Johan Hjertqvist

THE END OF THE BEGINNING

The healthcare revolution in Stockholm, part II

Timbro Health Policy Unit

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Summary

The End of the Beginning – a short international update on the Stockholm healthcare revolution – summarises the healthcare advances made in Stockholm during the 1990s, describing the reforming process and its good results, but also the new difficulties that have cropped up along the way. To prevent the Stockholm model from becoming a sick man itself, radical new approaches are needed to strengthen economic incentives and market mechanism. Are there any politicians with the courage to go further?

One thing, though, is certain. Healthcare in Stockholm will never revert to the allocation funding and command economy of the 1980s. The move towards consumer control, diversity and network healthcare has gone too far for that to be possible. The change we have so far experienced is merely the end of the beginning of a much bigger historical process. You ain't seen nothing yet!

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1: An idea spreads worldwide

Healthcare is a fascinating blend of international and local perspectives. Terminology and methods are global, culture and attitudes national. Even if the official attitude often seems to be that one's own medical system is best, the world is being scoured for best practices and good examples. Rising costs and the elusiveness of that perfect organisation are a universal bugbear.

Anecdotes abound of encounters at international airports between Swedish experts setting out on field trips to The Hague or Sydney and Dutch or Australian colleagues heading for Stockholm in search of inspiration for reforms. Just as one country introduces a buy-sell system, another is on the point of abolishing the selfsame model. The American DRG system has caught on in many countries. And so on.

But amid all this frantic searching for knowledge and success, the Stockholm model, as it has come to be known, has attracted a startling degree of interest. This Swedish endeavour to get more bang for buck in publicly funded healthcare has set up a loud international echo which can be quantified in more ways than one.

Inspiration

One way is by looking to see how other regions and counties have been inspired by the Stockholm County Council (SLL for short). The reforms in the Stockholm region began in 1991 and soon spread to other major cities in Sweden. Today about half of Sweden's 21 county councils are applying the Stockholm model, either in its original form or in versions of their own making.

Now that Tony Blair is attempting the reform Britain's NHS, one cannot help noticing the cue he has taken from SLL. Performance-related hospital funding, with greater independence for hospitals, free mobility between care providers, waiting time information on the web – the parallels are obvious. Several Canadian provinces have followed the same path, Stockholm influences are clearly apparent in the Netherlands, Denmark and Norway have imported availability guarantees and information systems, and so on. A couple of states in the USA have actually held referenda on the introduction of Swedish-style "socialized medicine" – both ending in defeat for the proposal, I might add.

Then there is the high frequency of field trips to Stockholm from near and far ever since 1991. "The healthcare revolution in Stockholm" has become a hot study topic.

A third – perhaps egocentric – yardstick concerns the extent to which the Timbro Health Policy Unit and myself have been involved in experience interchange and opinion formation regarding the Stockholm model. For my own part, in the two years of the Timbro Health Policy Unit's existence I have visited every continent except Australia and the Antarctic to lecture on one or other dimension of the reforming process in Stockholm. Interest has been clearest in Canada, where the Timbro Health Policy Unit itself has had a unique impact, due very much to smooth-running co-operation with partners like Frontier Centre in Winnipeg, the Montreal Economic Institute and AIMS in Halifax.

Value consensus

This interest can be put down to a consensus of values between Sweden and Canada. In addition to both belonging to the world's ice hockey, vodka and pine forest belt, our societies share a distinct egalitarian tradition having health care on equal terms as one of its cornerstones. Then there is the self-image of uniqueness. This is above all noticeable on the part of Canada, which is always positioning itself in relation to its big neighbour, the USA. If privately funded healthcare is common in the States, the opposite must apply in Canada. Public healthcare is elevated to the status of national heritage, "what makes us Canadians".

The value consensus appears, however, to be a matter of official policy. Sweden's Minister of Health and Social Affairs has formed an international coalition for "healthcare on equal terms", with Sweden and Canada setting the tone of things. And in its current quest for a political compromise on the ownership and funding of healthcare, the Swedish government has looked to Canada for ideas, the intention being that Sweden too should prohibit two-tier systems and make watertight compartments of public and private funding (at the same time as the running, even the ownership, of acute hospitals is to be opened up to private players within the framework of public funding). Which makes it all the more amusing to behold the booming ideological exportation of market influences to Canada, due very much to the Timbro Health Policy Unit and to Canada's receptiveness to innovative thinking.

I have the impression that Sweden's Minister of Health and Social Affairs is none too pleased about this. But independent think-tanks, by their very nature, are absolved from all concern with governmental sensibilities!

The attention aroused by the Stockholm model is more than coincidental. Sweden still has a good international reputation, and part of the impact is doubtless due to adherents of publicly funded healthcare, not least, feeling confidence in the light coming from

egalitarian, fair-minded Sweden, of all countries. The view seems to be, rightly or wrongly, that when the Swedes change things they do so with good reason and deserve a hearing.

A lot happening

I have previously summarised the main outlines of the Stockholm model for an international readership (*The healthcare revolution in Stockholm – a short personal introduction to change*, Timbro Health Policy Unit, 2002). Since then a number of things have happened which call for a new situation report. I have concluded my trilogy on the health care reforms in Stockholm and Sweden, and in the concluding part I have to admit that the Stockholm model has now become part of the problem rather than the solution to it. System maintenance has been wanting, and the reforms have lost momentum, added to which, SLL underwent a change of régime in the autumn of 2002, with power passing to a centre-left coalition.

This, of course, prompts one to ask how firmly rooted the "market reforms" have been. Did the electorate pronounce the Stockholm model a failure, or were they just following the Stockholm pattern of switching majorities at every election (as has been happening for the past 20 years)?

The new majority appears, as with previous régime changes, to be preserving all the foundation stones of the Stockholm model but, owing to the straitened condition of county council finances, will be forced into unpopular cutbacks. Pressure is heavy for improving the performance of the healthcare system, and reforms are very likely to come within the framework of the model. But values like free choice, diversity, competition and good availability are now so deeply rooted that a high political price will have to be paid for putting the clock back.

Neither in Stockholm nor anywhere else does the command economy appear to be the solution to our healthcare problems. The healthcare of tomorrow will if anything be shaped by affirming the care consumer. Stockholm and Sweden are well placed to continue spearheading developments in this respect, so long as political pragmatism is permitted to prevail.

Stockholm, May, 2003

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2: The beginning of the end?

September 2002. County council election time in Stockholm, the symbol of Swedish healthcare reforms of the 1990s. Will the centre-right régime be voted back into office to go on developing the market orientation of health care? Or will there be a backlash against the swing to the right and market experimentation?

What I have described in earlier books as "the healthcare revolution in Sweden" started in the Stockholm region at the beginning of the 1990s. This may sound dramatic, but the term "revolution" is justified, even though the initial change was confined to the Stockholm County Council (SLL) and mainly to its hospitals.

Anatomy of the revolution

Perhaps we should briefly recapitulate the implications of this big change, which was a revolt against 1980s practices in the control and management of public health care, not only in Sweden but in large parts of Europe. The manifesto adopted by the County Council in the early summer of 1991 read as follows:

• The County Council politicians define requirements, indicate the direction of policy and are responsible for follow-up but not involved in performance (which, until then, they had been).

• The providers shall be funded through earnings and not, as previously, with budget allocations. The earnings are based on a unit price system (DRG, Diagnosis Related Groups) in the form of an annual "price list".

• Financial control shall be performance-related.

• Competition between healthcare providers shall contribute towards higher quality and better utilisation of resources.

• There is to be more competition from producers outside the County Council. This competition is to be on equal terms.

• The healthcare producers shall, as far as possible, work on a commercial basis (e.g. covering their own, true costs). Any change in the terms of competition shall be by political decision (i.e. through an open debate, not through manipulation by the administration).

• Expenditure shall be comparable between all units (which calls for improved systems of accounting).

• Financial responsibility shall be combined with powers of cost verification. Quality control is highly important and is to be independent of production.

• There shall be a balance between financial incentives and control. Staff motivation presupposes incentives and bonus systems.

• Resource allocation shall be guided by the patient's choice of care provider. Contracts and agreements may not run counter to a patient-driven, market-oriented organisation.

Compared with traditional budget funding, which has been reviewed and tinkered with time and time again ever since the 1950s, without any tackling of its fundamental weaknesses, the new principles were pregnant indeed. Resources were to be allocated according to performance, not in return for promises of hoped-for achievements. Incentives, follow-up and control were parts of the same fabric. The strongly emphasised free choice of care provider was both an overriding objective and a funding allocation mechanism.

More care, shorter waiting lists

What, then, has this "revolution" meant to Stockholmers and to the people flocking in from other county councils to benefit from the shorter waiting times and greater diversity of care providers in the Swedish capital?

Hospital productivity rose between 1991 and 1993 by an average of 16 per cent as a result of the DRG reform. At some hospitals the improvement was nearly 20 per cent. In other words, care consumers and taxpayers got more value for their money.

Evaluations have shown healthcare organisations with purchaser–provider management to be 10–15 per cent more efficient than those retaining budget allocation. A distinct purchaser function is a precondition for being able to engage private, more efficient producers.

Waiting times for examination and treatment could be rapidly shortened when productivity rose. Waiting times fell by 30 per cent in one year.

Competitive procurement heavily reduced the cost of various healthcare services in the Stockholm region. The reductions varied from upwards of 10 per cent (e.g. for ambulance transport) to 40 per cent (medical laboratories, radiography).

The healthcare revolution made it possible for more private players to be engaged and, as a next stage, for many healthcare employees to start up on their own. These healthcare entrepreneurs have played an important part in improving health and safety conditions and staff involvement, and also in introducing a new style of working, which is particularly important in a conservative sector like healthcare.

For the first time there now existed a viable job market for healthcare personnel. With many employers to choose from, nurses and other categories were able to negotiate improved conditions of service. Start-up opportunities were an important motive force. Nurses' pay improvements in SLL outstripped the rest of Sweden's healthcare sector by 50 per cent. No wonder, then, that all union organisations in the healthcare sector support the process of reform from monopoly to diversity!

There are today 290 healthcare enterprises affiliated to the Swedish Association of Health Professionals (Vårdförbundet). Chairman Eva Fernvall, one of the strongest advocates of innovative thinking in healthcare, explains that they are owned and run by nurses, which goes to show how the job market has been transformed in the past decade.

Everyone satisfied?

Well, then, surely everyone should be satisfied and the political parties who introduced these changes should be confident of re-election? Surely patients and the electorate should reward them for this epoch-making change?

So how can it be that the opposite occurred, that the 2002 county council election returned a centre-left majority instead (albeit with a majority of one in an assembly of 101), after an aggressive election campaign in which healthcare was very much at the centre of attention?

A good question, as they say.

Let us analyse the situation. In certain comments, both national and international (by individuals and organisations disapproving of market elements in healthcare) I perceive a degree of gloating over the election outcome, on the lines of – now the Stockholmers have had enough of tiresome market-orientation experiments and voted for "good honest healthcare". Will we in future be spared hearing about how good the Stockholmers are at reforming their healthcare?

I have found others, sympathetically disposed towards the Stockholm reforms, to be somewhat perplexed and disappointed. Was popular support lacking for the remoulding of healthcare? Did the "reforming fathers" lose the election because something went wrong?

These are fair questions which I myself have asked in the book "*The end of the beginning*," soon to be published in Sweden, and upon which this condensed version is based. I find the main explanations to be as follows.

The Moderates, the biggest political party in the ruling constellation, also lost heavily in the parliamentary election which took place at the same time. Post-election analyses point to two main reasons for this. Firstly, just before polling day a succession of Moderate politicians were unmasked by a candid camera television programme as being heavily prejudiced against immigrants, and secondly, the party failed to explain how it would be able, at national level, to combine heavy tax cuts with the maintenance of welfare. This heavy loss of ground affected the electoral following in general, making the county council election much harder to win.

The Social Democratic government conducted a prolonged, fiercely negative campaign against the centre-right régime in the county council, with the Minister of Health and Social Affairs, not least, behaving as though he were leader of the county council opposition.

The county council régime obstructed the national equalisation policy of sequestering taxation revenue from the Stockholm region for payment to other parts of the country (a policy familiar to Canadians, for example) by underbalancing the budget, the object being to demonstrate the adverse impact of this redistribution policy in the people of Stockholm. In 2003 the people living in the Stockholm region will have to surrender MSEK 5,000 to the equalisation system.

Because the centre-right parties were unwilling to raise the county council taxation rate, the deficit grew. Healthcare was provided with the necessary funding by the expedient of borrowing, but many residents were worried as to how this chicken race between government and county council majority would end. Heavy budget deficits are not good for credibility, even with the searchlight trained on the redistribution issue. Moderate voters, not least, expect finances to be in good order. In short, the county council régime's credibility probably suffered.

No going back

Last but not least, the political change had gone so far that votes no longer had any real fears of a change of county council régime entailing a reversion to prohibitions and waiting lists. Many voters I spoke to argued roughly as follows: "I'm counting on the Social Democrats not being stupid enough to try and stop private alternatives and reduce

the number of options. They must have learned that that kind of thing doesn't go down well. If they try to put the clock back, it'll cost them the next election!"

Summing up, the 2002 county council election was not so much a struggle between distinct ideological healthcare alternatives as a general beauty contest, from which the left emerged victorious. And so the only conclusion that can really be drawn from the election outcome is that neither side has any possibility of significantly departing from the Stockholm model of free choice and diversity as now established.

In chapter 3 I describe the new county council majority's programme, which confirms the central position the Stockholm model has now acquired in healthcare policy. The reforms of the 90s, in other words, are far from dead. On the contrary, they have been elevated to the norm.

But this is not the end of the problems, because, as will be shown in my next chapter, the reforming strategies which succeeded ten years ago now have their limitations. Further steps must be taken in order to maintain the pressure of change. Can the Stockholm model be given a new lease of life?

3: Has the solution become part of the problem?

Today in 2003, putting it drastically, the Stockholm model is more of a patient than a saviour. Health care expenditure is rising more rapidly in the Stockholm County Council and other regions which have followed Stockholm's example than in places where allocation funding remains the practice. The substantial and promising productivity improvements of the 90s have been reversed. Several of the incorporated hospitals are running at a deficit. The new county council régime has heavily increased the taxation rate to cover the deficits inherited, but is still having to introduce a painful economisation programme.

True, there are reasons for all this. The well-educated, demanding residents of the Swedish capital are expecting more and more of healthcare. The population is ageing and the pressure on senior healthcare is growing. Staffing shortages – albeit less acute in Stockholm than in many other parts of Sweden – are a problem in themselves, leading to a steep escalation of salary and outsourcing expenditure. Rapid medico-technical progress is raising standards year by year, and every new diagnosis amenable to treatment costs money. These factors are familiar in many other metropolitan regions the world over.

But this is only part of the story. The dedicated and determined prosecution of the reforming process in Stockholm at the commencement of the period of change has been weakened. Uncertainty about means and ends has grown widespread. When doubts begin to spread, efficiency declines, as anyone with experience of processes of change will testify.

Why, then, has the unambiguous triumph of the 90s been eviscerated?

I can see several reasons, some connected with political manoeuvring, others with the structure of the Stockholm model.

• Crisis awareness faded

The early 1990s were dominated by the gravest economic crisis known in Sweden since the 1930s. Between 1992 and 1994 GDP fell by a total of 6 per cent, a loss which was not made good until the end of the decade. Crisis awareness was initially high, and a climate of political consensus was created which among other things allowed the Riksdag (parliament) scope for a comprehensive pension reform and the abolition of state monopolies in telecommunications, energy and transport. In healthcare, as I have already described, structural reforms were adopted which raised efficiency, with 80,000 job losses

in just a few years. There was a high level of willingness to challenge and reappraise. Necessity knows no law.

But towards the middle of the decade, with the crisis apparently over, the climate for change grew weaker. The risk of losing one's job diminished. So did the political pressure to deliver. While centre-right majorities affirmed healthcare reforms as intrinsically welcome, to the centre-left way of looking at things they were more of a necessary evil, dictated by economic contingencies. Now that the economy began to pick up again, the changes appeared less justified.

• Discipline was undermined by the mounting budgetary deficit

During the last term of office, the Stockholm County Council's budgetary deficit grew from MSEK 1,200 in 1998 to no less than MSEK 4,100 in 2002. Even though, as I have already mentioned, the deficit did not entail any cutbacks on healthcare funding (instead the healthcare budget rose by 30 per cent during this period), health care budgetary discipline was also affected. One can readily imagine the dilemma confronting a head of department or a hospital chief executive grappling with budgetary problems in his or her own organisation at the same time as leading county council politicians were defending huge deficits. Expenditure at Stockholm hospitals rose on average by 8 per cent annually, partly for this reason.

• Growing political confrontation

The planning of the great change of system at the end of the 1980s was based on a dialogue between Social Democrats and Moderates. It was a Social Democratic county council régime which, in the spring of 1991, took the decisive steps away from allocation budgets and introduced the DRG system and performance-related payments for hospitals. Co-operation on the system reform continued even after the election that autumn had led to a change of régime in the county council. Several years were to pass before the Social Democrats began criticising what they called "privatisation" and "the twist to the right".

This relative calm was broken when the Moderates, having recovered power in 1998 (as I have already remarked, the Stockholm County Council acquires a new majority at every election), sold St Göran's Hospital to Capio, a healthcare provider listed on the stock exchange. In protest, the Social Democrats withdrew from co-operation on healthcare development. The open conflict which now erupted undermined the long-termism and legitimacy of the policy pursued, because everyone knew that the Social Democrats were likely to recover power. The conflict also concerned the huge project of opening up the acute hospitals to competition, a project which the Social Democrats began opposing as a

result of the split. The Great Procurement, as it was called, was delayed for two years and its implementation became more and more of a political high-risk project.

• Hard making serious business of the orderer-provider relation

The efficacy of buy-sell systems depends on a realistic contractual relationship. If things stop short at "playing at business", with the parties continuing to behave as though yesterday's allocation budget still prevailed, the only result will be expensive bureaucracy and cynicism. Of on the other hand the intentions can be realised, with purchaser and provider meeting in a constructive dialogue, quality and methods can be developed without any need for rising costs. Increasing demands will then be put on both sides to define expectations clearly and to assess the results delivered.

Getting there proved to be a longer process than the "reforming fathers" of the county council had initially supposed. A credible business relationship of the kind characterising private enterprise requires a party to be able to turn to other players if he is dissatisfied with the conditions offered. In Swedish health care, the county councils are in practice the only buyer/financier, so that, even if the producer can increase healthcare output, this will make no difference so long as the dominant buyer does not want or cannot afford more.

Obstruction

Every big buyer is tempted to exploit his position. In this respect a county council is no different from a big corporation. On the other hand a buyer with no business experience is far more liable to impair business relations by delaying agreements, demanding heavy discounts during the currency of an agreement or framing contracts in such a way that interpretation disputes can very easily arise. Disruptions of this kind can easily occur of the administration disapproves of the new rules of the game, as was the case with many of the SLL officials charged with putting the reforms into effect.

Ralph Ledel, SLL's Moderate "prime minister" between 1998 and 2002, today admits: "We were mistaken in not sacking a huge number of officials already in 1998. We weren't strong enough to overcome the resistance to reform. And the fact is even a county council commissioner is taking a risk by falling out with 200 officials."

Payment arrangements are pivotal. In an allocation budget, for example, the department is allotted a given sum of money, on grounds which are not at all clear. This is based on the assumption of a certain healthcare performance (though the system does not react to the achievement or non-achievement of the target). In a DRG or any other performance-related model, payment will not be made until the services have actually been produced. If one or

other of these two models is strictly adhered to, the rules of play are fairly straightforward. But strict adherence is rare in practice.

Since the county council – be it with an NHS system or an HMO – usually lacks the money to pay for every potential hip transplant or cataract operation that can be performed, some kind of production constraint is needed. Usually this takes the form of a ceiling where compensation begins to be scaled down, disappearing completely above a certain level. In Swedish primary care, performance-related payment constitutes only a minor proportion of total payment. This limits the additional expense incurred to the county council if the volume of medical consultations increases, but on the other hand affords little incentive for primary care to be productive.

Whereas in 1991 clear instructions were given for productivity and prompt delivery, gradually the SLL payment system has become more and more similar to the old system of funding allocations. That, at least, is how developments are perceived by many producers. Another problem is that the DRG pricelist pays no heed to the quality of care. Nor did the funding allocation model, so DRG is far better, but with orderers wanting to put more and more emphasis on the good total outcome of an input, quality considerations cannot easily be excluded from payment calculations.

Another cause of discontent within SLL has been what some regard as favouritism towards certain private care providers. The County Council auditors, for example, have queried the neutrality of the agreement for St Göran's Hospital, which according to their inspection favours Capio, the public company owning the hospital. St Göran's Hospital has even been accused of "DRG slanting", i.e. in a choice between two diagnoses recording and requesting payment for whichever is most remunerative. Capio, of course, begs to differ. The former county council régime says, off the record, that perhaps some "priming of the pump" was needed to make the sale of St Göran's possible in the first place. But, they go on to say, the dynamic effects of this sensational privatisation have been so considerable that, all things considered, the County Council has struck a good bargain. And the fact is that SLL today is paying MSEK 120 less for treatments at St Göran's than if the same care were to be purchased from a council-owned hospital.

• Unfamiliar ownership role

Last but not least of the conditions which have all helped to undermine the Stockholm model, we have the diffuse nature of SLL's ownership. Both Social Democrats and Moderates thought at first that the internal market would settle the dimensioning of the production apparatus. SLL, the owner, would not need to take any action: buyer and seller

would strike the perfect balance between supply and demand. Competitive producers would survive, others would be weeded out. The whole thing was conceived of as a dramatic move away from traditional county council policy.

As I have already mentioned, the Social Democrats eventually backed away from this market policy. The Moderates stuck to it for a greater length of time and were intent on entrusting all healthcare to private entrepreneurs and council-owned companies operating on a commercial basis. No health care would in future be provided by administrative authorities. That was the idea, but the process proved a good deal more protracted than had at first been believed.

By the time of the 2002 elections, half of all primary care activities had been put out to contract, while in psychiatry and acute medicine the proportion was far smaller and SLL was having to act as owner, no matter whether the question was one of organisational planning, facilities, investments, R&D or the management of surpluses and deficits.

Confrontation the business idea

Public, politically controlled organisations seldom make active, vigorous owners. This is no coincidence. Structures of the kind are commonest in soft, welfare-type sectors where there is no tradition of entrepreneurial thinking, where indeed any such mentality has been ruled out of court by ideological considerations. In Sweden, policy-making in such value-driven areas as medicine, caring services and education often lives by creating confrontation which impedes long-term solutions, the intention being to sustain disagreements, not to arrive at a consensus view of things.

The saying goes that when A and B agree they start a business together, but if they disagree they each form a political party.

Not very surprisingly, the ownership role of county councils has generated serious conflicts which, in SLL's case, now appear to be moving towards pragmatic solutions. The danger is that unity will be created at the cost of difficult issues being swept under the carpet and ownership policy being watered down, in which case new problems will arise.

Thus there are a number of explanations for the dynamic model of management introduced in 1991 starting to run out of steam. I call it "lack of systematic maintenance" – the failure of politicians to adapt the rules of the game to a rapidly changing reality. Frequent changes of régime within SLL have destroyed long-termism, political confrontation and power-gaming have replaced the initial consensus. The system lacks a forward gear.

Now in this respect SLL is by no means unique in Sweden. Indeed, the World Health Organisation (WHO) has described the politicisation of healthcare policy and the frequent changes of power in county councils as a risk factor in Swedish healthcare.

One of the most startling political changes in Sweden in recent years can be construed as an attempt to allay this uncertainty and achieve greater long-termism. There are other interpretations as well.

Startling

What I have in mind is the way in which, following the privatisation of St Göran's Hospital in 1999, the Social Democratic government rushed special legislation through the Riksdag forbidding further sales of acute hospitals to producers operating for profit. In the 2002 election campaign the slogan was "no hospitals on the stock exchange", and the whole of Sweden's healthcare was said to be threatened with a spate of privatisation.

Now, in the spring of 2003, a completely different tone of voice prevails. A Government Commission, headed by a Social Democratic MP, recently put forward proposals which included two important recommendations. Firstly, segregation of private and public funding (on Canadian lines). This way, a producer will have to choose between being funded out of taxation revenue or through private insurance. In practical terms a prohibition of this kind will have little effect in the short term, but it can impede the emergence of insurance alternatives for the future. It is a political gesture against any change in the public monopoly of privatisation.

The second important proposal is the shelving of plans to forbid the sale and private operation of hospitals. The Social Democrats would seem by all accounts to have come round to thinking that the preservation of public health care hinges on funding, not forms of management. Indeed, more hospital entrepreneurs may be needed to graft on new ideas and working methods. The report shows that enlightened Social Democrats at least now perceive that private capital and profit can have a positive impact on development and commitment. Besides, a prohibition might have been declared illegal by the European Court of Justice (ECJ), which would have been very embarrassing …

So in 18 months the dominant ruling party in Sweden has swung from prohibition to affirmation. A positive spin can be put on this by saying that the Social Democrats wanted to create rules for the further development of healthcare that would be viable in the long term and for which widespread political support was forthcoming. And as an intellectual exercise, the defence of emergency legislation was growing more and more difficult.

The outcome of this autumn's Riksdag debate on the proposals remains to be seen, but the level of confrontation in Sweden's healthcare debate has been lowered considerably. Which is all to the good. The less that is decided by politics and the more by pragmatism, the more reasonable the outcome can be.

In many of Sweden's county councils, discussions of healthcare organisation still tend to be noisy. It is these issues that dominate the political debate, whereas the outcomes of health care are relegated to greater obscurity.

Different models

I like to divide Sweden's 21 county councils into three "families", according to the amount of progress they have made from traditional, allocation-based funding to performance-related payments. There are quite considerable differences in this respect.

Family A ("safety first"): nine county councils which still have allocation budgeting. Resource allocation, in other words, is based on last year's allocations, with marginal upward or downward adjustments. "Cost control" is usually the overarching strategy in this kind of county council, with less importance attaching to healthcare outcomes. The superstructure of politicians and officials remains unitary.

One should not be overhasty in looking for features in common between these county councils, but the reason for their not having ventured into changes of model or experimented with new forms of management can be that they have fairly small populations, are mostly conservative in matters political (which is to say that they are usually governed by a Social Democratic majority), do not have any major academic centres and, in several instances, embody a strong, economically circumspect small–medium enterprise culture. Private care producers are few and far between.

Family B ("make haste slowly"): four county councils where hospital care is still funded by allocation, at the same time as new models of payment are being tested in primary care. These county councils too have fairly small populations, but more private producers. (In the County of Västmanland, 40 per cent of family doctors are small private practitioners, in contrast to the standard Swedish arrangement of being employed by the county council.)

Family C ("incentive believers"): seven county councils, among them the three metropolitan regions of Stockholm, Skåne and West Götaland. These county councils have segregated the tasks of procurement and provision. Services are procured on a competitive basis and contracts drawn up with the producers. The hospitals are remunerated on DRG lines, while primary care has various combinations of fixed and performance-related

payment. But although these county councils have made most headway, and even with private care providers accounting – as in the case of SLL – for 50 per cent of primary care, payment for primary care is surprisingly uniform.

In these most-developed parts of the country, focus on outcomes, freedom of choice and good availability are more important than total cost control. Productivity is of the essence. This family includes the most populous parts of Sweden, with heavy centres of academic education and research and frequent changes in the state of the parties. Generally speaking, private healthcare producers are commonplace. In some cases the incorporation of county council hospitals is also being tested. Some of the county councils concerned have high availability and receive patients from other parts of the country.

Uniform

Sweden, then, presents quite a variety of conditions, but in all instances the entire healthcare system is financed out of taxation revenue and primary care is surprisingly uniform. Not even SLL has had the imagination or courage to introduce a hard-hitting reform of primary care. Instead it has retained the health centre as the basic unit, with employed staff and with capitation as the principal form of payment. Every county council in Sweden has a free hand in shaping its primary care, but there is massive national uniformity. Innovative thinking consists in getting private entrepreneurs to run the health centre on the same terms as before.

Sweden is surrounded by countries with efficient primary care systems, especially since Norway in 2001 dropped the "Swedish" structure and made a truly radical switch to the Continental European tradition of family doctors who are self-employed and paid primarily on a performance basis. This has always worked excellently in Denmark (and most other European countries for that matter). In this way Norway quickly overcame its chronic practitioner shortage. It can only be a matter of time before Sweden begins making use of sound economic incentives and abandons the command economy in primary care for a Danish solution.

Dr Göran Sjönell, Director of the Swedish Institute of Family Medicine, set up to reform Sweden's primary care system, critically observes: "Now that even Russia has abandoned health centres, Sweden and Finland are the only countries where the old Soviet model survives."

The shortcomings of primary care – poor availability and service (Swedish doctors stay open during office hours only and do not pay home visits) – reflect a perversity of incentive. Whereas family doctors in Denmark, Belgium and now Norway as well – to

quote just a few examples – are paid by performance and, consequently, can boost their earnings by taking on more patients, the opposite applies in Sweden, where 80 per cent of income derives from capitation. This way, keeping patents out of the reception is more profitable, and poor service is a perfectly logical consequence. And, since the Swedish family doctor is usually a public servant, the number of patients makes no difference to his or her salary.

The perverse incentives have been tackled head-on in hospital care, where the economic connection between productivity and income today is clear for all to see. Everyone has gained by this. The crisis in Swedish primary care, as I see it, confirms the utter wisdom of the DRG reform in hospital care. Healthy, logical incentives are needed in order for change to materialise. The only strange and deplorable thing is that the reform started with the big structures – hospitals – instead of the small, highly mobile primary care units. If only things had happened the other way round, perhaps the entire process could have been constructed so as to make the change of system more natural and the political dissensions less obtrusive.

4: The Stockholm model – alive, but not kicking

If the increasing market-orientation of Sweden's, and above all Stockholm's, healthcare were a bad thing, would the new SLL régime have stuck to it? Hardly. Surely, after the 2002 election they ought to have executed a complete about-turn and reverted to the allocation-funded healthcare which several county councils with Social Democratic majorities are still adhering to?

What are we to make of the new majority retaining all the basic elements of the Stockholm model in its healthcare budget for 2003? Before the election, the healthcare policy of the Moderate-led SLL majority was taking any amount of flak.

Just saying "That's politics, stupid!" is a bit too easy. True, the recovery of power mattered to the Social Democrats, but that is hardly the whole truth. I think there are two other, more important considerations involved.

In practice there is no alternative to the incentive-driven network healthcare with a diversity of producers which has emerged in the Stockholm region and in several other Swedish cities.

Things have gone too far in the direction of decentralised operating structures and contracted producers of various kinds for there to be any question of putting the clock back. Half of all primary care and a quarter of all healthcare in SLL today are being operated for the County Council by private care providers. One of the region's seven acute hospitals is completely privatised but publicly funded. Of the six which are council-owned, four are incorporated (though still under council ownership). Only two are still being run as part of the SLL administration.

Reversion to the state of things preceding the spate of reforms in 1991 is unthinkable. It would mean, for example, 50 out of 100 health centres being repossessed and nearly all acute healthcare being restored to administrative management. The County Council has no possibility of staffing the activities that would be affected. Any such roll-back operation would signal a new awakening of the command economy and centralisation, thereby provoking a mass exodus of doctors and nurses. The increasingly numerous short-term locums (nicknamed "relay doctors" in Swedish, and in themselves evidence enough of the public employer's shortcomings) would multiply still further. Healthcare efficiency would nose-dive, the waiting lists of the 1980s would be back again and all attempts at turning the County Council into a modern employer would be wiped out.

The ever-more-demanding care consumers in big cities, accustomed now to free choice and active participation, would never accept this reversion to yesteryear.

Little scope for realignment

In practice, therefore, no significant realignment is possible. If indeed the Social Democrats should wish for it, though personally I believe that a majority of the party's members have perceived the value of free choice and diversity. A minority, presumably, remain sceptical but for tactical reasons are unwilling in so many words to call for a change of direction. The middle-class vote is becoming too important to Swedish Social Democracy, which, like New Labour in Britain and the Liberals in Canada, cannot rely exclusively on a working class following. And middle-class city-dwellers want a free choice, not waiting lists.

First and foremost, therefore, the new centre-left SLL régime has promised business as usual. County Council Commissioner Birgitta Sevefjord, representing the Left Party, declares that incorporated hospitals are to stay that way and that contracts with private entrepreneurs are not going to be cancelled. The basics of the Stockholm model are to be left intact. (This – leaving aside the electioneering rhetoric – is not surprising. The same centre-left coalition controlled SLL between 1994 and 1998, during which time there were no departures at all from the Stockholm model.)

Which is not to say that nothing changes. Most palpably, the new régime has called off plans for opening up acute healthcare to competition. The original plan, with effect from 2003, was for acute healthcare to be outsourced (estimates show that 20 or 30 per cent of the total volume would have been affected) so as to do away with the prevailing structures and working methods. The former County Council régime wanted to admit private entrepreneurs on a grand scale. That isn't going to happen now. The new régime emphasises partnership instead of competition, and – a nice touch, this! – censured the centre-right majority for dogmatism and a command economy mentality.

The new régime has announced a number of new approaches in the superstructure of the healthcare apparatus. Some have already been introduced, others will be taking effect in the next year or two. The overriding aim is to improve efficiency and get more healthcare for the money. Healthcare finance is a problem and, as I have already indicated, the Stockholm model hasn't solved it. True, SLL is getting more bang for buck, but if there is still a shortage of bucks, then higher productivity is not the answer to the problem.

As from 1st April this year, healthcare policy-making has been centralised to the County Executive Committee. The former Healthcare Committee has been abolished. The six

Medical Districts, an instrument of local influence on healthcare, are no more. This leaves just one big purchaser of healthcare services.

The proprietary role of the County Council is to be asserted and owner management of SLL's own hospitals and healthcare units improved. Investments are to be co-ordinated, R&D used to greater effect.

SLL's overstretched finances are to be improved by structural measures such as evidence-based treatment methods and a new payment system for primary care (will that mean the Danish solution I just mentioned?). A new budgeting and payment system is to be introduced, as of course they must if anything is really to happen. The thing is to get independent players in large numbers responding to reasonable incentives, which in turn calls for great clarity, consistency and long-termism. Those measuring up to the targets must be rewarded, those failing to do so must feel the consequences.

As from 2004, the growth of SLL personnel costs is to be brought down from 7 or 8 per cent annually to 5 per cent (which, allowing for staffing shortages and wage slippage, comes close to a nominal pay freeze – at the same time as nurses will be demanding compensation for nursing assistants, following a strike in the early summer of 2003, having obtained bigger pay rises than had been budgeted …).

At the same time the County Council is to reduce expenditure on outsourced manpower and halve the growth rate of medication costs and healthcare costs generally. This is to be achieved by 2004 at the latest and, if so, will mark a historic trend inflection. Failure to achieve it will be just one more addition to a succession of political endeavours that have simply petered out.

New spending cuts

Already in the early summer of 2003 we find the County Council having to decide new, urgent cutbacks to salvage the budget. Things are not as bad as in Skåne and West Götaland, where waiting lists are now growing again and a frantic pruning of expenditure is in progress. But the Social Democrat and Left Party SLL councillors are already having to beak their election promises by raising patient charges and cutting back on mammography and senior healthcare among other things, all of which would have been unthinkable before the election. And even if the budget can be adhered to, the new majority – tax increases notwithstanding – will leave behind it an even bigger budgetary deficit than the much-maligned Moderate-led coalition that held office between 1998 and 2002.

So the last word on the structuring of SLL's healthcare and its management system has yet to be said. There is more likelihood of the Swedish economy continuing on its downward path than of a sudden recovery setting in. What we are now looking at is a less dramatic parallel to the deep recession which, at the beginning of the 1990s, helped to necessitate the radical reappraisal of healthcare policy. Sweden's public sector is so big and so expensive that even a minor, cyclically induced dip in taxation revenue evokes cutbacks and a growth of borrowing in local and regional government. Healthcare needs stronger funding for the long term, but if this is to be paid for entirely out of taxation revenue, taxes will have to be raised continuously and far above the pain threshold which has been reached already.

The acute funding problems confronting several of Sweden's county councils are focusing attention on the need for additional sources of finance.

So looking back at the rise and decline of the Stockholm model any reform politician can draw some conclusions:

• Be clear about the strategic purpose of reform – what do you want to achieve?

• Stay focused – do not let short-term considerations confuse the long-term goals.

• People (co-workers, health consumers) will behave in a rational way reacting positively to good incentives but will be negative to bad ones. Don't expect increased productivity or better service if the incentives are distorted.

• Members of the administrative staff are often negative to change (questioning the old, safe, style of work). Elected politicians must take it upon themselves to promote leadership and communication. Nobody else will do their job.

• Keep up the pressure for change – fat cats seldom catch the best mice.

5: The end of the beginning

No Swedish county council holds the solution for tomorrow's health care. Nor does the Swedish government, any more than other politicians.

The fact is that every political assembly, be it in the UK, the Netherlands, Sweden, Italy, Japan, Canada or the USA, is fighting a rearguard action against the population's growing claims on healthcare. For no matter whether healthcare is financed partly or wholly out of taxation revenue, its funding presents a growing challenge.

The hectic activity in progress in many regions and countries, in the form of reorganisation, changes of budgeting and management systems, new forms of payment, incorporation, public-private partnership, more competition or less competition and so on, reflects, I maintain, the confusion and uncertainty characterising the transition from one epoch to another. We are now moving away from healthcare Taylorism and entering a new cluster of values and behaviours.

Until very recently, it was still axiomatic for the patient to be subjected to a hierarchic system rooted in the military medicine of the 19th century. Rationing, needs assessment, largeness of scale and focus on production – a combination of the old deferential society and modern conveyor belt production – were vital elements of that system.

Values are now changing at an astonishing pace, leaving this mentality outmoded and devoid of legitimacy. Instead of being acquiescent and submissive, the patient now wants to be a well-informed, active consumer of care. And healthcare staff today regard their task, not as a vocation but as a skilled profession. Freedom of choice and participation are becoming important values. The possibility is now being demanded of being a healthcare consumer, as opposed to the satisfaction of needs predefined by the authorities.

Sweden would appear by all accounts to be well ahead in this process of change. The USA is furthest ahead of all, but Sweden is customarily viewed by market researchers as a market which matures early and one in which new products and services are tested. The Swedes are positive towards technology, as witness the emphatic breakthrough of IT and telecommunications. Social changes are welcomed, so long as they are not perceived as a threat to powerful Swedish needs for security and equality.

Conflict of interests

All the indications are that a conflict of interests is about to unfold in Sweden and other Nordic welfare states. On the one hand we have the ever-stronger healthcare consumer,

demanding free-choice systems, information facilitating active choice and respect, so as to be able to consume healthcare services with a view to achieving wellbeing and quality of life. In other words, individualised motive forces which challenge egalitarian values. On the other had we have traditional Swedish living patterns which emphasise uniformity and fair distribution of welfare services and whose maintenance will be called into question by health care consumers.

This is where the political system will have to come clean: will it restrain the development of consumption or affirm it? The reappraisal is most apparent in what are commonly termed Beveridge system countries, i.e. those with a publicly funded and operated system of large-scale healthcare (the UK and Scandinavia being the most conspicuous examples). These, typically, are the countries with the biggest rationing and waiting list problems, whereas the "Bismarck model" of continental Europe, with its multiplicity of funding sources and producers, has always had better availability in its smaller-scale systems.

Both in the UK and in the Nordic countries, governments are now trying to conjure forth better availability through combinations of maximum waiting periods and free choice between providers. This has the effect of strengthening the healthcare consumer's position, nationally in the first instance but eventually also within the EU. The ECJ is aiming to establish free choice of healthcare at European level as well.

The European Commission is intent on reinforcing consumer development, one likely motive – as yet too controversial politically to be expressly mentioned – being that Europe's negative demographic development will have to be offset by means of radical welfare reforms in which a growth of individual responsibility will be inevitable and in which many Europeans will be able to act more freely as healthcare consumers (at the same time as conditions for other inhabitants will deteriorate).

Consumption easier in Belgium

The people of continental Europe have by tradition enjoyed far better consumer status than, for example, the Swedes. Long waiting periods in healthcare are unknown here and would hardly be accepted either. Swedes visit a doctor perhaps three times a year, Danes five and a Belgian seven. There is no palpable difference between the three in public health terms, but healthcare consumption comes a good deal easier when, as in Denmark and Belgium, there is a plentiful supply of family doctors who make home visits and are on call at any hour of any day or night. Sweden lacks a family doctor tradition, and primary care is open during office hours only. Home visits by doctors are something that Swedes have to move to Brussels in order to experience.

Waiting lists occur mainly in countries with a strong egalitarian culture (inherited or politically dictated), e.g. Scandinavia, Britain and Canada. This expresses a rationing mentality which will clash with the healthcare consumer's expectations. I expect the clash to be heaviest in these command economy systems, because they have furthest to go in catering to consumer values.

What do these developments imply for Sweden and the Stockholm region?

The Stockholm model *per se*, if properly maintained, can be said to offer fair chances for the future. As we have already seen, it has created a potential for high output volume and good availability – so long as the authorities have the resources for purchasing all available healthcare capacity.

The fundamental premises of the model have now been adopted by all significant political camps. Accordingly, what I have called "the new network healthcare" in the Stockholm region is characterised by:

• A strong decentralising mentality, with autonomy for companies and entrepreneurs. Where ownership is vested in SLL, influence is to be exerted through owner directives and investment policy, not through interference with operative activities or through political caprice.

• The constructive antithesis between purchasers and providers. The forms of this interaction will doubtless change with the passing of time, but the basic principle will endure.

• Performance-related payment as a strategy will continue to develop. There is no question of reverting to allocation budgets (albeit that, as we have seen, output ceilings and total cost control have frayed the performance principle at the edges). The most effective way of developing the medical outcome is by linking that outcome to the payment received. This argues for the probability of today's DRG system being made to include a quality factor which affects payment.

• The many privately owned healthcare providers are here to stay. The favoured position they enjoyed in the 1990s will presumably deteriorate somewhat if and when neutrality towards competition is strengthened. With SLL's own units being forced to raise their efficiency under pressure from the entrepreneurs, in-house units are likely to land more contracts than they have been doing so far.

• Making money out of healthcare is perfectly *comme il faut* as far as SLL is concerned. The issue no longer figures on the agenda, and profit is acknowledged as a motive force.

What will happen between now and 2010?

This development, remarkable in itself, will be spurred on by the ever-stronger healthcare consumer. I don't have a hat I can promise to eat if I'm wrong, but I will be greatly surprised if healthcare in Sweden's cities by, let us say, 2010 is not characterised by the following:

• Extensive freedom of choice for the healthcare consumer, supported by systems facilitating well-informed decisions (e.g. Internet guides facilitating comparisons between treatments and providers).

• Payment that goes with the consumer. This will result in a progressively more standardised "healthcare voucher", which will help to create a national healthcare market and, in the long term, European mobility.

• Forms of payment putting a big premium on healthcare outcomes and productivity.

• Superseding 40 years of the command economy, an efficient family doctor system in which doctors and other staff are small-scale entrepreneurs who own their receptions and whose work input impacts directly on their wallets.

• Hospitals that are run by healthcare provider of several different kinds, both public and private. Development of public-private partnership relations. Ownership is secondary, healthcare outcome the prime concern. Producers working within publicly funded healthcare are certificated for cashing "healthcare vouchers".

• Medical guidelines – best practices – have been established and are a factor of competition between the providers wishing to attract "mobile" purchasers/consumers. Consumer information makes clear whether or not a producer applies best practices.

• A much-changed working organisation in healthcare. There are strong elements of networking, with many players co-operating in clusters, healthcare chains and other processes. Many functions are operated by subcontractors and partners. Large public workplaces have been turned into partnership between many private SMEs with public assignments. Organisations of patients and consumers are actively involved.

• The days of the county councils are numbered. They are part of the legacy of Taylorism and can cope neither with funding (this is apparent above all in repopulation areas) nor with the role of employer. Staff recruitment for healthcare depends on more attractive conditions of service and management. Parallel to the evolution of a national "voucher system", more and more financial responsibility is taken over by the state.

No dramatic changes, but rather an ongoing process of evolution characterised above all by decentralisation, consumer influence and better incentives. The Stockholm model as we have come to know it hitherto marks the end of the beginning of a great historic process of change, not the beginning of the end for incentives and the market. This adjustment to a new age will continue. You ain't seen nothing yet!

Swedish healthcare in 2010 – and the same goes for the whole of Northern Europe – remains publicly funded, but growing sectors of the population have taken out private health care insurance policies (which include elderly care). It will take another decade or so for mixed funding to materialise, on roughly the same lines as in many European countries or the USA today. In Sweden this kind of change will hardly be jumped at, but it will be necessitated by the gap between the potential for taxation finance and the actual demand for healthcare. In addition, clear consumer values will justify private funding articulating individual purchasing power.

New equilibrium

One might think that Sweden was a suitable environment for the introduction of what are notionally termed Medical Savings Accounts. They can be described as an attempt to balance demand for healthcare against individual assumption of responsibility for health and healthcare consumption, and in future they could constitute a compromise between different political interests. Outright consumer behaviour regarding a service perceived as "free" is liable to result in that service being heavily over-utilised. Old-time rationing, on the other hand, detracts from quality of life and obstructs the consumer pressure which is needed in order for the healthcare apparatus to focus more clearly on outcomes.

Medical Savings Accounts will become the basis for financing the individual person's consumption of healthcare. It is easiest to see how, in particular, hospital care and primary care are covered by the account. Disaster medicine, for example, will probably require comprehensive insurance which is the same for everyone. The financing of the account can be entirely public (through taxation and contributions), entirely private (through personal saving and insurance) or a combination of both. The important thing is to introduce incentives for assuming direct responsibility for one's own health, by rewarding positive behaviour in different ways and making clear, by means of a franchise etc., that healthcare is not a "free benefit".

Just as with existing account solutions, e.g. in Singapore, South Africa and the USA, there should be some kind of high cost barrier which will not deny all opportunities of care to a person whose account is empty.

Funding arrangements of this kind can be linked to scenarios in which healthcare becomes an important growth industry instead of being regarded as a burden. The account can very well be linked to participation in consumer organisations, access to information systems for the assessment of treatment methods and healthcare quality, and so on.

At the commencement of its triumphant progress just over ten years ago, the Stockholm model was an attempt to renew Swedish healthcare by enlisting new motive forces and mechanisms. The basic objective remained: good healthcare for all, but delivered in partly new forms. The more far-reaching changes which I have been discussing have, to my mind, the same purpose: good – indeed better – healthcare, even when conditions are changing. Healthcare consumption and individualised funding can turn out to be the next decade's methods for meeting the challenge to healthcare. Not only in Sweden but in all the ageing welfare states which will have to negotiate the transition to welfare societies in which everyone's commitment and resources are made use of and in which big public organisations are no longer expected to provide the solution.

And so this brief contemplation of the Stockholm model and the healthcare reforms ends where it started: with change as the necessary prelude to improvement, and with the realisation that, once you have set out on your journey, no path is as straight as you began by believing.