the next step in the reengineering process can be a new way to distribute purchasing power by a voucher system including an even larger number of certified service producers. In such a system the Council is the bank and the individual free to make his or her own decisions.

And of course there is the electoral ballot.

As I mentioned before, the electorate in the metropolitan region almost by tradition changes the majority every four years. As most people still make the same choices in all three simultaneous elections (national, regional, and local level), you cannot be sure to what extent the performance of health care services affects their deci-

sions. But the regional majority is up for grabs in September. One year ago you could easily predict a renewed mandate for the Centre-Right coalition, today things are a good deal less predictable. With the Social Democrats dramatically advancing in the national polls, the party in the metropolitan region most likely will gain by the example. Will the swing be powerful enough to compensate for the general progress in health care services? After the September election we will know.

MEETING THE EXPECTATIONS?

Is Stockholm's "new health care" measuring up to consumers' expectations? Do people see and appreciate the kind of systems reform we are discussing? The impressions are mixed.

Though highly ranked for its credibility and legitimacy, we meet increasing criticism all over Sweden of the performance of the health care system. The public picture is strongly influenced by the media, which seldom report on advances but tend to focus on failures. The impact of increasing medical quality evidently does not offset the shortcomings of the daily care given, which is illustrated by old patients left on their own in a hospital corridor. General health conditions are improving year by year, but more and more people feel neglected and forgotten.

There are comparisons between the 20 councils of Sweden regarding health care consumer attitudes. The overall impression is that the lack of choice is becoming a strong reason for complaint. In 2001 twenty thousand patients all over Sweden complained to the Patientnämnden (the Patients' Committee) about bad access or lack of choice, a ten per cent increase from the year before.

Moreover, you will still find quite satisfied patients in old-style councils, where the population is generally older and probably more tolerant of long waiting times for examinations and treatments. In the bigger cities, younger and well-educated inhabitants are much more demanding.

A DOWN-TREND

Let me give you some Stockholm examples of health care consumer satisfaction. Three major consumer polls taken during the 90s, showed that:

- The general level of satisfaction is falling.
- There is a big difference in attitudes between citizens trying to get in touch with the system and those who have already received treatment; the latter are very satisfied, but the "contact-seekers" are increasingly critical.
- The main reasons for their criticism are bad access to primary care and a lack of influence or freedom as to when and where a treatment will be provided.
- In 1994 80 per cent found it reasonably easy to contact their family doctor by phone. In 1999 less than 50 per cent were satisfied. Among patients in general surgery, the proportion allowed to choose the day for an operation themselves fell from 38 to only 17 per cent.
- Patients visiting private producers (with public funding) are significantly more satisfied. Among the hospitals the St Goran is no. 1.

WHAT CONCLUSIONS?

You can draw completely different conclusions from these figures.

To critics it would be easy to deny any progress: the poll figures are going down. Evidently the Stockholm transition is a failure, they would say.

To enthusiasts the figures send the message that change is of the greatest importance. The negative response shows dissatisfaction with the remaining old-style health care functions. The increasing number of private providers is appreciated.

Being a "middle-man" myself, I would say that this proves that it takes time to change the direction of a supertanker. Reform is no doubt necessary to meet the strong demand for choice, pluralism, and access. That goes for the employees as well. And satisfaction with health care as well as with most other public services (and many private ones, to be honest) is falling in all county councils. Consumers are demanding more.

WHO IS IN CHARGE?

The quality of the development process is, basically, not controlled by the Council; during the second part of the 90s there was a severe shortage of doctors and nurses to repair the shortcomings of, mainly, primary care. No reform step – for example the purchaser-provider split – can in itself solve the problems. You will need the whole package, and even with strong incentives a change of culture and behaviour will take several years. So there is a need to go on fine-tuning and adjusting until the next relevant steps can be taken.

As always, you must ask the question: What are the alternatives? What would the situation be without reform? Is it likely that politi-

cal involvement in everyday details, as it was done before the reforms, would increase efficiency? Would co-worker motivation problems automatically solve themselves if we were to reintroduce hierarchy? Would a return to global budgets make people in health care more cost-conscious? Were patients more satisfied when choice was less supported and you lacked all kinds of waiting time information?

NO WAY BACK

No, there is no such thing as "good old health care" to return to. In my view the present problems are primarily related to the clash between – on the one hand – increasing demand (because of demography, values, access) and – on the other – delivery limitations (due to top-down organisations, lack of consumer strategy, bad personnel policies, and a painful shift from traditional governance to market-influenced networks). So the challenge is how to make health care systems quickly adapt to the new reality and, from this base, build the integrated services which are so badly needed – not to look back at something which was not fit for yesterday's conditions and is even less fit for tomorrow's!

7.

THE FUTURE

The "new" health care. What will it look like in ten years' time?

Headlines warning of a cost explosion in health care are well known. Using roughly one-tenth of the total resources in Western European societies, health care systems are no doubt costly. But compared to what? Repairing the demanding welfare society member has never been cheap. The driving forces analysed here will make it more and more expensive. The accounting devices provide cost figures but seldom evaluate the outcome. What is the price tag on getting people back to active life after a heart attack? What value can be put on avoiding pain while waiting for treatment? How do you factor into the GDP equation the rehabilitation of schizophrenics, breaking their isolation and giving them the chance to live a normal life?

We see that health care budget figures are rising. But we lack the imagination and the methods to compare outcome with costs. Not until then will we have the answer whether health care is worth the money.

In my opinion it is an illusion that total health care costs can be cut. In single operations and segments – yes, but not in the "business" as a whole. Just look at the demographic trends!

Not only is it the ambition of most Europeans to retire at the age

of 55 when you can still play golf (in many countries today people retire even earlier). Such behaviour can be changed – at great political cost. But making people younger is quite another thing!

GREY WILL BE THE COLOUR

Europe is getting greyer every year. Or, more drastically speaking, it is a dying continent. During this very decade, the "self-generated" population of Italy will start shrinking, followed gradually by most other European countries. This future will put an enormous stress on demand, recruitment and funding. An extremely important choice will have to be made between self-sufficiency and openness. As I see it, there is no alternative to large-scale immigration from outside Europe. Regardless of the outcome, the welfare state as a European landmark will expire, at best replaced by a new kind of welfare society.

Soon Western Europe will be one single market for health care services. The EU assumes harmonisation, treating health care as one of many services. In most member countries citizens can already choose the caregiver they prefer. Thus a national freedom of choice already exists. The legal situation is not yet fully defined, but the European Court is evidently inclined to support mobility. There will probably be setbacks, but for the next decade anything but equal access to health care services within the Union would be absurd and counter-productive.

A EUROPEAN PRICE TAG ?

What about the funding then? This is always a key question, of course.

One interesting aspect of this emerging European health care market is its price transparency. The greater the numbers of consumers crossing the borders backed by public and/or insurance funding, the stronger the pressure on the providers to offer price information which will make critical comparison and benchmarking possible. When there are "EU price tags" on hip plastics, heart surgery or cancer therapies, the consumer's influence will grow again.

Such a development will open the way to another important shift of power, viz making the individual – assisted by relatives, social networks and professional guidance – the purchaser. Here there will be opportunities within the public system (tax-funded individual health care accounts etc.) as well as in private health insurance.

PUBLIC FUNDING – NOT ENOUGH?

As I see it, public funding offers important advantages. In general it is efficient, with low transaction costs as every citizen (or at least the large majority of them) takes part in the financing and has open access to the system. The more borderline problems, the less efficient the system will be. If you fear marginal over-consumption, there are, for example, user-fees.

Having stated this conviction, I must admit that I strongly doubt whether public funding will be enough to meet the kind of challenges I have been examining. Most likely there will be a need for additional funding, probably starting in elderly care, then moving into health care. In Sweden there are already suggestions – from left as well as right – regarding additional insurance funding of services for older citizens. The number of private health care insurance poli-

cies is rapidly rising, albeit from a low starting level. The baby-boomers already will have to use their pensions and income to pay for a lot of extras.

You cannot travel European first class without paying for the soft seats and good food...

THE CHOICE

Soon we will have to make a choice: maintenance of purely public funding or a mix? Can Sweden stand the taxes needed to safeguard public funding? Whatever the outcome, the future health care network of solutions will have to be very flexible, made to meet the increasing individual consumer demand. Manpower will become a gigantic bottleneck, forcing health care to focus, not only on consumers but staff conditions.

Here you might find that the re-shaped network health care structure in the Stockholm region will turn out to be the most successful in handling the new situation, finding the tools to bring all useful resources together in a pragmatic way, making public and private co-operate to satisfy the needs for better health.

The road there will be a long one. If you bring a good compass, you can rely on inventing the map as you go. In Stockholm they are already on the move. The sooner the better. The future will not wait.