



Healthcare Systems:
Sweden & localism – an
example for the UK?

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Overview of Swedish Health Care

Swedish healthcare is financed from general taxation, heavily subsidised at the point of use and has traditionally been almost entirely publicly provided, thereby creating some basic parallels between the current British healthcare ethos and that of Sweden. However, in two crucial respects, the Swedish national healthcare system differs from the British NHS.

The main difference between the two is the longstanding Swedish commitment to subsidiarity (matters must be handled by the lowest authority capable of handling them effectively) and therefore to a localist rather than centralist approach to the delivery of healthcare, and of public and welfare services in general. In Sweden, both financing and provision lie with the regional and municipal levels of government, whereas the NHS still tends to be characterised by central control and a lack of clear lines of accountability between voters and the health service below the Westminster-Whitehall level. Defenders of this system in Sweden argue that keeping the management of the system in closer proximity to voters and users in this way creates greater responsiveness and accountability, driving up service quality and strengthening public ownership and willingness to pay for quality health services. Further, although Sweden has historically shared this local governance model with the other Nordic nations¹, it has so far largely rejected 're-centralisation' reforms on the scale now being pursued in neighbouring Denmark and Norway, perhaps fearing that the Swedish system's treasured efficiency and accountability would be lost if it were to follow suit.²

Another more recent difference is that although health services in the Swedish health system were once entirely publicly provided, since the 1990s Sweden has seen the expansion of private sector provision within the public system on a scale unmatched in many other traditional public provision health systems. For example, several large former public hospitals and over a quarter of Swedish primary care clinics are now run by the private sector, though they remain taxpayer-funded and broadly accessible to all residents and the political centre-left in Sweden is beginning to accept the trend on this basis. Again, this is now setting Sweden apart from neighbours such as Norway and Denmark, where health provision remains largely a public function, and also somewhat distinguishes it from the UK NHS. However, it is worth noting that due to the local structure, even Swedish health services that remain public still tend to be noted for their relative responsiveness and quality.

The key features of the Swedish healthcare system can be said to be the following:

- Healthcare is a universal public service financed from general taxation, as in the UK on the NHS
- Access is intended to be universal and based mostly on need, not ability to pay
- Healthcare should be high quality and cost-effective
- In recent decades, as in most European health systems, patient choice and competitive drive have increasingly become priorities and public monopoly provision is no longer viewed to be essential
- Unlike in the UK and increasingly the other Nordic countries, Swedish healthcare provision is premised on a principle of subsidiarity, meaning that responsibility for healthcare financing and provision lies within the lowest appropriate administrative level

Above all, outcomes in Sweden are strong – Sweden is among the top five for mortality amenable to healthcare out of 34 OECD nations, seventh for life expectancy and best for Potential Years of Life Lost (PYLL) for males (fourth for females). Sweden’s healthcare system has also been found to deliver a decent deal for its consumers in some rankings and polls. It was ranked sixth out of 34 European nations in the Euro Health Consumer Index (EHCI)³ and in a 2010 Ipsos/Reuters poll of 22 countries, 75% of Swedish respondents felt their system made it easy for a “very ill family member to get quality, affordable health care services”, more than any other country surveyed and more than in the UK (55%).⁴ As a result, Sweden is envied by some policymakers in other countries and it is well-worth asking what it is that makes their model work so well and whether there are lessons we in the UK can learn.

Origins and Basic Structure

Sweden first began to establish broad access to healthcare after 1946, when the Social Democratic Hansson government set up a system in which all working Swedes contributed to and were covered by social health insurance, comparable to the 1911 National Insurance Act reforms in the UK. However, since at the time not all Swedes were covered and out-of-pocket health costs remained high for some, in 1969 the Social Democratic government of Tage Erlander put Swedish healthcare through further reforms that rebased their system predominantly on general taxation financing and direct public provision of health services, comparable to the UK after the establishment of the NHS in 1948. Some academics have therefore noted similarities in how and why the Swedish and UK systems were originally developed.⁵

Under the reforms, from 1970 onwards 21 county councils and regions and 290 municipalities were in charge of providing universal care to their residents, financed from general taxation. In 2012 the Swedish government extended subsidised urgent-care coverage to undocumented immigrants, the standard of coverage legal asylum seekers already received, as well as providing comprehensive free care for their children.⁶ In their 2012 review of the Swedish system, the World Health Organisation’s European Observatory on Health Systems and Policies stated that the following are the key principles of the Swedish system:

“The Swedish health care system is a socially responsible system with an explicit public commitment to ensure the health of all citizens. Three basic principles are intended to apply to health care in Sweden. The principle of human dignity means that all human beings have an equal entitlement to dignity, and should have the same rights, regardless of their status in the community. The principle of need and solidarity means that those in greatest need take precedence in medical care. The principle of cost-effectiveness means that when a choice has to be made between different health care options, there should be a reasonable relationship between the costs and the effects, measured in terms of improved health and improved quality of life.”⁷

In 1982, the Health and Medical Services Act further clarified the dual responsibilities and freedoms the localities had in providing healthcare to their residents. The role of the central Ministry of Health and Social Affairs is to oversee national standards and make sure that the localities work in accordance with the 1982 Act. There are also several national agencies that work with the ministry, overseeing strategy and helping uphold national standards in the system, which is a vital part of the intricate state-local balance in the Swedish system. These national agencies include:⁸

- **The National Board of Health and Welfare (Socialstyrelsen):** “the central government’s expert and supervisory authority”⁹, this board issues guidance and general advice in order to establish national norms for healthcare and scrutinises health legislation and

local council activities. It also handles certification for health professions and publishes statistics on health and social care services, public health and disease and is “commissioned by the government to provide evidence-based guidelines for the care and treatment of patients with serious chronic illness...in collaboration with other actors, most importantly the Swedish Council on Technology Assessment in Health Care, the [Medical Products Agency] and the [Dental and Pharmaceutical Benefits Agency]”. Some functions of the Socialstyrelsen were recently transferred to a new authority created in June 2013, the Health and Social Care Inspectorate (IVO), but the Socialstyrelsen still handles certification¹⁰

- **The Medical Responsibility Board (HSAN):** HSAN investigates “complaints about care or treatment of patients”¹¹ and “possible breaches of standards by health care professionals”¹² – the National Board of Health and Welfare can then revoke the certification of medical professionals based on HSAN’s advice.¹³ 99% of all medical malpractice complaints are handled by HSAN, rather than the Swedish courts¹⁴
- **The Swedish Council on Technology Assessment in Health Care (SBU):** This council “reviews scientific data and provides information to guide decision-making”¹⁵ and “seeks to identify the best treatment methods for patients and most effective use of resources”¹⁶, comparable to the role that the National Institute for Health and Care Excellence (NICE) plays in the British NHS¹⁷
- **Medical Products Agency (MPA):** This is “the national authority responsible for regulating and monitoring the development, manufacture and marketing of drugs and other medical products”.¹⁸ The MPA also “approves medical products”, “ensures access to safe and effective products of high quality” and aims to ensure that products are “used in a rational and cost-effective manner”.¹⁹ Unlike other agencies, the MPA is funded by charges to manufacturers²⁰
- **The Dental and Pharmaceutical Benefits Agency (TLV):** a “central government agency assigned to determine whether a pharmaceutical product or dental procedure should be subsidized by the state”.²¹ It also “[contributes] to quality service and accessibility of pharmacies”²²
- **The Swedish Agency for Health and Care Services Analysis (Myndigheten för vårdanalys):** this agency “reports on the quality and efficiency of activities” in both the public and private health sectors, including dentistry, and on social services – it aims to do so “from a patients’ and citizens’ rights perspective”. Further, it also “assesses the effects of Government reforms and initiatives”²³
- **The Swedish Social Insurance Agency (Försäkringskassan):** the Försäkringskassan exists to “administer social insurance and to ensure that you get the benefits and allowances you are entitled to”. It administers the employment-related contributions that part-fund the Swedish health and welfare systems, similar to National Insurance contributions in the UK²⁴
- **The National Institute for Public Health (FHI):** public health is mainly a county and municipal responsibility due to the subsidiarity principle, but the institute nevertheless exists to provide them with central support and supervision with regards to prevention and health promotion, “especially for population groups most vulnerable to health risks”²⁵

Together, the Ministry of Health and Social Affairs and these various agencies provide a clear national framework for healthcare in Sweden and set basic uniform standards that must apply across the country, in order to ensure strategic oversight and a sense of the national within the localist system.

Subsidiarity and Localism

Meanwhile, local government in Sweden – the 21 counties and 290 municipalities – are in charge of day-to-day management of the health system and its facilities, raise over 70% of the financing for the system through local taxation and can make decisions locally about how services are organised and provided in their areas, in line with the will of their local electorates. Hospitals and clinics have historically been under local government ownership and mostly still are, though a trend towards independent management of taxpayer-funded health services has been widely noted in the last two decades (see ‘Market Reform: Growing Consensus?’ below).

While the county councils tend to manage medical services, the smaller municipalities tend to handle social care, as under the principle of subsidiarity it is felt that this more community-based service is best handled at a lower level than the counties. The 1992 Local Government Act outlines in law that the municipalities “are responsible for matters relating to the inhabitants of the municipality and their immediate environment”, while “the main task of the county councils and regions is healthcare”.²⁶

The Swedish Association of Local Authorities and Regions (SALAR) represents the localities and their interests and has long argued the case for the localist model. In a report on the Swedish health system, BBC health correspondent Nick Trigg interviewed a representative of the Association, Roger Molin, and noted that Mr Molin felt that the localist system meant that Swedish healthcare services are “more responsive to patients’ needs than a more centrally-controlled system such as the NHS”.²⁷ In a 2008 report, SALAR compared different health systems and noted that “Finland and Sweden, the two countries with decentralised, tax-financed healthcare systems, [come] first and third in terms of cost-effectiveness” and also that “Spain, which is ranked second, has national tax financing but delegates responsibility for management and services to the regional level”. They also noted that three international comparisons at the time had placed Sweden second (of 27 countries), third (of 17) and sixth (of 29).²⁸ These findings, suggesting a link between Swedish-style decentralisation and healthcare quality, are somewhat consistent with a more recent Civitas analysis of comparative health data conducted in 2013.²⁹

In Sweden, local elections are held in September every four years, most recently in 2010 and next on September 14th 2014. Since the high costs of funding modern healthcare weigh heavily and account for 90% of council activity, this means that health tends to be a prime issue in Swedish local elections and that it can be voted on somewhat more directly than in UK general elections, which are still the main form of democratic input into the NHS. Though Sweden’s eight national political parties dominate in the county elections too, at the county level various branches of the local minor Sjukvårdsparti (Healthcare Party) sometimes do win seats.³⁰ However, in a 2009 report, the Social Market Foundation (SMF) also noted that placing responsibility for health services with local government as the Swedes do, rather than introducing a directly elected element into separate local health bodies as is sometimes suggested as another means to democratise the NHS, can be beneficial. The report reasoned that this “establishes a link between local elected members and the local health system without requiring additional local elections” and allows “a democratic influence on the local health system but without the single issue politics that could emerge from a directly elected board”.³¹ The latter is arguably demonstrated by the continuing dominance of the eight broad-based national parties relative to the small local Healthcare Parties, even in the county elections.

Voter turnout in Swedish local elections is also far better than in UK local elections, perhaps demonstrating engagement with the healthcare policymaking process and providing some support for the claims of both the SMF and SALAR. It is sometimes hard to compare this fairly, as although over 80% of Swedes tend to vote in the regularly-scheduled council elections this is in part because they always occur on the same day as general elections for the Riksdag (national parliament), although even this is still substantially higher than comparable general election turnouts in the UK in any case (65% in 2010, 61% in 2005, 59% in 2001).³²³³ However, more significantly, one-off council by-elections in Sweden also tend to boast much higher turnout than regular UK local elections. Historically Swedish council by-elections draw turnouts of over 70%³⁴ and turnouts in four by-elections held in mid-2011 with “low” participation by Swedish standards ranged from 44% to 65%.³⁵ In contrast, average turnout for regular UK local elections has been estimated at 42% and in practice is often well under 40% - our council by-election turnouts are usually even lower.³⁶ The increased power and importance of local governments in Sweden and their lead role in managing the country’s health system may not be the only reason for the far greater voter engagement in their local elections, of course, but it is a compelling explanation.

According to a 2004 report for the centre-right local government think-tank Localis by journalist Simon Jenkins, ‘Big Bang Localism’, in Sweden there were 667 voters per elected official, while in the UK the figure was 2,605.³⁷ Though noting that Swedish county governors, who act as “[intermediaries] between the municipalities and the centre”, are Stockholm-appointed, the report otherwise praised the “Swedish model” and its devolution of healthcare, taxation, social welfare, education and services to the localities. It also noted that since the 1980s “free communes”, localities with near-total autonomy from the centre, have been established due to a feeling that public services were still being seen as “unresponsive and over-bureaucratic” and were “not close to the public and failed to involve the public as citizens”. This did lead to service models in the free communes that varied “from traditional social democracy to Thatcherite neo-liberalism” and “modestly diverging service standards”, but Jenkins also noted that “County and civic pride is strong in Sweden and devolution has been able to capitalise on that, greatly contributing “to the country’s democratic, economic, social and cultural development””.³⁸ Jenkins also noted that a 2004 UK parliamentary committee concluded that the localist system “has clearly encouraged a high degree of interest and participation in local politics by the Swedish electorate”. More recently in July 2013, Jenkins argued in *The Guardian* that in light of NHS care quality scandals we should move away from the NHS’s 1940s-era central nationalisation model and towards the Nordic model, where “hospitals are run by local county authorities and answer to patients through them” and where “There are no annual reorganisations, political shouting matches and constant “crises”” – he concluded that “It works because it is small.”³⁹

Another report in 2007 published by the centre-left think-tank The Smith Institute entitled ‘Real Localism’, which was compiled by *Guardian* writer David Walker and to which Simon Jenkins was a contributor, also voiced support for empowering local government in areas such as health as a means for engagement. Jenkins wrote that “Two-thirds of total public revenue in Denmark is local. In Sweden the figure is 50%...In Britain it is a meagre 4%. Yet all these countries contrive to use central grants to reallocate local funds from rich to poor areas” and that “Foreign experience suggests that local autonomy closely allied to the quality of service delivery tends to increase faith in public services and thus a willingness to pay more for them” – the latter might explain Sweden’s higher tax rates and the fact that its per head health spending is slightly higher

than Britain's (see 'Financing' below).⁴⁰ Dermot Finch of the Centre for Cities argued that "For key services such as health, education and welfare, central government should set core national entitlements but allow local providers to get on with the job of delivering them", potentially a basis for a Swedish-style localist settlement in the UK, while Labour MP Graham Allen called for full fiscal localism and argued that in light of the poor turnout in UK local elections – which contrasts sharply with high Swedish turnout as we have seen – "it is time either to create genuine democratic local government or stop the pretence, wind it up and convert the government regional offices and council chief executives into a prefecture openly appointed by the centre".⁴¹

Creeping Centralisation?

As with any healthcare system, the Swedish localist model may of course have a few drawbacks. The main criticisms, and the apparent rationale for a current trend towards greater centralisation in the health services of several Nordic countries that previously shared Sweden's model over the last decade, have been that the localist system may not allow for sufficient strategic oversight and may not be the best way to control costs at a time when European health systems are increasingly forced to do so. Another point of debate, and a common objection to localism in UK healthcare, are the "diverging service standards" ("postcode lotteries" in common UK terminology) that Jenkins mentioned.

In the same 2009 report that praised Sweden's localism, the Social Market Foundation (SMF) noted the Nordic recentralisation trend, pointing out that the Norwegian government recentralised regional hospital ownership in the early 2000s due to the inability of the regions to stick to set budgets and that "A similar pattern of regional consolidation and a strengthening of the state role has occurred in Denmark, the Netherlands and Poland, and is under way in Sweden and Finland." However, the report authors still stressed that embracing radical decentralisation was still worthwhile despite this trend, as the NHS had "reached the limits of improvement through centralised control", meaning radical thinking was still needed to meet challenges, and because the current heavy centralisation in the NHS meant that "if decentralisation occurs in England while the rest of Europe recentralises health policy, this can actually be seen as a convergence, rather than a divergence, of policymaking".⁴²

A March 2013 article on the London School of Economics website addressed the Nordic centralisation trend further, noting that despite the many strengths of the localist healthcare model, the shift "occurred initially in Norway and Denmark, and it now appears that a similar, though slower process, is underway in Sweden and Finland" – they attribute this trend to "a combination of rapidly changing technology, growing pressure from patients, and stark, if as yet unrealised, fears about the cost consequences of an ageing population". Both Norwegian and Danish councils have lost their taxation powers and been merged into larger regional authorities, Norway's regional politicians are no longer elected and in Denmark new central controls have been imposed on spending and hospital planning, while Sweden (along with neighbouring Finland) has seen a lesser form of "indirect consolidation", driven by "long-term concerns about quality of care and equal access to health care services regardless of where one lives in the county". Since 2006, the Swedish government has "sought to exert more strategic authority" over the county councils, including requirements for new permits, recommendations that the 21 counties should merge into 6-8 regions (though on a purely voluntary basis, and this has not occurred as of yet) and new national guidelines on resource allocation and clinical priorities, the latter of which "are also used as an instrument for the national government to

exercise control over local political decision-making”.⁴³ However, at least one measure that the LSE academics cited as an example of centralisation, the central government’s publication of comparative data on the quality of health services in the various counties, is not such a bad thing, as such information empowers Swedish health users to make more informed choices. Further, the academics also restated that “evidence from the Nordic countries has traditionally been strongly supportive of decentralised approaches”, despite the current trend.⁴⁴ The Swedish Association of Local Authorities and Regions, while noting the centralisation trend in Norway and Denmark, had asserted that “Sweden and Finland still have decentralised healthcare systems”.⁴⁵

It is also important to add that while the instinctive concerns about “postcode lottery” that the LSE academics noted as a driver of centralisation are understandable, it is worth remembering that the centralised NHS model has never been truly successful at stamping these out in the UK - *Guardian* health and society editor Patrick Butler once wrote that the “postcode lottery is a big issue in the NHS, where the gap between the rhetoric of a comprehensive and universal ‘national’ service and the reality is increasingly stretched”.⁴⁶ By contrast, the Nordic model at least means that service differences will come about as a result of deliberate and open decisions made by elected local office holders accountable to their immediate electorates, in contrast to the inadvertent and opaque ways in which they arise in the NHS – services may well vary slightly by postcode, but it is not an unpredictable “lottery”. As Simon Jenkins has put it, “divergent standards are the price of localism, even though centralism has not delivered consistent ones”, hence why such differences have traditionally been met with “widespread acceptance” in Sweden.⁴⁷

Therefore, if policymakers wish to ensure accountability and flexibility, and realise the proven cost-efficiency benefits of localism, the Swedish model remains admirable. Swedish policymakers would be well-advised to resist any further centralisation, and British ones would be wise to learn from the current Swedish decentralisation approach.

Financing

Healthcare financing is also predominantly localised – over 70% of Swedish public health spending comes from local county and municipal taxation. However, much of the remainder (more than 25%) comes from block grants from the central government, financed from national-level taxation. This balance is important for two reasons. The first is equity, since regional variations in wealth would dictate service standards excessively in a system that was funded solely from local taxation. The block grants therefore function as “equalisation payments”, allowing broad local autonomy while ensuring a measure of redistribution towards poorer areas and a sense that the service is still national, much as Britons seek from the NHS. Since locally-levied income taxes in Sweden tend to be flat (directly proportional to income) while national income taxation is progressive, the central grants also add some additional progressivity to the financing of the Swedish system.⁴⁸ The second reason the balance is important is because the national government has to avoid fully surrendering control of the politically-important finances of the health system in order to retain its national standard-setting and oversight role within the localist system, as only by ensuring that the localities are still marginally dependent on the national government for funding can it ensure compliance.⁴⁹ Thus this funding split is a vital part of the delicate state-local balance that underpins the Swedish localist model.

One benefit of localised taxation over national is that it in effect acts as a form of hypothecation, ring-fencing most local tax revenue for healthcare. This is because health spending accounts for roughly 90% of Swedish county council activities and spending, so they function primarily as health authorities and local taxes are close to being ‘health taxes’ (dental care, county development, further education for county employees and a few other functions make up the remaining 10%).⁵⁰ Further, since the taxes are local, this delivers an additional bonus that nationally-levied taxes do not, as taxpayers know that the revenues of a local tax will ultimately be spent entirely in their own area and benefit them directly. This is the basis of Simon Jenkins’s argument that localism creates “faith in public services and thus a willingness to pay more for them”, potentially explaining Sweden’s oft-noted higher tax rates⁵¹ - a *Guardian* article a few years ago described Sweden as a country “where tax goes up to 60 per cent, and everybody’s happy paying it”.⁵² A World Bank document on decentralization, ‘What, Why and Where’, similarly argued that “the political objectives to increase political responsiveness and participation at the local level can coincide with the economic objectives of better decisions about the use of public resources and increased willingness to pay for local services”. The World Bank document also stressed the importance of devolved financing, stating that “the decentralization framework must link, at the margin, local financing and fiscal authority to the service provision responsibilities and functions of the local government - so that local politicians can bear the costs of their decisions and deliver on their promises”. Also important was “a mechanism by which the community can express its preferences in a way that is binding on the politicians” – in Sweden’s case, this is the local elections.⁵³ Therefore, devolving the financing of healthcare to the elected local councils, rather than simply the management of it, is an important part of the Swedish localist system.

Additionally, a February 2012 poll by Research!Sweden perhaps provided additional evidence – albeit of a specific and hypothetical variety – for the potential value of hypothecated funding in healthcare. It found that 81% of Swedes responded in the affirmative when asked “Would you be willing to pay 10 SEK more in taxes (per month) if you knew that it would go to medical research to improve health?” (10 Swedish Kronor, SEK, is about £1). 77% also felt it was “very important” that Sweden maintain an international edge on medical research, 92% felt that the government would need to invest more in medical research if Sweden were to “maintain a well-functioning health care [system]”.⁵⁴ This shows some willingness on the part of overwhelming majorities to support small tax increases if they are specifically aware the money is ring-fenced for healthcare causes they value.

	UK	Sweden	OECD Average
Total expenditure on health, as a percentage of Gross Domestic Product (GDP)	9.4	9.5	9.3
Total expenditure on health, per capita (US\$, adjusted for purchasing power parity)	3405.5	3924.8	3338.6
Public expenditure on health, as a percentage of total health expenditure	82.8	81.6	72.2
Public expenditure on health, per capita (US\$, adjusted for purchasing power parity)	2821.1	3203.6	2426.7
Out-of-pocket payments (households), as a percentage of total health expenditure	9.9	16.2	19.6
Out-of-pocket payments (households), per capita (US\$, adjusted for purchasing power parity)	338.3	635.5	563.0
Annual growth rate of total expenditure on health, in real terms (2010-2011)	-0.4	3.7	4.1

Figure 1: OECD Health Data 2013 data on Swedish and UK health financing, OECD average also given (Source: ‘OECD Health Data 2013 – Frequently Requested Data’)⁵⁵

As we can see from Figure 1, Sweden's overall spend on health is very similar to that of the UK, and like ours is in line with the OECD average, when looked at as a percentage of GDP. The percentage of this that is public (financed from taxation or social insurance contributions) is also within a percentage point. In light of Sweden's superior performance on clinical outcomes and satisfaction relative to the UK (see 'Outcomes, Service Quality & Patient Satisfaction' below), this would appear to mean that Sweden gets more 'bang for buck' from the raw percentage it spends. However, on a per capita basis, Swedes appear to get both more money and more public money spent on their healthcare, due to Sweden's GDP being higher when measured on a per capita basis. Swedish health expenditure is also growing at a time when ours has begun contracting (this started in 2009-2010 and continued into 2010-2011) – this is the result of the global financial crisis and the subsequent onset of austerity not having affected Sweden or its healthcare system much, in sharp contrast to the heavy impact on the UK.⁵⁶

Out-of-pocket (OOP) health spending is however noticeably higher in Sweden. This may be partly because few Swedes carry voluntary health insurance (VHI) – 4%, compared to around 10% in the UK – and private insurance accounts for only 0.2% of Swedish health funding.^{57,58} It may also be because Sweden's taxpayer-subsidised public healthcare system is not fully free at the point of use in the same way as much of the NHS. Instead, it requires over-20s to pay upfront charges ranging between 80 and 320 SEK (£8-30) for services including GP and specialist appointments, emergency department visits, inpatient stays, prescriptions, dentistry and ambulance services.⁵⁹ This has been the case ever since the founding of Sweden's modern health system in 1970. Imperial College Health Policy Professor Peter Smith noted in a 2006 SMF report that this made Sweden "one of the first of the traditional public sector [healthcare] systems to experiment with quite small user charges across a wide range of health services", while report editor Jessica Asato noted that such charges fund 2% of Swedish health expenditure.⁶⁰ Swedish health expert Johan Hjertqvist argued for the free-market Canadian Atlantic Institute of Market Studies (AIMS) that the system regulates demands on the health system, citing an experiment in Stockholm in the 1990s which showed that demand rose when fees were removed and then fell again when they were re-imposed.⁶¹ The charges have been described by some as "modest and generally affordable"⁶² and are subject to "high-cost protection ceilings", one for outpatient services (1,100 SEK, about £110) and another for prescriptions (2,200 SEK, about £215), after which full public coverage kicks in and a person does not have to pay for the remainder of that year⁶³ – this is also known as a deductible system.^{64,65} However, Peter Smith also clearly warned that charging "resulted in reduced utilization amongst low-income Swedes, and a concern that equity of access may be compromised".⁶⁶ This claim was supported by a Commonwealth Fund 11-country study of healthcare experiences in 2011, which found that Swedish "sicker adults" were slightly more likely than British ones to report that they had had "serious problems paying or [were] unable to pay medical bills"⁶⁷, and also by two studies in Sweden itself. One found increases in user charges in the 1990s were associated with "inequalities in utilisation in Sweden favouring the better-off"^{68,69}, the second found that one-in-four Swedes had avoided seeking care for financial reasons (particularly "weaker groups in society such as the unemployed, students, foreign nationals and single mothers") and that "patients who reported their financial state as poor were ten times more likely to forgo care than those who reported their financial state as good", which the authors warned undercut the Swedish government's promise to ensure that "good care should be available to everyone on equal terms".⁷⁰

Overall, however, from a financing perspective Sweden's healthcare system delivers phenomenal value for money compared to the NHS and the localised taxation structure

underpinning Swedish healthcare financing is very much enviable for the way that it strengthens democratic accountability, fosters flexibility and encourages a willingness on the part of the public to fully fund public services. It is therefore highly recommendable for Britain to learn from this specific aspect of the decentralisation model as well.

Outcomes, Service Quality & Patient Satisfaction

Perhaps as a result of the efficiencies created by the Swedish model or its resultant higher per-head health spending, Sweden also tends to perform better on clinical outcome and service quality metrics.

Outcomes

First, if we look at outcome data made available by the OECD, *The Lancet* Global Burden of Disease 2010 study (released earlier this year) and the Commonwealth Fund, a clear pattern emerges showing that Swedish health outcomes are substantially better than our own. First, the OECD's outcome data.

	UK	Sweden	OECD Average
Life expectancy at birth, years	81.1	81.9	80.1
Infant mortality, deaths per 1,000 live births	4.3	2.1	4.1
Potential years of life lost, years lost per 100,000 females aged 0-69	2537.3	1883.7	2415.0
Potential years of life lost, years lost per 100,000 males aged 0-69	3992.2	3072.8	4632.6
Amenable Mortality, deaths per 100,000 in 2007 (Nolte & McKee definition)	86.0	68.0	95.0
Amenable Mortality, deaths per 100,000 in 2007 (Tobias & Yeh definition)	102.0	78.0	104.0

Figure 2: OECD Health Data on Swedish and UK health outcomes, OECD average also given (Sources: 'OECD Health Data 2013 – Frequently Requested Data' & 'Mortality Amenable to Health Care in 31 OECD Countries')^{71,72}

	UK	Sweden
Amenable Mortality, deaths per 100,000 (Nolte & McKee definition)	83.0	61.0

Figure 3: 2006-2007 amenable mortality data compiled by Nolte & McKee, published by the Commonwealth Fund (Source: 'Variations in Amenable Mortality—Trends in 16 High-Income Nations')⁷³

On every single one of the OECD's outcome measures, Sweden leads the UK. It is also 7th for overall health in the OECD's Better Life Index, better than the UK (12th). On the specific measure of infant mortality, the number of UK deaths recorded by the OECD is almost exactly double that of Sweden. Related to this, a separate study published in *The Lancet* entitled 'Health services for children in western Europe' found that the UK is the worst of 15 pre-2004 EU (EU15) nations for preventable child deaths and had the equivalent of five more deaths each day than Sweden, which was the best-performing nation – one of the researchers characterised this as a "national scandal" for the UK.⁷⁴ The authors attributed the difference in part to the Swedish system successfully incentivising focus on paediatric care and encouraging other specialities to work more closely with paediatric experts. The report further elaborated about Swedish children's health services:

"Chains of care supplement multiprofessional primary care centres, where general practitioners, paediatricians, and children's nurses work closely together. The system was developed as a response to fragmentation of care resulting from excessive decentralisation of services with professionals working in separate organisations. Early assessments showed problems with weak incentives for collaboration, perceived challenges to power structures, and conflicting values in

participants (especially physicians). Implementation was eased by giving patients roles as active participants, allowing sufficient time for change, developing supportive policy and financing instruments, and maintaining motivation by focusing strongly on quality improvement.”⁷⁵

Conditions	UK	Sweden	Conditions	UK	Sweden
Ischaemic Heart Disease	14	10	Pancreatic Cancer	4	13
Stroke	13	4	Diabetes	1	10
Lung Cancer	12	1	Oesophageal Cancer	19	4
Lower Respiratory Infections	18	4	Prostate Cancer	11	17
Chronic Obstructive Pulmonary Disease (COPD)	17	5	Aortic Aneurysm	18	15
Breast Cancer	18	1	Non-Hodgkin Lymphoma	17	4
Colorectal Cancer	9	4	Leukaemia	8	2
Self-Harm	4	15	Ovarian Cancer	16	14
Road Injury	4	1	Brain Cancer	6	12
Stomach Cancer	8	4	Alzheimer's Disease	11	16
Congenital Anomalies	16	3	Bladder Cancer	9	7
Preterm Birth Complications	18	2	Falls	8	5
Other	14	4	Chronic kidney disease	3	2
Cardiovascular/Circulatory					
Cirrhosis	11	4	Kidney cancers	9	6

Figure 4: Ranking for age-standardised Years of Life Lost (YLLs) for specific conditions (Lancet National Performance Rank, 2010) (Source: Global Burden of Disease Study 2010)⁷⁶

The above chart details the relative position of Sweden and the UK in terms of Years of Life Lost (YLL) for 28 conditions listed by the Global Burden of Disease Study 2010 published in *The Lancet*, which compared the original 15 members of the European Union, Australia, Canada, Norway and the USA (the EU15+). The UK outperforms Sweden on self-harm, pancreatic cancer, diabetes, brain cancer, prostate cancer and Alzheimer’s disease, but otherwise generally underperforms by varying degrees. Particularly striking is breast cancer, a high-profile condition on which Sweden ranks first and the UK near-last among the 19 nations. A study published in January 2013 in the *British Journal of Cancer* provided a partial explanation for Britain’s poorer outcomes for some cancers in particular. In a recent six-country study investigating differences in cancer attitudes among over 50s, researchers found that although basic knowledge of the relevant symptoms was broadly similar across all nationalities, Britons were the nationality most likely (34%) to respond that being “worried about wasting the doctor’s time” might “put you off going to the doctor with a symptom that might be serious”, while Swedes were the least likely (9%). The study authors argued that this suggested that one of the possible contributing factors to the UK’s lagging cancer outcomes is an excessively “stiff-upper lip” attitude to illness and the usage of healthcare services among older Britons, relative to Sweden and other nations.⁷⁷⁷⁸ This shows that although Britons are admirably responsible about healthcare system usage, a more confident and empowered Swedish-style attitude might serve Britons well.

Another crucial difference is Sweden’s superior performance on mortality amenable to healthcare, which refers to the number of “premature deaths that should not occur in the presence of effective and timely care” under the age of 75. This to some extent severs the specific performance of the health system from general background and public health factors, which can skew more general indicators. OECD statistics show that tobacco and alcohol usage and obesity are each somewhat lower there than in the UK, for example, Sweden is consistently one of the world’s cleanest nations in the Environmental Performance Index (EPI)⁷⁹ and poverty and income inequality, commonly associated with negative health outcomes, are also lower than in UK.⁸⁰⁸¹⁸² Likewise, *The Lancet* EU15 child health study stated in reference to Sweden’s

low child mortality that “many aspects of child health are affected by government policies, especially policies that affect the distribution of resources, employment, housing, education, and health care. Thus, countries with high spending on social protection for families generally have low rates of child death”.⁸³ An August 2013 Bloomberg study was also criticised for this very reason – it did find Sweden to be 10th most cost-efficient among health systems, with the UK 14th, but reached this conclusion simply by cross-referencing each nation’s health spending with life expectancy.^{84,85} Meanwhile, the intended focus of amenable mortality on healthcare intervention makes it a far better measure of the comparative effectiveness of health systems than infant mortality, PYLL or life expectancy, and Sweden’s strong performance and the UK’s relative poor standing by this indicator are therefore immensely significant.

Swedish outcomes are also the envy of some neighbouring countries. In October 2011, incoming Danish Prime Minister Helle Thorning-Schmidt stated in her first address that “we Danes are not as healthy as citizens in other affluent countries. The life expectancy of a Dane is two and a half years shorter than that of a Swede”.⁸⁶ In Britain we would do well to set ourselves the same benchmark and attempt to learn from Sweden’s higher outcomes.

Quality and Satisfaction

Sweden’s healthcare system has also been declared to deliver a decent deal for its consumers in some rankings and polls. The 2012 Euro Health Consumer Index (EHCI), a ranking compiled by the Stockholm-based company Health Consumer Powerhouse (HCP) that HCP feels “takes a consumer and patient perspective” and “offers reality checks for policy makers, empowerment to patients and consumers and an opportunity for stakeholders to highlight weak and strong aspects of healthcare”⁸⁷, placed Sweden sixth out of 34 European nations. The UK ranks twelfth. The study specifically also stated that Sweden ranks “All Green [unfailingly positively] on Outcomes” – an honour only it and Norway achieve that would appear to be fairly consistent with the outcomes data we explored above – and has “technically excellent healthcare services”.⁸⁸

Among the 43 quality measures the EHCI includes, Sweden outperforms the UK on the use of no-fault malpractice insurance, individual patient access to medical records, heart infarction (heart attack) case fatalities, infant deaths, cancer deaths relative to incidence, Preventable Years of Life Lost, MRSA infections, Caesarean sections, undiagnosed diabetes, depression, infant 4-disease vaccinations, long term care for the elderly, having 10% of dialysis done outside of clinics and having a rapid deployment rate for novel cancer drugs. Despite our lower overall rank, the UK does outperform Sweden in certain areas, though; we have a healthcare law based on patients’ rights, patient organisations are more involved in decision making, we have a registry of bona fide doctors, we have a provider catalogue with quality rankings, patients have more access to on-line booking or appointments, we have better same-day access for family doctors, are more likely to receive cancer therapy in less than 21 days, we have more kidney transplants (per million population), dental care is included in our public healthcare offering and we have prescription subsidies and faster access to subsidised new drugs. The report also praised Sweden for its user-friendly pharmacy system, where “more than 85% of all prescriptions are sent to a central e-mailbox, and the patient can then walk into any pharmacy in the country, where they simply pull down the prescription from the mailbox” and which has since 2005 featured a publicly-available and easy to use comprehensive data collection “on all drugs registered and offered for sale”, one of the first countries to do so.⁸⁹

According to the OECD's 2013 health data, Sweden also has more practicing physicians per 1,000 people than the UK (3.9, to our 2.8) and more nurses per 1,000 people (11.1, to 8.4 in the UK). Sweden is also above the OECD average for both of these indicators, whereas the UK is below it for both, especially for numbers of doctors. Both countries have a relative lack of hospital beds, however – the OECD average is 4.8 per 1,000, in the UK it is 3.0 and in Sweden it is 2.7.⁹⁰

In an April 2010 Ipsos/Reuters poll of 22 countries, Swedish respondents were the most likely (75%) to respond that their health system made it easy for a “very ill family member to get quality, affordable health care services”, more than any other country surveyed and more than the UK, where only 55% felt this was the case.⁹¹ A follow-up Ipsos/Reuters poll in June 2013 was perhaps less favourable, as Swedish respondents were only about as likely as Britons to feel their system had improved in the last five years, although relative improvement and absolute confidence in the system are of course different measures.⁹² In the February 2012 Research!Sweden poll, 46% of Swedes agreed that “patients in hospitals in Sweden have access to the safest and most effective treatments available”, while only 14% partly or fully disagreed, and 45% agreed that “the Swedish health care system will take good care of me when I need it” to 16% who disagreed.⁹³ In November 2012, the organisation Swedish Quality Index (Svenskt Kvalitetsindex AB) claimed that most Swedes were happy with their healthcare, especially locally, and that satisfaction was particularly good “when it comes to social services, such as nursing homes and home care.”⁹⁴ However, it is also always important to remember that while satisfaction surveys are important, in contrast to empirical performance data they are somewhat relative, dependant on timing and question structure and can be skewed by satisfaction with the government of the day.

In 2010 a joint publication between SALAR and the National Board of Health and Welfare (Socialstyrelsen), ‘Quality and Efficiency in Swedish Health Care: Regional Comparisons 2007’, included data from the Swedish National Patient Survey. 78% of Swedes “agreed wholly or in part with the statement, “I have access to the health care I need” and only 7% disagreed, which was both an improvement from 2004 (when 69% agreed) and consistent with the 2010 Ipsos/Reuters findings on easy access to “quality, affordable health care services”. 56% had confidence in the primary care system, 66% said the same about hospital care, 89% felt they were “given respect and consideration” by their primary care-giver and at least 77% felt that they were given sufficient information about their condition.⁹⁵ The 2010 National Patient Survey shed further light on the performance of the system. With regard to primary care, 83% felt they were treated very respectfully, 65% felt very involved in their treatment (25% partially), 56% felt they received enough information (22% partially), 77% trusted their doctor or nurse and 73% felt their needs were being taken care of by their clinic and that they would recommend it to others. For their local emergency department, 68% of Swedes felt it took care of their needs and 71% would recommend it.⁹⁶ A report by the Swedish Agency for Health and Care Services (Vårdanalys) in 2012 on patient-centeredness did however issue six recommendations on how the Swedish system could improve further:⁹⁷

1. “Ensure compliance with existing legal obligations to strengthen patients’ position”
2. “Establish patients as full partners with their providers with a role”
3. “Engage and involve patients and their representatives in health”
4. “Sustain efforts to facilitate coordination and continuity of care”

5. “Define a framework for assessment that reflects the priorities of Swedish patients”
6. “Strengthen efforts to assess and track patient centeredness”

Overall, therefore, though there are certainly aspects of the EHCI categorisation and certain satisfaction studies showing there are some areas where Sweden needs to improve - as is likely to be true of any national health system - the general weight of the evidence shows that the Swedish system delivers more for its users than the NHS does at current and that public and patient satisfaction is perhaps also stronger. Between this and Sweden’s vastly superior health outcomes, it is again demonstrable that there is much the UK can learn from the Swedish approach to healthcare.

Market Reform: Growing Consensus?

Along with the longstanding distinction between the UK and Swedish tax-financed public health services in terms of the latter’s decentralisation, another trend that has become noticeable since the 1990s is the increasing internal marketisation and expansion of consumer choice within Sweden’s public health system. This has of course also occurred in the UK too, and may increase further following the passage of the Health and Social Care Act 2012 and its competition provisions, but Sweden is generally agreed to have gone further with such reforms.

Free Choice and Provider Competition

First, since the early 1990s Swedes have had a broad right to choose to receive elective treatment at any hospital, including those in other counties – ‘free choice’ – in order to empower patients and induce competition between public hospitals (a similar right has existed for UK NHS patients since 2008). A 2007 study however found that at that time in Sweden, “Thus far, relatively few patients have opted for care at hospitals in other parts of the country”, only 5-8%, and not all of these were examples of “chosen mobility” as these figures include those forced to seek specialised treatment in other counties. It was therefore concluded that “the use of patient choice is still quite limited in Sweden”.⁹⁸ It is debatable what causes this – is it high existing satisfaction with local providers, reluctance or inability (physical or financial) to travel, lack of awareness about the right to choice, a lack of variance among providers or a lack of available information on differences between providers? If the last two are factors, it will be interesting to see if the increasingly pluralistic mode of provision in Sweden or the publication of comparative data on the quality of health services in the various counties will encourage more use of free choice. Data tends to support the case that awareness of the right may be a problem – in 2004 (over a decade after implementation) only 51% were aware of it, though among those that were aware 66% felt the right to choose their hospital was important. Another study from 2012 also suggested that while waiting times in different areas can influence choice, reluctance or difficulties in relation to travel often leads people to stay in their own area.⁹⁹

However, the 2007 study also noted that “a limited supply of private providers...and some restrictions in publicly funded access to private facilities” was another factor and that information provided by the counties on choice (before the central government became more involved more recently) “varies considerably” and “gives no clinical information such as ratings of care quality and treatment outcomes, and is therefore of little help to the individual patient’s decision-making process.” The report also appeared to suggest that to some extent, a conflict of interest could exist when publicising free choice and providing comparative information to

inform choice were county responsibilities. This arose because the county where a patient lives still has to pay for the treatment in the other county the patient chooses, which also tends to be more expensive, creating a financial disincentive for the counties to fully promote patient choice - this means there may be a justification for the expanded role of the centre in this particular aspect of the system.¹⁰⁰ While free choice can be good for patients and can perhaps push hospitals to increase standards, on top of the implementation difficulties, the 2012 study also noted that it has a drawback in terms of equity, as evidence shows that “younger, healthier, better educated and well-situated citizens are more likely to use the opportunity to exercise choice”.¹⁰¹ Increased efforts to inform people of their rights, and perhaps increased government support to help disadvantaged people with travel, are therefore advisable.

General competition between government-funded hospitals, including the many that were and are still public, and more market-like approaches to management in the public healthcare sector became commonplace in Sweden from the late 1980s onwards, as in the UK. ‘Implementing Change in Health Systems: Market Reforms in the United Kingdom, Sweden and the Netherlands’, a 2004 book written by Michael Harrison of the Agency for Healthcare Research and Quality in the US, had some insights into the process, benefits and problems of marketisation in Sweden, and also into the relationship between marketisation and the local management model, potentially an important point for those interested in both types of reform:¹⁰²

- Marketisation brought about “new ways of thinking about hospital services that originated in the world of business and industrial engineering” and a “view of hospitals as ‘a kind of industry’”, and thus new approaches to the “streamlining” of production in elective operations
- In one county in western Sweden, a public polyclinic Harrison investigated was forced to compete with “private physicians and among clinic physicians”
- Marketisation and patient choice “contributed to institutional change by making patient needs and desires central to health care and requiring providers to become more attuned to patient concerns”
- The reforms “signalled a radical reduction in paternalism in the planning and delivery of health services”
- Patient free choice specifically helped “[boost] service production” and allowed at least some patients who exercised the right “opportunities for exercising the ‘exit’ option” – it was added that “By linking hospital revenues to patient choice, the reforms gave hospital managers and physicians strong incentives to provide the types of service sought by patients and to make these services more appealing”
- The reforms were said to add “momentum to the broad drive within Sweden toward greater accountability of hospitals and other health care providers” in terms of County Council purchasing, public discussion of quality assurance and decisions about priorities in health spending
- Market and decentralisation reforms weakened the ability of the Swedish Medical Association (SMA) to dictate health policy, “because the SMA was not well organised at the county or hospital level, its influence over policy eroded further, with the progressive decentralisation of the health system”
- Marketisation varied across the country due to county discretion, but also “continued the trend toward devolving authority for health-care financing and management to the CCs”, despite some regionalisation threats brought about by new styles of management
- The localist system allowed policymakers to experiment and avoid problems other areas had suffered by varying their policies accordingly – for example, some counties in western Sweden avoided linking hospital payments to production (fee for service), as this inflated costs when it was employed in Stockholm
- Overall, “the market programs contributed to a shift in outlook and behaviour among hospital managers and professionals, whose efforts were critical to sustaining improvements in efficiency and effectiveness. Increasingly, hospital providers recognised the necessity of cost containment and the importance of attracting and satisfying patients”

However, the following caveats were also stated:

- In some areas, staff failed to “market their services” on the grounds that locals already preferred the service and those from rural areas had to come due to a lack of alternative services in their own areas
- In some respects Sweden’s 1990s-era market reforms were less “fundamental” than those in the UK NHS at the same time, in Harrison’s view, in that sense that “purchasers in Sweden said little about seeking value for money or seeking provider efficiency”
- Resistance to market reforms and strong public attachment to Sweden’s traditional welfare state meant that market discourse “disappeared” in the mid-1990s after initial implementation (but was revived again later) – this arguably mirrors our own debates over the NHS and the at times ‘stop-start’ nature of British healthcare reform
- Due to Sweden’s often more consensus-based political system in which coalition-building is important, market reforms required the support of “multiple parties and interest groups” – this is in contrast to the UK, where reforms tended to be forcefully enacted in Westminster by single-party majoritarian governments, in Harrison’s view
- There were productivity gains in the early 1990s, though “the question remains as to how much purchasing and hospital competition contributed to these productivity gains. Close examination of the available quantitative performance data raises doubts”, though Patient Choice and Care Guarantee reforms in the early 1990s were perhaps contributing factors to productivity gains
- A bold market reform in one county created “extra costs” rather than savings, “as they devoted substantial resources to negotiating contracts and monitoring results”
- Politicians sometimes intervened in the market in ways “unanticipated by market theories” – for example, some counties curtailed patient choice when the policy was losing them money

In 2001, Randolph Quaye published ‘Internal market systems in Sweden: Seven years after the Stockholm model’, investigating various privatisation measures. One was the new Diagnostic-Related Groups (DRG) reimbursement payment system introduced in Stockholm in the early 1990s – a mechanism along the lines of the Payment by Results (PbR) scheme introduced in the NHS in 2004, intended to incentivise good results according to defined metrics – of which Quaye said “Our findings suggest that physicians are generally satisfied with their working conditions and look favourably on the use of the DRG-based reimbursement system as an effective way to allocate health care resources”. Much as Harrison did, Quaye also noted the special role that Sweden’s administrative decentralisation played in the marketisation project – “The most intriguing aspect of the Swedish experience is its degree of decentralization. Counties can and will continue to experiment with several health care modalities. Ultimately, the country as a whole will gain from such experimentation if the experiments are properly evaluated and refined to deal with economic changes as they occur.”¹⁰³

In 2011 Henrik Jordahl of Sweden’s Research Institute for Industrial Economics carried out a meta-analysis of foreign studies on the impact of competition in public health services, in order to inform debate about the possible effects of healthcare marketisation in Sweden. Examining the outsourcing of public services, he claimed that “Taken as a whole, the empirical literature indicates that public sector outsourcing generally reduces costs without hurting quality”. This was referring to public services in general rather than referring to healthcare specifically and some services such as refuse collection were found to be more “perfectly contractible”, but healthcare formed part of the evidence base. He cited two studies in the US about medical care in prisons, one showing that “several health outcome measures improved” when such services are contracted, though another found that mortality increased. He also looked at the evidence base for competition between public NHS hospitals in the UK, describing the data as “partly conflicting”, but two of three studies he looked at were positive - “one found that competition saves lives without raising costs”, another found that it “strengthens management quality and reduces heart attack mortality rates”. Jordahl went on to discuss the theoretical differences

between public and private ownership under competition, concluding that the private sector has greater incentive to be cost-efficient – “If there is an ownership effect, private costs should be lower than public costs, regardless of whether this translates into higher profits or lower prices”.¹⁰⁴

Growing Privatisation – A New Public-Private Mix?

It has also become increasingly common since the 1990s both for public hospitals to be denationalised and for private firms to be allowed to open new facilities, especially primary care clinics - this however remains under the auspices of the universally accessible, subsidised at the point of use taxpayer-funded county health services. This has again occurred in the UK to a degree, with an increasing range of NHS services handled by the independent sector under contract, but in Sweden it has gone on for longer and to a much greater degree. For example, while in February 2012 one NHS hospital was controversially placed under private management (on a 10-year contract and as part of the taxpayer-financed, freely accessible NHS system), the first privatisation of the management of a Swedish public hospital occurred in 1999 and this has since occurred at several more, while over 25% of Swedish primary care is now provided by private firms.

A 2006 study by Monica Andersson at Gothenburg University, ‘Liberalisation, privatisation and regulation in the Swedish healthcare sector/hospitals’, looked at the same trend. She argued that the “first wave” of marketisation in Sweden came in 1976, when “in the Göteborg [Gothenburg] and Stockholm areas private providers of emergency and outpatient care were expanding”, followed by the second early-1990s wave Harrison explored. In 1994, St Goran’s hospital in Stockholm “was converted into an independent subsidiary company” in “the first and most outstanding example of privatisation within Swedish hospital care” – this was followed by the conversions of Huddinge Hospital, Danderyds Hospital and St Eriks eye hospital (all in Stockholm) in 1999, all of which became “independent subsidiary companies, but still owned by the county council”, and by Söder hospital and Karolinska Hospital, which “were also previewed to be independent companies in 2000” (also both in Stockholm). A ‘Stop Law’ was however passed in December 2002, “[forbidding] the selling of emergency hospitals to commercial for-profit companies” (this was abolished in 2007).¹⁰⁵ A “third wave” followed in 2006, following the election of Prime Minister Fredrik Reinfeldt’s centre-right Alliance coalition. She also observed that localism had varied these differences – “In Sweden changes of political parties in majority in the different county councils...have affected the actions undertaken. The presence of different administrative levels in a decentralised model, opens up for different political parties to hold the power at municipality, county council/regional and national level”. She also added that most localities “have welcomed the purchaser-provider [split] model since the 1990s” and that “public as well as private providers are concerned by reimbursement based on performance” within this new internal market.

Within this new system, private providers must have an agreement with the relevant county council in order to be able to be reimbursed for treating public patients – this and other council regulations means the councils remain in control of the internal market. However, Andersson also added that quantitative targets and contracts could lead to “profitable” rather than “necessary” care; that in practice the internal market system means there is “no real competition, as healthcare is in the hands of the county councils” and that the capitation system favoured by the councils “is suppressing an increase in productivity”. She also described existing capitation arrangements as “unfair” since reimbursement does not take account of the socio-

economic status on patients and thus capitations favour areas with “a healthy and prosperous population...not in need of expensive hospital care”. However, Andersson also noted a 2004 report by Olga Panfilova of Gothenburg University entitled ‘Effects of alternative modes of operation: A study of organizational change in primary care’, which Andersson claimed said privately-run primary care clinics performed better than public counterparts in terms of “increased productivity, enlarged range of service, reduction of costs, better access and access to the same staff because of lower turnover”, as private clinics were able to eliminate some of the bureaucratic “obstacles of public organisation”, though these changes did occur “in absence of competition” rather than because of it. Andersson therefore notes that “private entrepreneurial providers” can increase efficiency, but also notes that this doesn’t necessarily ensure equity or cost-efficiency – on the latter point, duelling studies have shown competition to both increase and lower costs in different Swedish counties, Andersson says.¹⁰⁶

Anders Anell of Lund University also observed that “The public sector has been reduced as a welfare producer and supplemented increasingly by private operators” and sought to assess the impact on cost and quality of a dramatic increase in the involvement of non- and for-profit organisations in healthcare in Sweden in the 2000s. Anell said that there is no “correlation between the share of private management and outcomes for counties as a whole” – Kalmar and Stockholm counties (the latter a site of substantial privatisation) had “the highest productivity”, Halland and Kalmar counties had the “best availability” and Östergötland, Halland, Kalmar, Kronoberg reported “good results in combination with low cost”. Examining competition in the hospital sector of nearby Germany, Anell found that though an early 2000s study concluded that public hospitals were the most productive, no productivity differences between public, private and for-profit facilities had been found in mid-2000s data and private for-profits had “higher quality (as measured by risk-adjusted mortality in hospitals) compared to other hospitals”. For the UK, he reported that “competition from given compensation levels stimulates better quality” (though price competition could degrade it). Since the introduction of competition, 200 new facilities had been opened – 80% of these were concentrated in five counties; Stockholm, Västra Götaland County (the second most populous county, containing Gothenburg), Skåne (the third most populous, containing Malmo), Jönköping (the fifth most populous) and Halland (only tenth most populous, but located between the major areas of VG/Gothenburg and Skane/Malmo). Data from 2010 also outlined the varied ownership of primary care clinics in the three major counties and Halland, showing how pluralistic primary care provision has become in some parts of Sweden:

- Halland County: 46% under public management, 13% run by large national private companies (such as Capio, Carema and Praktikertjanst), 22% by local or regional private companies, 19% run as individual private surgeries
- Skåne County (Malmo): 60% public management, 17% run by large national private companies, 10% by local or regional private companies, 13% run as individual private surgeries
- Västra Götaland County (Gothenburg): 58% public management, 13% run by large national private companies, 19% by local or regional private companies, 10% run as individual private surgeries
- Stockholm County: 38% county/public management, 32% individual private surgeries, 30% larger companies (data from a separate 2009 report that categorised management differently)

Overall, Anell did conclude, based on a number of studies, that choice of providers had “Improved accessibility and productivity”, though this was less identifiable in Stockholm County, and that patient satisfaction with private facilities was higher.¹⁰⁷

The Swedish website Ekonomifakta also published some data on the extent to which the public sector in Sweden now relies on the private sector for welfare services, including healthcare. Between 2002 and 2011, the County Councils consistently spent 9%-11% of their budgets paying private providers, while in municipalities (tasked with social care and public health) there has been an upward trend – they spent around 7% on private contracts in 2002, but closer to 11% in 2011.¹⁰⁸ In the UK, both *The Economist* and *The Guardian* have recently published news articles noting the Swedish privatisation trend, particularly the early example at St Goran’s Hospital in Stockholm, and some of its positive effects. *Economist* writer Adrian Wooldridge praised St Goran’s as both “one of the glories of the Swedish welfare state” and as “a laboratory for applying business principles to the public sector”, noting that the hospital is run by the private equity-backed healthcare firm Capio and uses the “Toyota model” of “lean” and efficient management. Wooldridge notes that despite its takeover in 1999, St Goran’s is still publicly funded and that as a result, “From the patient’s point of view, St Goran’s is no different from any other public hospital”. It is also run on contract by Capio for the county council, as opposed to being owned fully or permanently by Capio.¹⁰⁹ He claims that by maximising efficiency and output and making savings in terms of luxury ‘hotel services’, the hospital had reduced waiting times and increased focus on basic care and that accepting a public-private provision mix might be the best way to keep Europe’s proud public healthcare tradition affordable. Wooldridge did however note some problems, saying that “in Sweden, the mood [towards private companies] has grown more hostile since some private-equity companies were embroiled in scandals at nursing homes” - King's College London comparative management expert Dr Gerhard Schnyder has written in-depth about these problems.¹¹⁰ Wooldridge also reported that “most people in the private-equity business think there are easier ways to make money than taking over bits of the state”.¹¹¹

Randeep Ramesh of *The Guardian*, meanwhile, noted that privatisation of St Goran’s (one of “six private hospitals funded by the taxpayer in Sweden”) and other services were being watched in Westminster as a potential case study. Ramesh quoted the chief executive of St Goran’s as saying that emergency patients are seen within half an hour, meaning that an A&E department “that dealt with 35,000 patients a year...now treats 75,000”, that the hospital performed well on patient satisfaction and hospital acquired-infections and had produced “year-on-year productivity gains”. Stockholm County therefore extended Capio’s contract to run St Goran’s in 2012. Ramesh also quoted one patient and former staff member as saying “I am one of those Swedes who do not agree that private hospitals should exist...The experience was very good. I had no complaints. There’s less waiting than other hospitals.” Göran Dahlgren, a former head civil servant at the Swedish Health Ministry, did however warn that the 200 new primary care facilities founded by for-profit firms had predominantly been set up in “wealthier urban areas” – an assertion perhaps supported by Anders Anell’s findings (see above) and by Professor Bo Burstrom of the Department of Public Health Sciences at Stockholm’s Karolinska Institute medical university¹¹² – potentially creating health inequalities and perhaps showing the need for greater strategic control over the siting of the new private clinics. Ramesh did though also highlight that the private equity-backed UK health firm Circle, which now manages an NHS hospital in Cambridgeshire that has seen interesting rises in standards since its takeover in February 2012, has modelled itself on Swedish firms like Capio.¹¹³¹¹⁴ In his 2001 investigation into privatisation, Randolph Quaye had said “Most of our respondents were supportive of the

various market reforms strategies, including the privatization of St Goran's hospital. As one remarked, 'If what is good for St Goran is good for Stockholm then we should see more hospitals taking that route'¹¹⁵.

Ramesh also noted the work of a Swedish think-tank, the Centre for Business and Policy Studies (SNS), in the area - "[the pro-competition view] was challenged last year when a business-backed research institute, the Centre for Business and Policy Studies, looked at the privatisation of public services in Sweden and concluded that the policy had made no difference to the services' productivity. The academic author of the report, who stood by the findings, resigned after a public row."¹¹⁶ The report in question was 'The Consequences of Competition. What is happening to Swedish Welfare?' by Laura Hartman. It concluded that "there is a remarkable lack of knowledge of the effects of competition in the Swedish welfare sector. On basis of existing research, it is not possible to find any proof that the reform of the public sector has entailed the large quality and efficiency gains that were desired and said it could not "give any general conclusions about either gains or losses".¹¹⁷¹¹⁸ However, these findings were about competition in welfare generally as opposed to healthcare specifically and were in part due to a general lack of credible statistical data or empirical studies about it. Therefore, Hartman did not find proof against the marketisation approach per se, merely a relative paucity of data about it. She also explicitly states "a public monopoly can also manage their operations wrongly, for example due to fear of conflicts, a lack of interest or pure ignorance. The reason why these operations were opened up to competition in the first place was because of the extensive inefficiencies that welfare services had suffered for decades" and on health and social care specifically, her comments included some relative positives:¹¹⁹

- "One area that possibly deviates slightly from this general picture is primary care, where accessibility as a quality measurement appears to have increased"¹²⁰
- "In all areas, **apart from health and medical care** (and individual and family care services where there is a lack of information), groups that are socio-economically stronger seem at least slightly overrepresented as customers of private companies, which indicates that open competition can have segregating tendencies" (emphasis mine). Privatisation in healthcare has therefore not, overall, created demonstrable inequalities in access, even if it may have done in other areas of the welfare state¹²¹
- "The increased element of choice within primary care and deregulation of the pharmacy market seem so far to have created better availability, more services and better opening hours. The customers of the private operators are also somewhat more satisfied"¹²²
- "Evaluation of choice of care in Stockholm shows that more people use health care after the introduction of the choice. Most significant is the increase [in usage by] care heavy groups¹²³ and in areas with lower incomes. The private operators often have lower costs. But it is too early to draw any general conclusions about the effects on the quality, efficiency and distribution. The same applies to hospital care, where the effects of exposure to competition are less explored". The study also found that care heavy groups increased their usage of primary care services in particular¹²⁴
- "The research on the care of older and disabled people does not show any clear effects on either the quality or effectiveness of competition and the increased element of customer choice. Both surveys on customer satisfaction and more specific quality measures give an ambiguous picture. The distributional consequences are illuminated in a very limited degree, but existing studies suggest that the winners - as a group - are younger people with physical disabilities. This is because this group, through assistance reform, has significantly more influence over their means and thus more power over their lives"¹²⁵

A section of Hartman's report by Anders Anell also included data on the extent to which different counties in Sweden relied on private actors for the delivery of specific health services, obtained from SKL, part of the Association of Local Authorities and Regions (below). This

confirmed again substantial privatisation in Stockholm, but also showed that 25.9% of all Swedish primary care was privatised.¹²⁶ Additionally, these statistics also appear to support Andersson's observation that due to Sweden's democratic localism, "In Sweden changes of political parties in majority in the different county councils...have affected the actions undertaken"¹²⁷; a cursory investigation shows that some of the most pro-privatisation counties are ones where centre-right pro-market parties hold office locally, while the county with lowest percentage of spending on private provision – Dalarna County Council – is run by a centre-left coalition, for example.¹²⁸ Three additional SNS studies are on-going, which may be worth watching for in future; one is due to be released this autumn, with the next two following in 2014.¹²⁹

County/Regional Council	Primary Health Care	Specialised somatic care	Specialised psychiatric care	Dental care	Other healthcare	Healthcare excluding dental care
Stockholm	47.9	16.1	14.6	26.0	24.5	22.9
Uppsala	22.2	5.2	3.8	6.5	3.4	7.9
Sörmland	14.9	2.2	2.6	10.6	0.6	4.6
Östergötland	17.0	4.0	8.5	21.0	0.0	6.3
Jönköping	7.4	1.4	2.0	5.5	7.3	3.3
Kronoberg	22.1	1.9	4.4	19.1	1.2	5.4
Kalmar	11.5	1.0	1.6	8.7	0.6	3.1
Blekinge	8.4	1.1	0.5	3.3	1.3	2.5
Skåne	29.7	4.5	8.5	33.0	13.1	10.1
Halland	34.8	5.8	1.0	2.3	0.9	10.9
Vastra gotaland	21.2	4.6	2.5	6.8	1.8	7.5
Värmland	8.4	2.6	3.5	7.2	0.0	3.5
Örebro	16.6	2.9	2.1	7.1	0.9	4.9
Västmanland	40.2	2.2	2.9	4.8	9.1	10.2
Dalarna	4.6	1.2	4.4	10.8	1.9	2.3
Gävleborg	17.0	3.5	5.1	25.0	1.6	6.7
Västernorrland	17.3	2.9	1.9	10.8	0.1	5.3
Jämtland	8.9	2.4	0.4	12.3	0.1	3.5
Västerbotten	17.9	0.6	2.0	5.9	0.0	3.8
Norrbotten	8.9	1.5	1.7	1.9	0.8	3.0
Average	25.9	6.2	6.8	14.4	7.6	10.3

Figure 5: County Councils and regions' purchase of care from private companies in 2009 (% of health spending) (Source: SKL/SALAR, 2009)¹³⁰

Alongside acute hospitals, primary care, dentistry, psychiatric care and social care, another area of new competition has been pharmacies, and as Hartman mentioned, this may have improved services in this sector. Prior to 2009, all Swedish pharmacies and thus all provision for both prescription and non-prescription drugs belonged to a state-owned enterprise, Apoteket AB, which was created in 1970 at the same time as the rest of the modern Swedish healthcare system. This ended when the government sold over half of the 900 Apoteket pharmacies to private firms in 2009 and also allowed the firms to open new pharmacies – 20 firms have

subsequently entered the market and over 300 new pharmacies have opened. The Health and Social Affairs minister at the time argued that "We want to increase accessibility and think that can be achieved through competition", though EU competition law was also a consideration.¹³¹¹³² Competition is said to be intense, forcing some of the new companies to take a loss and some new pharmacies to close, though Apoteket still retains a "special position" in the market and a Swedish newspaper did state that "A report from the Swedish Competition Authority (Konkurrensverket), published in January 2011, concluded that one effect of the deregulation of pharmacies has been that many small towns now have pharmacies that did not have one prior to July 2009", potentially explaining the strengthened access in the pharmacy sector that Hartman referred to.¹³³¹³⁴

Civil society involvement

Though most of the private providers moving into the new public health and social care markets in Sweden tend to be for-profit firms and are often large ones like Capio and Carema, marketisation has the potential to create new opportunities for the civil society sector in Sweden.

As in the UK following the founding of the NHS, the establishment of the modern Swedish public healthcare system in the mid-twentieth century significantly reduced the scope of non-profit and voluntary sector involvement in Swedish healthcare. For example, the diverse non-profit mutual aid friendly societies (sickness funds) that had previously handled the financing of healthcare for their respective memberships became obsolete as the public County Councils effectively took over their role on a territorial basis in 1970, in contrast to the integral role their German inspirations the *Krankenkassen*¹³⁵ still play in Germany's modern-day health system. The Swedish funds had "varied in origin, affiliation, structure, benefits, and funding" and had ties to powerful early twentieth century political movements such as the Temperance movement. In the first two decades of the twentieth century, two representative organisations for these funds (the General Sickness Fund Association and the National Sickness Funds' Central Organization) "were united in opposition to a reform that would eliminate competition entirely by permitting only one fund to operate per local area", despite disagreeing on the subject of whether a national insurance scheme should be established – the latter eventually occurred after 1946 and the former in 1970.¹³⁶ Moreover, the takeover of the provision side of the system by the County Councils in 1970 also left almost no scope for the non-profit and voluntary sector to run hospitals and clinics – in 1980, just 0.8% of Swedish hospital beds were in the voluntary sector.¹³⁷ In a 2009 report, the European Observatory on Health Systems and Policies made an interesting observation about the impact of the post-war decline of the voluntary and non-profit healthcare sector in Sweden and the Nordic states on the modern politics of healthcare, one which arguably holds true for the UK as well - "Another distinguishing feature of Nordic health care systems, however, has been a tendency to oppose private expansion. The common understanding has been that health care should be under the ultimate control of democratically elected bodies, and not left to commercial market forces. This is partly because there is little tradition of voluntary or not-for-profit healthcare care in the Nordic countries (after the Second World War) and 'private' is, therefore, equated with 'for profit'".¹³⁸

The current reforms of course leave the generally effective post-1970 structure fully in place on the financing side, with healthcare continuing to be funded from taxation and the County Councils acting as purchasers of care on behalf of their local electorates, but the trend toward pluralism of provision since the 1990s may nevertheless be giving Swedish civil society another

chance to take responsibility for healthcare provision. According to a 2005 report by the Centre for Civil Society (CCS) at the London School of Economics, in 2001 Social Democratic then-Prime Minister Goran Persson "spoke of the increased demand for non-profit companies in health care, education and social services". Further, his Ministry of Health labelled non-profits as a "valuable alternative in the area of health care", the CCS claimed that the Persson government "prefers third sector organisations as welfare providers [to] for-profit organisations, particularly in the field of health care", a new association representing non-profit health providers called FAMNA had "received support" from Persson and it was said that Persson even favoured the establishment of "non-profit hospitals in every county".¹³⁹ In the 1990s marketisation wave, the percentage of healthcare staff working in the non-profit private healthcare sector increased slightly, from 3.4% in 1993 to 5.9% by 2000. By comparison, the share working in the for-profit private sector held fairly firm – 1.4% in 1993 to 1.3% in 2000 (although in the inpatient care sector specifically, the share employed by for-profit companies and public-interest corporations was more prominent and increased substantially in 1999/2000, likely due to the privatisation of St Goran's hospital as discussed above).¹⁴⁰ Four private hospitals in Sweden are non-profit entities – the Sophiahemmet, Ersta and Röda Korset (Red Cross) hospitals in Stockholm and Carlanderska hospital in Gothenburg.¹⁴¹

An article by Richard Saltman in the *European Journal of Public Health*, which examined the increasingly complex and often-oversimplified issues around "privatisation" and the public-private boundary in European health systems, said that "In Sweden and Denmark, for example, private not-for-profit nursing homes, owned by religious organizations, receive substantial public funding to care for patients". Saltman also noted that Praktikertjänst, which is the largest of the for-profit private national healthcare firms and is responsible for many clinics, is also a cooperative owned by its employees.¹⁴²¹⁴³ A March 2013 NOVUS poll commissioned by the FAMNA association also appeared to find that Swedes are beginning to understand these distinctions and have the most faith in the non-profit sector - 62% felt care quality in the non-profit sector was good and just 7% felt it was bad, compared to 57%-14% for public provision and 38%-31% for for-profit provision¹⁴⁴ (however, it is also worth bearing in mind Hartman's general finding that "The customers of the private operators are also somewhat more satisfied").¹⁴⁵

Integration

Another concern in the UK about current plans for more NHS competition is whether it is fully reconcilable with the simultaneous aim of greater integration between social care and different fragments of the health system, given the possibilities that competition could further fragment the health system or that competition law could conflict with attempts at integration. Sweden too is making efforts towards both integration and competition at the same time – for example, they are one of a number of countries piloting "payments for whole care episodes and year-of-care payments for some chronic conditions", Loraine Hawkins of The King's Fund has pointed out.¹⁴⁶

A 2013 presentation for the NHS Confederation by Leading Health Care, a Swedish health think-tank, assessed the integration elements of Sweden's healthcare reforms. Tools for integration include: "Boundary-spanning commissioning contracts, covering both health and social care; Possibilities for providers to target their services towards certain patient groups, e.g. elderly with complex needs; Increased possibilities for patients to choose 'service packages' covering both health and social care; Integrated reporting and evaluation of results [and] Boundary-

spanning reimbursement systems". Additionally, they added that further possible tools included a "Block funding/common budget for health and social care; Bundled reimbursements for care episodes/mutually dependent service components; Capitation adjusted for a combination of health and social care loads; Personalized care budgets, with or without individual control; Pay-for-performance based on joint outcomes". However, the presentation did also note that "Increasing political emphasis on user choice, competition and diversity between providers" and "Growing numbers of private providers" raised questions and created a "need to find tools for integration across multiple organizations".¹⁴⁷

An exploratory study in Sweden by two academics, Bengt Ahgren and Lars Nordgren, has attempted to address similar questions. They noted a conflict may arise between the Swedish freedom of choice agenda and an expectation for the primary care sector to "integrate its activities with other providers for the creation of 'local health care'", the latter of which is intended to better orient Swedish health and social care "towards common diseases and the needs of major population groups, for example the elderly and patients with chronic diseases". Their findings suggested that free choice between providers was not a major inhibitor of integration and that "Incompatibility between the two policy concepts seems to be limited to young citizens' definite preferences" since they only sought care very rarely and prioritised waiting times. By contrast, senior citizens were "a dominant group in primary care, and their active choices seem to facilitate the development of local health care in accordance with the guiding principles in general and, in particular, possibilities of establishing and fortifying the continuity of care", since they were more attached to a "somewhat conservative attitude" that led them to better value their sense of confidence in providers and relationships with particular caregivers. Ahgren and Nordgren did add that "this is compatible with choice of care only because the conditions are not completely free; instead these are limited, in turn entailing more or less nonexistent competition between care providers" and that successful integration "entails a loss of competition between care providers and thus also a loss of any possible gains from competition". Nevertheless, overall they concluded that "With the exception of younger citizens, choice of care and local health care would thus seem to be compatible policy actions in practice".¹⁴⁸

Conclusions – the start of a new consensus?

As Monica Andersson at Gothenburg University observed, the marketisation processes has occurred in Sweden in a sometimes stop-start fashion under both Social Democratic and centre-right national governments, though the trend has accelerated somewhat under the Prime Minister Fredrik Reinfeldt's centre-right Alliance¹⁴⁹ coalition since 2006 and has always been particularly pronounced in Stockholm County, where the Alliance parties run the council and all public hospitals are now under private management (market reformers in Sweden call this the "Stockholm revolution"). However in a July 2013 interview with *The Guardian* Stefan Löfven, leader of the opposition Social Democratic Party and a former trade union chairman, was described as being "pragmatic about the role of profit-making companies in education, social care and health in Sweden, proposing tighter regulation rather than bringing their operations back under direct government control" – Löfven himself said "It's more important to deliver quality than it is who runs it...Quality is the most important thing."¹⁵⁰ Randeep Ramesh had also commented on this in his own *Guardian* article – "The Social Democrats, the main Swedish opposition party, have given up the idea of renationalising the health service and instead argue that profits should be capped and quality of care more tightly regulated. With hardline opposition to private healthcare limited to the far-left parties, Swedes are likely to see more

changes.”¹⁵¹ Löfven’s remarks were also similar to a sentiment Swedish Medical Association (SMA) board member Dr Thomas Flodin expressed in 2005 about the use of private providers in the health system - “What is important is not who provides the care, but that it remains available to everyone”¹⁵² (interestingly, when Civitas put a near-identical statement to a sample of the British public in a March 2013 ICM poll, 83% of Britons in theory agreed).¹⁵³ Klas Öberg of the governmental National Board of Health and Welfare has said “Today the discussion is not whether private health care should have a role in the system, but rather what role private health care will have.”¹⁵⁴

If such statements are similarly reflective of Swedish public opinion, this perhaps demonstrates the beginnings of a new consensus around a social market approach to healthcare – a continued devotion to the longstanding social principle of universal access to high-quality collectively-financed healthcare, but married with a fresh belief that pluralistic provision rather than a sole government monopoly may in some instances be the best means of delivery for it. While it appears that further research is still needed, and the additional research expected from the Centre for Business and Policy Studies (SNS) in the near future will be particularly valuable, there does appear to be some tentative evidence across various parts of the health system that private provision can strengthen quality, efficiency and access, under the right circumstances. Further, where examples of market failure are identifiable, it is important that both Swedish policymakers and observers in the UK remain measured in their responses – take the reported skew in the siting of new private primary care clinics towards “wealthier urban areas” that Anders Anell appeared to find and Professor Bo Burstrom, former civil servant Göran Dahlgren and some marketisation critics in the UK have warned about, for example.¹⁵⁵ If marketisation in primary care is causing inequitable access, it is certainly not something to be laissez-faire about, but it is also important to remember the tentative findings by Hartman, Anell and others about improvements in quality, access and satisfaction in primary care since the introduction of competition. If the involvement of private providers is delivering better primary care services in some areas, but current market incentives favour inequitable placement of the clinics and thus disadvantage weaker segments of the population, the logical response should surely be for the Swedish government to strengthen strategic oversight or retool incentives in order to ensure that the siting of the clinics is more fairly spread, rather than simply returning to outright nationalisation. Upholding the right balance of market innovation and state intervention should be at the heart of the social market.

Remaining Problems

Perhaps the only visible Achilles’ heel in the otherwise world-class Swedish system is waiting times, which are fairly widely acknowledged to be a problem. In an OECD ranking of 11 countries, Sweden was second-worst on both waiting times of more than four weeks for specialist appointments (55% had waited more than four weeks in 2010, compared to 28% in the UK, 18% in Switzerland and 17% in best-ranked Germany) and waits of more than four months for elective surgery (22% had waited more than four months, compared to 21% in the UK, 5% in the Netherlands and reportedly 0% in Germany).¹⁵⁶ In a *New York Times* piece about Swedish healthcare and the lessons it could hold for the now-reforming US healthcare system, American economist Robert Frank described how when he asked Swedish experts about the drawbacks of their otherwise-good system, “several mentioned the waiting times for certain nonemergency services. One told me that whereas in the United States a wealthy or well-insured patient might schedule a hip replacement with only a week’s notice, in Sweden the wait could be as long as three months” (though Frank did add that one expert “described such waits

as a design feature, noting that they allowed facilities to be used at consistently high capacity, and thus more efficiently”).¹⁵⁷

Consequently, the researchers behind the Euro Health Consumer Index and the SALAR report into Swedish performance blame waits for Sweden’s consistent sixth place rank in the EHCI – the SALAR report says that what “obscures the assessment of Sweden are the long waiting times for planned, non-acute [elective] treatment. All Swedes have access to medical care but often have to wait too long for doctor’s appointments and planned treatment.”¹⁵⁸ In the 2012 EHCI, a Swedish former healthcare CEO and chief operating officer of the Stockholm-based Health Consumer Powerhouse organisation that produces the ranking, Dr Arne Björnberg, appears to confirm the SALAR claim:

“Sweden in 6th place, (762 points, up from 9th place in 2009) and Norway (9th place, 756 points) are now the two countries enjoying the distinction of scoring All Green on Outcomes (treatment results). For six years, it has not seemed to matter which indicators are tried on Outcomes (at least for rather serious conditions); Sweden keeps scoring All Green, and has now been joined by Norway. At the same time, the notoriously poor accessibility situation seems very difficult to rectify, in spite of state government efforts to stimulate the decentralized county-operated healthcare system to shorten waiting lists. The HCP survey to patient organizations confirms the picture obtained from the official source www.vantetider.se, that the targets for maximum waiting times, which on a European scale are very modest, are not really met. The target for maximum wait in Sweden to see your primary care doctor (no more than 7 days) is underachieved only by Portugal, where the corresponding figure is < 15 days. Another way of expressing the vital question: Why can Albania operate its healthcare services with practically zero waiting times, and wealthy countries such as Norway and Sweden cannot?”

Dr Björnberg further added that:

“The Swedish score for technically excellent healthcare services is, as ever, dragged down by the seemingly never-ending story of access/waiting time problems, in spite of national efforts such as Vårdgaranti (National Guaranteed Access to Healthcare); Sweden still makes a good 6th place with 775 points...The Swedish healthcare system would be a real top contender, were it not for an accessibility situation, which by Belgian or Swiss standards can only be described as abysmal”

Dr Björnberg also argues in the same report that “BBB; Bismarck Beats Beveridge [is] now a permanent feature” of the EHCI ranking. By this he meant that Bismarckian social health insurance systems – in which financing is based on hypothecated social insurance taxes or premiums and “there is a multitude of insurance organisations, Krankenkassen etc, who are organisationally independent of healthcare providers” (including the Netherlands, France, Switzerland, Belgium and Germany) - on average perform better than nations with variants of the general taxation-based Beveridgean system, “where financing and provision are handled within one organisational system, i.e. financing bodies and providers are wholly or partially within one organisation, such as the NHS of the UK, counties of Nordic states etc”.¹⁵⁹ Therefore, despite the many strengths of Sweden’s healthcare system, there are voices even there who argue the potential benefits of the alternative social health insurance model, at least in terms of the possible difference this distinction may make to access and waiting times (it is also worth remembering that between 1946 and 1969, Swedish healthcare was a type of social insurance system based on sickness funds).

The only other pressures facing Swedish healthcare are more general and will be familiar to most Western countries, including the UK – an ageing population, chronic illness, rising demands and technology costs and the resultant need to ensure that the system is fiscally sustainable for the future. It is partly these concerns that have driven the marketisation trend. In Canada, a comparable Beveridgean healthcare nation and thus one where Swedish reforms have been noted, the *Canadian Medical Association Journal* stated that “As countries the world

over struggle with rapidly changing technologies, spiking medical costs [and] rising demands for service with noncorresponding appetites for increased fees or taxation, Sweden is increasingly turning to the private sector to reduce the burden on a health care system at risk of being crushed under its own weight".¹⁶⁰ Simultaneously, these pressures and a resultant desire for strategic control are also the cause of temptation among certain Swedish policymakers to re-centralise the system along Norwegian or Danish lines so that the central government can enforce cost-control at the expense of local discretion. Health experts at the London School of Economics stated that "recent evidence indicates that this Nordic commitment to a reduced role for their national governments in the health sector may be weakening. In these countries, and elsewhere in Europe, it would seem that a combination of rapidly changing technology, growing pressure from patients, and stark, if as yet unrealised, fears about the cost consequences of an ageing population have led Nordic countries to considerably increase the steering and supervisory role of their national governments".¹⁶¹ However, it is worth noting that Sweden does spend only 9.5% of its GDP on healthcare, similar to the UK and in contrast to Denmark, Canada and some countries on the European continent which spend closer to 11-12% and the US, which spends 17% of its GDP on healthcare.¹⁶²

Lessons for the UK

Overall, despite the challenge of waiting times and the more general modern pressures it faces, the Swedish system performs very strongly. Crucially, it outstrips the NHS on many key performance indicators. Given the relative similarities of the Swedish and British health models in origins and overall ethos, the two crucial distinctions we can identify between our respective national models should be the main takeaways for British policymakers:

1. **Localism works.** In June 2013 health journalist Bob Hudson wrote that "Public and patient engagement (PPE) in the NHS has been weak ever since [Nye] Bevan's centralised model trumped [Herbert] Morrison's municipalism in the 1940s".¹⁶³ By contrast, in Sweden the fine-tuned balance of state and local strengthens engagement and accountability, makes services more flexible and makes the public more willing to pay for services, while still ensuring common national standards and solidarity in funding are maintained. Empirical evidence also suggests that more localist tax-financed healthcare systems, including Sweden, perform better than more centralised ones such as the UK. Accepting localism will however involve a shift in ethos in the UK. We will have to renew our trust in local government, let go of our attachment to centralism (and the hope that it can ever fully stamp out 'postcode lotteries') and accept that a degree of local variance will naturally come with local democratic discretion - as Simon Jenkins put it, "divergent standards are the price of localism, even though centralism has not delivered consistent ones"¹⁶⁴
2. **Pluralistic competition can strengthen standards and access.** Though the post-2006 stage of the Swedish market reforms is still an on-going project, the evidence base is not entirely comprehensive as of yet and there have been some inevitable market failures, there does appear to be emerging evidence supporting market reforms when the right conditions are present. A majority of Swedes valued the hospital choice rights introduced in the 1990s and marketisation had forced providers to think more about patient needs and start to compete for their custom, compared to when local public monopolies existed. Stockholm and some other areas are highly productive, provider choice has improved accessibility and productivity in at least some areas and satisfaction with private providers is reported to be higher. The oft-cited privatisation at St Goran's

hospital in Stockholm appears to have brought better productivity, reduced waits, fewer hospital infections and higher satisfaction. In primary care and the pharmacy market, service quality may have increased and crucially, the evidence from the Centre for Business and Policy Studies suggests that inequitable access is not always a problem with privatisation in the healthcare sector – access may even have increased in some respects. Pluralism is creating a new space for non-profit and voluntary involvement, reinvigorating Swedish civil society in a way that should inspire Britain too, and there also appears to be an emerging political consensus around the new reforms. Finally, the Swedish system's localism has been vital in the marketisation process; it has allowed electorates to influence the nature and scale of marketisation in their own area, creating varying service models across different counties, and allows local policymakers to observe best practice and learn from successes and failures in other counties

Sweden Statfile (most recent figures from the OECD unless otherwise stated, most recent UK figure and OECD average given for comparison)¹⁶⁵

Funding

Total Health expenditure: 9.5% GDP (UK: 9.4%, OECD average: 9.3%)

Total expenditure on health per capita (US \$, adjusted for PPP): 3925\$ (UK: 3405\$, OECD Average: 3339\$)

Public expenditure (as a percentage of total health expenditure): 81.6% (UK: 82.8%, OECD Average: 72.2%)

Public expenditure per capita (US \$, adjusted for PPP): 3204\$ (UK: 2821\$, OECD Average: 2427\$)

Out of pocket expenditure (as a percentage total health expenditure): 16.2% (UK: 9.9%, OECD Average: 19.6%)

Out of pocket expenditure per capita (US \$, adjusted for PPP): 636\$ (UK: 338\$, OECD Average: 563\$)

Resources

Practising physicians (per 1000 population): 3.9 (UK: 2.8, OECD Average: 3.2)

Practising nurses (per 1000 population): 11.1 (UK: 8.4, OECD Average: 8.7)

Total hospital beds (per 1000 population): 2.7 (UK: 3.0, OECD Average: 4.8)

Waiting Times¹⁶⁶

Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations): 55% (UK: 28%, Germany - best: 17%)

Percentage waiting four months or more for elective surgery (study of 11 OECD nations): 22%
(UK: 21%, Germany - best: 0%)

Outcomes

Average life expectancy (at birth): 81.9 years (UK: 81.1, OECD Average: 80.1)

-Male: 79.9 years (UK: 79.1, OECD Average: 77.3)

-Female: 83.8 years (UK: 83.1, OECD Average: 82.8)

Infant mortality (per 1000 live births): 2.1 (UK: 4.3, OECD Average: 4.1)

Potential years of life lost (females, aged 0-69 years): 1884 (UK: 2537, OECD Average: 2415)

Potential years of life lost (males, aged 0-69 years): 3073 (UK: 3992, OECD Average: 4633)

Mortality Amenable to Healthcare (OECD, Nolte & McKee Method*): 68 per 100,000 deaths
(UK: 86, OECD Average: 95)

Mortality Amenable to Healthcare (OECD, Tobias & Yeh Method¹⁶⁷): 78** per 100,000 deaths
(UK: 102, OECD Average: 104)

Mortality Amenable to Healthcare (Commonwealth Fund – Nolte & McKee method*¹⁶⁸): 61
per 100,000 deaths (UK: 83, US - worst: 96)

* Nolte & McKee method: mortality amenable to healthcare defined as “premature deaths that should not occur in the presence of timely and effective health care”

** Tobias & Yeh method: mortality amenable to healthcare defined as “conditions for which effective clinical interventions exist [that should prevent premature deaths]”

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¹ The Nordic countries include Norway, Sweden, Denmark, Finland and Iceland, all of which feature the “Nordic model” social democratic welfare state, high tax rates and associated tax-financed and publicly-provided healthcare systems, though traditionally in the region these have been locally rather than centrally managed. Contrary to common usage, the phrase “Nordic countries” is in fact different from the often interchangeably-used “Scandinavia”, which refers primarily to Sweden, Norway and sometimes Denmark

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