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Swedish health-care reform: From public monopolies to market services

M. MICHEL KELLY-GAGNON:

...par respect pour tous les participants et pour les conférenciers, je vais vous demander d'être de bons élèves et de restreindre vos interventions pendant les conférences pour éviter le bruit qui peut être source de... de déconcentration.

Et comme je l'ai mentionné, nous aurons une brève période d'interventions où les gens, après la présentation, pourront lever leur main et prendre le micro.

Comme la période de questions est assez courte, on aura à peine dix (10) minutes, étant donné qu'on est en retard sur l'agenda, je vais vous inviter à... aux questions... à formuler des questions plutôt que des questions discours.

It is sometime the habit of certain people to actually make a long speech that they've carefully prepared instead of a question and if possible, it would be interesting to have questions that would enlighten and help the exchange.

Without further due... je veux donc vous présenter monsieur Johan Hjertqvist. Monsieur Hjertqvist fut maire-adjoint de la Ville de Tyreso en Suède ainsi que conseiller, auteur et directeur de recherche sur la réforme des services sociaux en Suède.

Il a participé à la création d'un organisme nordique visant à implanter des soins de santé modernes dans les pays baltes. Il agit également à titre de conseiller pour le réseau de santé du Conseil Métropolitain de Stockholm, il dirige le projet "La Santé en tradition... en transition", pardon, qui est un projet-pilote dont l'objectif est d'analyser et de valider le fonctionnement d'un marché concurrentiel au sein de l'appareil public.

De plus, il est actuellement à l'écriture d'un livre expliquant comment les nouvelles valeurs, jumelées au progrès scientifique, vont changer la signification et la portée des soins de santé.

In his presentation, Mr. Hjertqvist will explain to us how the considerable savings can be made and dealing with the problem of long waiting lists.

So without any further due, please welcome Mr. Johan Hjertqvist, thank you.

MR. JOHAN HJERTQVIST:

Thank you Michel and thank you for inviting me and gathering here to hear if anything happening in Sweden could be interesting to you in Canada.

I'm especially happy to come here as Sweden and Canada has a lot in common, I would say. Not only that we are freezing in winter, not only that we are a recycling hockey place, ice hockey place, we send them when they're young and ripe here and then they come back as broken men but bringing twenty... thirty million bucks ($30,000,000.00) on the bank when they come... come back playing ice hockey in... in Sweden.

We even imported a couple of Canadians playing in Swedish top series now, I could tell you. And I was informed during lunch that we also have in common moose hunting, it seems to be a national sport in Sweden as well as Canada during autumn.

To be a little more serious, one thing we have in common is positions as welfare states, welfare societies.

And let me take that as a background for what I'm talking about here. How to reform health care within the frame so the welfare state, a welfare society and maybe that could be something to go on discussing.

This will be recorded, as I say, and let's look upon it as a official breakthrough in Canada for Swedish health care reform.

Dr. Coffey, could you give me a sign when I'm running overtime so... Let me make just a few statements before I continue.

What's happening in Sweden now is that you try to speed up productivity to reform the way you deliver services.

It's important to note is that how to deliver services not how to reform the financing. As a large majority in Sweden, both when it comes to patients and politicians, I would say, to save the present system of one-tier... one-tier system, tax financing equal excess, we don't have any much debate about that but we concentrate the discussion about how to improve deliverance of services to patients and to old people and so on within that framework so that's what I'm going to talk about.

I put... it's a little tricky, roomless, some pillars and so on, I hope you all manage to see this and if I'm standing in front of you, please let me know.

I put those slides, those power point pictures on the Web site of the project I'm running so you can pick them down later on if you want to so you don't have to write everything down if you... if you don't find it quite necessary.

Now, let me start by a short presentation of how the Swedish health care system is built to make it easier for you to understand and follow the changes that are taking place right now.

We have a system where the national government take care of all the of money, to start with, our tax money and then distribute it to... money to two (2) levels, the regional level, taking care of health care.

We have a system of elected regional and local governments, you can say. So some of the money

go to the regional governments, some of the money to a local government running different kind of welfare operations, nursery homes, health care for elderly people staying in nursery homes, et caetera.

So the role of the national government is to collect and distribute tax money and to regulate and control the whole system.

Not very unique, I would say, rather common way to do it, except maybe for... for the different levels and that politicians responsible for... for the system on different levels are directly elected.

How does it then work in... when it comes to health care? We have that kind of system also when it comes to education and so on, all kind of public services.

You can say that as a tax payer, you pay health care tax, if you want to put it that way, regional tax around fifteen percent (15%) of your income goes to the national government, sends it back to the regional governments, (inaudible) roughly a hundred billions (100,000,000,000) Swedish crowns, that is to the actual current exchange rate, around fifteen... maybe a little more, fifteen billion Canadian dollars ($15,000,000,000.00).

What you should have in mind is that we have three (3) kinds of... three (3) ways of operating health care in Sweden, you can say.

The still... the one that still dominantly is that the councils, the public authorities own the facilities and also operate them, it could be primary care clinics, it could be emergency hospitals, the old way to do it if I may use that word.

We see and that I will concentrate on, the second type, that is owned by the council, politicians (inaudible) framework but it's operated by private contractors, private contractors working within the system on behalf of the councils.

And you have a very small amount of purely private health care, less than one percent (1%) of all health care delivered that is that you pay the whole cost yourself and that it's privately operated.

You can look away from that, I would say it's not very interesting in this context but let's concentrate on... on health care operated by contractors.

As Sweden leaves possession as a centralized very homogeneous country and moves quite rapidly into what you could call much more of a regional alliance, a weaker central force, stronger local regional forces, of course, the result is that you have different kind of developments and different kind of the different parts of the Sweden.

And you can say that you... to be... to make it easier, that in less populated parts of Sweden, you don't welcome this transition in the same way, you can put it, there, you still work with a different kind of reforms when it comes fee for service, diagnosed related groups and all kind of systems.

You try to promote not contractors, not entrepreneurs but intrepreneurs within the system, that is that you give a clinic some kind of semi-independent possession and so on, run by... by agreements rather than contracts and you try to promote private producers, you don't have some messy impact but you try anyhow to promote private producers, mainly at least, one stronger driving force to make it easy to recruit personnel, doctors and nurses, as you have in large part of North Sweden.

I understand you have the same situation in Canada, it's not very easy to... to recruit health care personnel to go there.

And as you see, it's much easier to recruit doctors and nurses if they can run this as an independent

business, you also see that kind of operations in the Northern part of Stockholm.

In other parts, in southern parts, more populated, you can say that you have, in Stockholm region, a strong impact, in southern part of Sweden, other parts of the southern Sweden increasing impact for... for these new ideas, that is to let contractors compete for all kind of assignments, that you turn publicly or, should I say, council-owned tax financed hospitals into companies still owned by the council but operating more efficiently with professional boards, et caetera.

You have some privatization in a pure sense, that is, for example, when it comes to ambulance services, you close down the council operations and you rely only upon contracted operators.

And you... you use some effort to develop market information and by that, I mean information to contractors making it easier for them to compete and for patients making it easier for them to make an informed choice.

So there is a uniform pattern but that's on the whole what's... what's happening. Okay, the Stockholm region which I'm now concentrating on where the changes most dominant, what's happening there, what does the Stockholm region look like, to start with?

Close to two million (2,000,000) inhabitants, roughly twenty percent (20%) of the national population, we are nine million (9,000,000) people, close to, in Sweden.

We have, on a national level, center left government dominated by the social democrats, we have on the regional level in Stockholm, center right, a government which causes some friction, I could say, between the regional and the national levels.

In general, Stockholmers are younger, better educated and better paid. And they probably, as a result of those conditions, education and so on, they consume more health care than Swedens in general, you see those figures and they are maybe especially interesting the more you read, that is that twenty-five percent (25%) of all health care services produced in this region is produced by private contractors, much more, much higher figure than in the rest of the country.

And when it comes to primary health care, already sixty percent (60%) of all primary health care in the Stockholm region is privately produced but within this, as I stressed, public framed work or public financing and public contracting.

So you already have a strong impact for new ways of... of working health care.

Also, in Stockholm region, when it comes to the greatest (inaudible) council, of course, you have a hierarchy, we like this systems in Sweden, since the middle ages when we had a king called Gustav Olsa who centralized very... with some quite decisive message, I would say, all of Sweden and since then, we like these kind of structures with different levels.

So the greatest (inaudible) council, you can compare with a national government, formulate policies, responsibility for financing, send some of the money to the central health care board, central authority and the regional level to purchase different kind of home health care services and they deal mainly with the emergency hospitals, I hope you can read this even if it's... hold the picture to fill it with the information.

We have seven (7) emergency hospitals in the Stockholm region, one (1) is sold out to private actors, the other six (6) are in... owned by the council, two (2) are already, during this year, this spring, turned into council owned companies and the four (4) rest, the rest of the four (4) are going the same way in the coming years.

We have all... so a regional organization, you can say, decentralized, six (6) local health care

purchasing boards with own budgets and they contract mainly primary care, a hundred twenty (120) primary health care units, eight hundred (800) GP's, et caetera.

So they deal with primary care and up till now, development had been concentrated here, now in the years to come, you will compete for most of the emergency health care services.

So you're moving from the periphery into the center of health care if you want to call emergency health care like that, at least all emergency health care doctors I know are... agree that we... when I say that's the center, that's the heart of... of health care.

Of course, the parts most complicated to measure, to... to put price on to buy on some kind of internal market.

Okay, what's happened then in Stockholm during the nineties ('90s), what you could call the Stockholm transition maybe.

Nineteen ninety-one (1991), this process started by putting all non-medical services on competed contract, different kind of technical services, restaurant, laundry, et caetera, as well as ambulance services and already by then, all personnel was supported to take over public operations to build their own companies compete for running health care units, et caetera.

In mid-nineties ('90s), since nineteen ninety-five (1995), you also compete for medical support services, X-ray, laboratory, et caetera.

You had the first emergency hospital converted into a company, then still owned by the council. You introduced or complete purchase a provider model in nineteen ninety-five (1995).

Nineteen ninety-eight (1998), all primary care turns gradually into competed contracts and it will be efficient, I would say, from next year, all holding (inaudible) will be closed, all primary care will be competed for.

And last year, the council sold out one of the hospitals, the Saint-George Emergency Hospital, to listed company, listed health care company, quite big one but with Swedish origin, I would say, operating in Sweden and in Norway and I think they also opened up activities in the UK and then in Polland.

This year, two (2) more councils... council owned emergency hospitals are turned into companies and they decided to go on competing for, as I said, emergency care.

Those contracts will be valid, at least if they can keep their present timetable, it will be valid from two thousand 0 three (2003) and the volume of these contracts could be probably roughly twenty billions (20,000,000,000) Swedish crowns, between three (3) and four billion canadian dollars ($4,000,000,000.00), which is forty percent (40%) of their cost of all emergency care in the Stockholm region.

What they mean is reasonable to start with, if this process continues, in a couple of more years, of course, you will compete for a hundred percent (100%), I would say.

If you put together some kind of informal vision based on a lot of interviews I made by... with politicians and top management for the report I just written about this transition process will be published in the middle of November, with the project... four (4)-year project I'm running, you can say roughly like this vision of what will happen in the coming five (5) years, all emergency hospitals will be turned into council companies and maybe one (1) more is sold out.

Then you read some kind of critical mass for being able to compare privately owned and council

owned hospitals and draw some conclusion from that, that's the idea.

All primary care units will be run by private companies, mainly formed by former council personnel.

You will be able to recruit full staffs of doctors and nurses all over the region we have in Stockholm as in many other places of the world, the south-north dimensions, I'd say, meaning that it's been difficult for twenty (20), twenty-five (25) years to recruit mainly doctors to the southern parts of the region, where you have more of the social problems, it's not so fancy to work, et caetera.

Probably they will be able to deal with that by this reform. You will be able to speed up quality when it comes to these services, build change of treatment, et caetera, which everybody talked about since ten (10) years but we still see very few examples of.

And also, of course, this has economic aspect too, it will be naïve to believe anything else, council expects roughly four percent (4%) increase a year when it comes to productivity and referring to new policy that all clinics, hospitals, health care units, et caetera, will work smarter, more efficient when they are owned or controlled by many of the employees.

And when it comes to the politicians, they will hope for a new assignment, meaning that they could pull out completely from production, let's say, and concentrate on representing the electors when patients... when it comes to purchasing and formulating policies and so on.

So that's the vision behind this transformation. Then we come to probably what you all are waiting for to get an (inaudible), thus competition pay, what's the upside of this transition.

Of the roughly ten (10) years, I would say that in the Stockholm region, we have evaluated and well documentated experiences, in not all but most of those... those fields.

And you can say... look upon the Saint-George, it was, as I said, turned into a council company already in nineteen ninety-four (1994), you can see that they've been quite successful in reducing costs or increasing productivity, how you want to put it, per unit, roughly by thirty percent (30%), differences, of course, between clinics, et caetera.

It means that they are today able to receive one hundred thousand (100,000) patients more every year with the same resources as they had before.

How come? A combination of... of professional management, I would say and involvement of all personnel.

Our experience is that when this transformation starts, it could be a large scale hospital or a small local health care unit, you create very strong activities from personnel, taking part in shaping this new company, everybody scrutinizing, overlooking routines, how you buy equipment, how you work, how you take care of the patients, et caetera, et caetera.

And this, with very few exceptions, lead to better activities, better services and lower costs and which is very, very important in a knowledge industry like health care, a much more satisfied personnel.

Competition between laboratory and X-ray contractors, cut costs during the nineties ('90s) by fifty percent (50%).

It's well documented, if you maybe think that it's... it looks a bit too good to be true, every laboratory and X-ray operators, maybe not (inaudible) development but evidently, most of them are still in the market, still delivering good services to half the price.

When ambulance transport was put to the market, you could at once, in nineteen ninety-three (1993), in the first step, reduce costs by fifteen percent (15%) and increase quality.

Today, all the people working in ambulance services, for example, are licensed, licensed and well educated, they were not before.

When it comes to the local level, running nursery homes, you can see that by using contractors, you could reduce costs by, in average, thirty percent (30%) during the nineties ('90s).

Parallel to that, you were able to increase the quality. In this matter, I mentioned during an interview today and I want to repeat it, there have been some problems, of course, that's a problem of maturity in the system, you don't go from the old system into the new one, you don't become very competent, creative, innovative purchaser from one day to another.

So, of course, it's a tough job to be able to create the right demand, the right conditions for the contractors.

And when it comes to nursery homes, we had in Sweden some kind of quality problem, you can say. Now, I guess that my impression is that you are getting over those problems but I want to stress this, as you might maybe think that this is quite uncomplicated operation which is not.

I want just to stress what I said about the people working and health care is much more satisfied today, an article from a Canadian newspaper recently, interview (inaudible) who's head of the nurses' union and one of the strong supporters of this transition.

I would say, in Sweden, all concerned trade unions followed this transition and one strong reason for them, of course, is that in the old system, they should discuss salaries with a monopoly employer and monopolies seldom are very keen about what their employees think.

Today, (inaudible) and her members can discuss salaries... well, let's say fifty (50) to a hundred (100) contractors competing for the best personnel, of course.

And that means that they've been quite successful in raising their salaries which, of course, in the long run, makes health care more costly but if you try to balance that cost towards not being able to recruit personnel, I think it's quite clear that it's better to have a fairly well paid nurses than having no nurses at all.

It's proven that Swedish private specialists in primary health care are more efficient than their colleagues in public services, ten (10) to forty percent (40%).

According to a study in nineteen ninety-seven (1997), they are better on delivering value for the patient.

Thanks to increased productivity, waiting lists have been quite dramatically cut, I know that in Canada, waiting list is a most interesting topic and let me come back to that in two (2) minutes.

As I said, when you do this transformation awareness, all realities do increase in all organizations.

Also, in the publicly run, you feel the waves from the private competitors and you start thinking over what can we do to become more productive to serve the patients better even if we are not out in the market in regular sense.

Companies focus on patient quality, employees, as I said, prefer working for entrepreneurs, it's easier for entrepreneurs, for contractors to recruit personnel.

And as I said, since (inaudible) and her members worked, started working in this new environment, they've been quite successful in raising their salary.

Sorry?

M. MICHEL KELLY-GAGNON:

Two (2) minutes.

MR. JOHAN HJERTQVIST:

Okay, I'm fairly according to plan. Let me come back to waiting lists. We had, during late eighties ('80s), a problem with waiting lists in the Stockholm region in the Swedish health care (inaudible) in general, I can say, meaning caused lot a problems for the patients and their relatives.

At least now, run by the confederation of councils, you have a national Web service where you can look upon and check the waiting lists in most hospitals in Sweden as well as the council of Stockholm operates an owned service, making it easier for the patients to select the most efficient or most accessible health care clinic or hospital.

If you look upon waiting time, actual waiting time, so I checked this up two (2) days before I left here.

Now, I'm talking about examinations and treatments that are not put on a priority list, that is maximum waiting time, you can say.

If you are a more emergency case, if you have a lot of troubles, you will be dealt with much sooner the list.

You can see that in maybe the most that... two (2) interesting things here, first, that you have comparative short lists in Stockholm, in general, the other is that if you compare with other councils who use the non-reformed health care, if you want to put it that way, you can see there are quite differences, not only depending on what regimes, so to say, but I would say that one important information on background.

So you can see that if you need primary hip plastic, for example, or trouble with your heart, et caetera, you can be taken care of in Stockholm, I'd say three (3) or four (4) weeks if you're not put on a priority list.

In other parts of Sweden, it's... you have to wait much longer. And this is one very important topic in Sweden, not that people are very satisfied and dissatisfied in the Stockholm region but in other parts of Sweden, and I think that's one argument for experimenting with this new idea.

Okay, I sum with my last picture, I would say that this is a win-win situation. Let me... or make clear once again that this is reforming how you deliver services, not when it comes to financing, we want to keep the one-tier system, we want to keep the tax financing but we want to reform the productions, so to say, of health care services.

And you can say that the Swedish or the Stockholm model show that consumer pays get a better focused care and there's a multitude of contracted-licensed producers to choose from that gives a new dimension to freedom of choice for the patient and new branches emerging, not to forget.

In Sweden, we believe, at least we are good on health care and we are good on pharmaceuticals, we have been, at least.

And why shouldn't we able to make a new combination, what you call health care services but, of course, you can't develop that kind of new services in a monopoly situation, you have to have a competition.

The employees get better conditions, as I said, politicians can renovate their assignment, concentrate on their old genuine assignment, I would say, to represent the patients, not the production.

And, of course, the consumer or tax payers get more health care for their money, more result for their bucks.

So with this, I'm not advocating a specific system, I'm not trying to sell a ready model, I don't think these models exist so much of local conditions, et caetera, you have to consider but what I'm trying to do and I hope you appreciate it, is to give you a picture what's happening in Sweden, in... mainly in the Stockholm area and maybe that could start a new kind of discussion in Canada.

Thank you.

M. MICHEL KELLY-GAGNON:

So thank you very much, Johan. As I mentioned, we will have very exactly fifteen (15) minutes for a Q and A period.

So I... I guess the only system that we have since we don't have microphone all over the place is I'll try and run toward you, once you raised the hand, and hopefully it won't go from back to... but... or you might want to walk toward me and promise that you'll give back the microphone afterward.

MR. MIKE ROPER:

Mike Roper of Montreal General. I was surprised how closely you match Montreal in your population served, one point eight million (1.800,000) people is about our population.

We service about two point eight million (2.800,000) considering a referral from our file and in many ways our medical manpower and our number of beds do not take into account that, how does... how does Stockholm... do they receive extra funding if they get referrals from... from other areas, in regional funding, how is that managed?

MR. JOHAN HJERTQVIST:

That's right, we have an inflow of patients from other parts of Sweden, as many people not living in the Stockholm region work here and of course, some people come here because of a short waiting lists, but you have a large number of specialists, et caetera.

So that's right, as a commentary question, that's an extra funding, the... the council, where the patients live, pay a certain sum to... to the council that produces the services, so to say.

So that's a certain flow of money between the council... not very large sums, I will say, but, of course, if you get some kind of national health service markets where people tend to move more between different councils in different hospitals, you have that right already, you have maybe, I should stress that, in Stockholm region, you have a patient guaranty or treatment guaranty saying that maximum waiting time of ... of ninety (90) days, I would say that it's rather rare that you have to use that time but you have a limit there.

If you can't be offered examination or treatment within that period, you're allowed to go to another part of Sweden, rely upon other councils.

And then, of course, the Stockholm region have to pay to other parts of the country, that's the way it's organized.

UNIDENTIFIED VOICE:

Hi! I was wondering if you could tell us a bit about the problems or difficulties that you've encountered with your experience, I'm thinking that presumably, not all of the benefits can be attributed to competition, for instance, in terms of integration of services, continuity, quality, the contracting process and criteria are key, I'm wondering if you could talk more about that aspect.

MR. JOHAN HJERTQVIST:

What's critical in this system, as I recall that you have competent partners working together as in all other markets where you buy and sell things or services.

That is that you have to build competent staffs, formulating the demands, standards, what you want from the contractors, how you build long-time relation with contractors and the service markets.

And that's not very easy if you don't have that background and as this system is new in Sweden, we lack that tradition.

In the Stockholm region, you lost ten (10) years gradually built it, but as you saw from my pictures, you started with the technical services, you moved to primary care and now, you're moving to emergency health care and that means, of course, that you are, today, quite good, I would say, when it comes to ordering laundry services, ambulances services or maybe also primary care.

You had a number of years to build that competence but, of course, when it comes to requiring and buying emergency health care services, it's... you lack the... the background and of course, these services are much more complicated.

So to be able to run this system, you got to have that competence and of course, you have to be able to create good dialogue with the... the producers.

As you know, in other markets, you have to be two (2) to tango, as they say, you have to be two (2) to be able to develop services, you can't sit in your ivory tower as a council and then formulate demands and not without knowing that contractors are ready to fulfil their demands.

So, that is quite a challenge to build that competence and I know that in the council of Stockholm, they are looking virtually all over the world to... to learn from different kind of experiences.

So that's... you're right, to... if this reform should work out to optimum, you have to build that kind of competence and that's not... not quite easy.

M. MICHEL KELLY-GAGNON:

We have a list of people who want to ask questions, we're obviously not going to be able to take them all, I apologize for that.

I want to say though that after the event will be formally over, some of the people have to run away, I will... but I know for a fact that Johan, for example, might stay for another extra thirty (30) minutes.

So after the event is officially over, if you want to stick around, we do want you to have a shot but we just can't do it all.

And now, Dr. Gratzer is going to be allowed to ask a question since he will have to jump on a plane and won't attend the panel questions so I'll do a small violation to our rule and then extend to the next question of the gentleman back there.

Dr. DAVID GRATZER:

Just a very quick question, this concept of internal markets has been tried in other places, Britain, New Zealand and so on.

The British experience is much less favourable, what did you guys do right and what did they do wrong?

MR. JOHAN HJERTQVIST:

I think good... it's a good question, I think, of course, certain influence came from UK, from the USA, I would say also when it comes to measuring results on, but from the beginning, this was not very sophisticated, it was a built-in, made in Sweden and I think it's a combination of... that you moved rather gradually forward, you didn't take all the bite in one step.

And that we've been able to... or the council, I would say, been able to create quite a good working relation between the purchase and provider.

And, of course, that many of those companies are quite new, they are not, as you... I hope you noticed, based on (inaudible) who have been in business for, let's say, thirty (30) years.

But a lot of paramedics, young doctors, no critic towards older team (inaudible) don't take it that way.

But also, paramedics, nurses, et caetera creating new companies, maybe without the reference, the historical reference, they look upon themselves as rather new players and not as if they had some kind of... of possession they have to defend and so on.

That might be not very sophisticated, not very scientific explanation but I don't think it's... it has some truth in it.

M. DANIEL DESLAURIERS:

Yes, Daniel Deslauriers. Thank you, Mr. Hjertqvist, for your nice presentation. As a medical biochemist and lab manager, I'm particularly concerned about the quality control and the quality control measurement.

So just, for example, in the lab testing area, we can make the same measurement with different kinds... kinds of tests at different price, different in prices and different in quality too.

So how can you be sure you could get the best quality at the best price all the time in your system?

MR. JOHAN HJERTQVIST:

Let's say that you got the quality you asked for, you got enough quality, all those contracts are probably not based upon achieving, what you call, top quality but let's say, optimal quality, that is good quality for... for lower costs.

When it comes to quality control, which is one of the key factors, of course, in the system, you have the national authorities checking up quality, when it comes to deliverance of different kind of services, you have regional authorities, of course, going into scrutinizing these contracts.

And the good thing is that if you don't get the quality or the services you're paying for, of course, you can... you can break a contract, you can make the... a contractor got to pay back some of the money they had received, et caetera.

So that has not been very common. Maybe you should have been more drastic in some cases, I guess, but in general, quality of services had not been a critical factor in the Stockholm region, I would say.

MRS. ANGELA CHAN:

Hi, it's Angela Chan from Montreal Retinite Institute, it's an eye institute. I have two (2) short questions.

The first one is: do you see an eye center become one of your contractors? The second question will be: how do you increase the doctors' productivity?

MR. JOHAN HJERTQVIST:

To start with your first question, yes, we already have an hospital specialized on eye treatment, that's turned into a... also that one is turned into a... a council owned company and it's operating (inaudible) as independent actor, you can say, with quite good results up to now.

And how do you increase productivity of doctors? That was your second question. By giving them larger freedom to find their own solutions, I would say.

In Sweden, in general, you can say where you have a large freedom to define the way you do the operation, it could be education, it could be health care, it could be nursery homes, whatever.

So you're quite free, in general, to organize the activities, to amend them, et caetera. And what we see in the Stockholm region is that when you let creativity be combined with this freedom, you get quite a good result.

I would say that productivity in health care, many people say that you don't have any increase of productivity in health care, I don't agree, I would say that Sweden and probably a lot of other countries show that you have increased productivity quite rapidly if you look upon how you improved techniques for... to treat people.

You can, for example, today, do surgery, heart surgery on people eighty (80) years old or maybe older.

You couldn't, ten (10) years ago, a lot of these people would have died, et caetera, et caetera. You can... I put actually on this web site I gave you one document we developed together with KPMG, the consultants and in other projects showing this... how productivity increased in health care.

But it could be more... done much more, of course and if you are free to organize your operations, the company you build together with colleagues, nurses and so on, we probably will be able to even more increase productivity.

M. MICHEL KELLY-GAGNON:

So thank you very much. As I mentioned, I realize there are at least a half a dozen, probably more people who want to ask question and Mr. Hjertqvist is going to stick around for another extra thirty (30) minutes at least after the event.

So I want to thank you very much, I think it's been very informative and people have appreciated, so thank you and... So we're going to move along...

MR. JOHAN HJERTQVIST:

Yes, excuse me...

M. MICHEL KELLY-GAGNON:

Sure.

MR. JOHAN HJERTQVIST:

... Michel. Thank you very much and I also appreciate that you put me first in the waiting list because when speacher number 3 or 4 showed his forty-six (46) overhead pictures, you will be rather tired so I'm glad I'm one... first in line, thank you.