Montreal Economic Institute

Ideas for a More Prosperous Nation

Health Care: What the Romanow Commission could learn from Swedish Reforms

Speech before the Montreal Economic Institute by Johan HJERTQVIST, Manager, Health Unit, Timbro Policy Group Montreal, April 15 2002

I. Presentation by Johan Hjertqvist

I'm very happy to say that when it comes to my relation with Canada it all started here, in this very building, two years ago when I was invited by Michel for the first time to visit Montreal and Canada to lecture on the health care reform process in Stockholm. And I'm of course very happy to see that some of those ideas and reports have been - maybe not implemented in practice - but at least, to a certain extent, "mentally" implemented in Canada. And that's due to some kind of growing feeling that there's a need to reform the Canadian health care system.

I will meet with the World Bank on Friday in Washington and I will tell them that in the future they shouldn't take two years to refer to my writings! No more than three months should be a reasonable waiting time, in health care as well as in getting published!

Swedish and Canadian attitudes

To return to the subject of this evening, it's very nice to be back. I always notice how many things remind me of Sweden when I come to Canada. Not only ice hockey but also the attitudes, especially in health care. I provoked people the first and second time I was here by saying that the "policy attitudes" regarding health care in Canada remind me a lot of the way we used to look upon those things in Sweden in the 1980s. We then still regarded Sweden as unique, very special: "you should be grateful you were born in Sweden and have access to first class Swedish health care". Today we don't have the same "self-esteem" after the early 1990s severe economic crisis. We had overlooked a lot of attitudes and today we are moving into a more open "climate" in Sweden.

But of course when it comes to health care we still have a lot in common with Canada. I noticed one perhaps less positive [example of] cooperation between the Swedish Health Minister - who will be in Canada next week - and his Canadian counterpart. Evidently, Mr. Engqvist got the impression that it would be a good idea to import some of the restrictions you have in Canada regarding a public-private mix of funding. So he suggested that you ban in Swedish law the opportunity for private insurance to buy services and production capacities in publicly funded hospitals. You don't have that kind of transactions today but evidently the Minister believes that it would be a suitable regulation for Sweden. While, to me, such transactions would be a step in the right direction. So, I guess next week you won't get exactly the kind of description of the situation in Sweden that I will provide here today. No wonder as health care is one of the main battlefields in the coming Swedish general election. Evidently, both left and right believe that they will gain from dramatizing the situation. I will tell you in a minute that in the basic discussion there's a general agreement between left and right. But there are some differences too and both sides focus on these more drastic features.

Post-tayloristic health care

I would say that to understand what's happening in Stockholm especially - there are reforms in other parts of Sweden of course but Stockholm is ahead of the other county councils - you ought to look upon what's happening in other parts of the economy, not only in Sweden but in most

developed countries as well. What you see is that when it comes to service production - and to me health care is part of the service industry - you can say that we're moving from hierarchy to networks or flat organization. You move away from regulations and directives from above to implementing more market incentives, you build much more on the enthusiasm and the motivation of co-workers, you build relations with the consumers, and so on. That's the way you deal with those matters regardless if you work at McDonald's, an energy department or whatever it is. We're moving away from tayloristic approach or tayloristic society where you produce enormous quantities of products for clients ready to accept the "Black Ford Car" as there's no alternatives.

In health care you still have this tayloristic approach, I'm sorry to say. You have a lot of hierarchy, you refuse to accept the consumer as an equal partner, you still look upon the client, the patient, as an inferior partner in the relation. You deny the need for good working conditions when it comes to the staff, etc. So you have a focus on the production side. You're much more interested in - especially when it comes to politicians I would say, at least in Sweden - the processes and the way you organize production rather than the quality of the outcome for the consumer. Of course to develop efficiency, to keep the reliability and acceptance from the public, you must change this pattern quite dramatically.

In Stockholm, this is one of the key driving forces I would say. You notice quite dramatically that you have recruitment crises - and I understand from a conversation I had with Edwin Coffey a couple of minutes ago that you have the same conditions in Canada too. People are turning away from health care. Working as a doctor, a nurse, a midwife, etc., is not as attractive today as it was 10 or 20 years ago. There was a poll just a couple of weeks ago showing that of all new young doctors working as trainees before their final exams, one out of two said "I will never work full time. I can think of working as a doctor but I want to have a lot of free time for my hobbies, for my family, and so on. I will hardly work for a county council. I would rather want to work for a private health care producer." 1% of all doctors said that they couldn't think of working as a doctor in health care, and the same with the nurses. It's a general trend, we're moving into a recruitment crisis. And Europe as a whole, as a continent, is ageing. We will run into quite severe crises if we don't open up for immigration or take some kind of radical action. So the demography is quite negative and it will also affect the funding.

The information we get from this kind of picture is that you must rethink the way you attract, recruit and handle people working in health care. In Sweden we notice that an increasing number of health care personnel suffer from different kind of burn out syndromes related to the incapacity of the employers (the councils, the cities) to handle the policy personnel. That's again the old style tayloristic approach. You for long, could tell the world that "Ok, some nurses quit and never come back, but we'll recruit new ones, it's not a big problem." But that's not the situation today. You must build better productivity to deal with the long waiting lists, you must improve efficiency. And what's efficiency in health care? To me it's not to meet the budget goals, to me the idea of health care is not to keep the budget within limits but to provide good health care for people.

So you can say, if you put the Stockholm reforms into perspective, that you notice a number of steps taken to implement a post-tayloristic system or strategy. And how do you do that? You do it by supporting personnel who want to stay in health care but wish to operate under new conditions. That is, that you, as a doctor, nurse, mid-wife, lab technician, etc., can run the operations yourself. You can join a number of colleagues and start a company, you can get a contract to run a primary health unit for example. So you can remain in health care but you get more freedom, you get the right incentives, you will be much more satisfied. We have a number of evaluations showing that. But you can contribute to health care production. And we notice in Sweden that a large number of young people interested in entering health care want to do it as entrepreneurs, not as hired personnel.

You must also build this partnership between producers (providers) and clients or consumers. As the health care of tomorrow will be built from networks where you must rely on partnerships, you really must start using, inviting the consumers or patients to add their competence. The patient is no longer weak, badly educated, etc. Today more and more consumers want to take part in the process. They want to make their own decisions and cooperate with their doctor and the health care personnel. That's the case in Stockholm and probably is in Montreal as well.

The purchaser-provider split & public funding

You must also, I'm quite sure about that, invite, in the long run, new funding. We had a discussion before the conference about the lack of funding in Canadian health care. You notice that we have public funding in Sweden today, except for a small user fee. That's not controversial. Nobody in Sweden advocates that you should replace the public funding by a private system. But I'm quite sure that as the demand increases and the number of productive people paying taxes goes down, you will be forced to open up for additional funding from private insurance and from other sources.

In Stockholm, the system allows freedom of choice, very well reflecting the shifting values of the well educated, quite demanding population. They want the potential to make their own choices and in Stockholm the system works like that: we have public funding but a large number of providers work on public mandates (contracts) and patients have the freedom to visit any producer. We don't have any regulation regarding reference of patients. You can visit a specialist without first having to consult with a general practitioner. (There were attempts to introduce this kind of regulation but they failed every time) People in Stockholm evidently want to safeguard their freedom of choice. So we have an indirect vouchers system. The funding follows the patient and the producers attracting large number of patients will gain from that in comparison to the ones who are less attractive.

Waiting lists: the Stockholm standard

We also have a guarantee system, meaning that you can't wait more than three (3) months for treatment (between examination and treatment). And that guarantee, considering Swedish conditions guarantees quite short waiting lists. It means that in Stockholm you can have a hip replacement in 90 days; in large parts of Sweden it would take you a couple of years maybe. And that goes for all kinds of treatment. Supreme access is very important to people living in Stockholm who would, again, never accept the kind of waiting lists we have in less reformed parts of Sweden.

So my ambition and my hope is that Sweden will continue to deregulate its health care system, introduce more market incentives. I said in my introduction that health care policy would be a very hot topic in Sweden's upcoming elections, but here I'm happy to say that in general both left and right agree on the consumer influence. We agree that waiting lists must be shortened. The Health Minister declared just a month ago that the ambition is to spread the 90-day Stockholm standard to the rest of Sweden within three (3) years. He's moving from the left to the centre as the whole social democrat government now evidently is.

When it comes to primary care it's quite interesting. The national government welcomes all kinds of private producers so we'll gradually have in other parts of Sweden a growing number of private producers contracted by the county councils and operating with public funding to deliver services to the population. It's quite evident that we're moving in the right direction: more incentives, more decentralisation, more provider pluralism. It would be bad if the Swedish government got the impression that the kind of regulations you have in Canada would be a good thing to import in Sweden. To me that would be a wrong direction to take.

The only reasonable way to look upon the future of health care is that you put health care, as I mentioned, into the big perspective, the big framework of service production. You must reform the way you relate to the consumers or patients. Then you will be able to increase efficiency and safeguard the freedom of choice. And by those measures you build a pressure from below. You can't force health care to become more efficient with signals from above, only by implementing a consumer pressure from below. And by doing that you can develop health care.

Growing costs

You must probably accept, in the long run, growing costs, reflecting not only the demography I referred to earlier but also the changing values of individuals who put a higher price on their well-being and their quality of life. That's quite an important and basic shift of value you notice in all developed countries. In a democracy you can't prevent that kind of change. As a politician, as an administrator, you must try to manage that kind of change but you can't prevent it, you can't say

that people's values are of no concern. They are! And to me that's not a threat, it's more of an opportunity to reform health care by putting in place new strong signals from the consumers.

I heard from Edwin Coffey that every new poll trying to assess the Canadian public opinion on health care funding say that people want to keep public funding but also want an opening for additional money. That's one of the important reforms of course. You can't look away from that need. And while safeguarding equal access - which to me is quite important - you can combine, you must combine interests that today might look as if they are antagonistic. They aren't to me! They could join and become a force to develop health care. Anyhow, I'm rather optimistic about the future of health care. It will look quite different tomorrow but it will probably look much better than today. Thank you!

II. Question period

Michel Kelly-Gagnon, Executive Director of the Montreal Economic Institute

Thank you Johan for that speech. I would have a critique which is that you have been way too modest because since 1993 the reforms in Stockholm have had a spectacular impact, especially the privatization of health care and its impact on waiting lists. And although you alluded a little bit to this I would like you to elaborate a bit more because, again, the data that I'm aware of are quite impressive and I'm sure that our audience would like to know what the situation was before privatization and what is the situation after.

Johan Hjertqvist

We have a deal Michel and I… I'm always too modest in my speech and he then has the opportunity to correct me! But that's quite right and I will elaborate on that.

In the beginning of the 1990s we had quite long waiting lists in Stockholm as well. Then a number of steps were taken. One was that "you get paid for the services you deliver" (not the services you promise) was introduced when it comes to reimbursement of hospitals. That increased the productivity by 19% from one year to another. A number of scientific evaluations noticed that a control group of unreformed county councils (with global budgets) increased its productivity by 2.4% between 1990 and 1993 compared to the council of Stockholm with a 19% increase due to a combination of production increase and reduction of costs. You can also notice that using other methods, inviting private producers (contracted on behalf of the council) they added a lot to reforming the way you treated the patients. It brought a number of good ideas into the system. You also increase the independence of the hospitals. Today they are, or are in the process of becoming, publicly owned limited companies. You may add the purchaser/provider split also. With this split you separated the politicians, made them leave the production side, to focus on representing the electorate when it comes to formulating the vision, the demands, and so on. Together those reform steps reduced waiting time quite dramatically and, as I gave you the figures today, it's now very acceptable for Swedish conditions. But you notice for example that the new government in Denmark is going for a 60-day or two (2) months maximum waiting time. So they're ahead of Sweden.

You can also notice as an outcome of the reform, an increase in the number of private producers. Today you have 150 new providers contracted by or operating on public funding, therefore reforming the health care personnel labour market. For the first time nurses and doctors can vote with their feet. They can leave incompetent employers (councils) and, due to the lack of personnel, they're of course able to raise their salaries quite well. That's why the health care trade unions are quite strong advocates of the reforms. They have been for a long time and, since a couple of years the Trade Union Congress (the social democratic union you can say, for the less skilled staff) also supports the transformation of health care in Stockholm. They also support the important actions taken by the private producers.

Caroline Barbir

I'm at an extended care facility in Montreal and I'm very intrigued by the Stockholm standard that you were describing. I was wondering how long it took to get to the standard and get the standard applied. What were the incentives that were used to get the institutions to accept the standards

and to abide by the standards? Are there sanctions if institutions do not abide by the 90-day standard?

Johan Hjertqvist

There are no legal sanctions in the Stockholm system. There's a discussion about implementing a national access standard similar to the Stockholm standard as I mentioned. But it's not according to Swedish tradition to make such laws. There will be some kind of agreement I would say. So, still you lack the strength as a consumer. You can't sue the provider or the council. But as a benchmark, as a guideline it would be fairly efficient. In Stockholm this kind of access regulation was introduced in the early 1990s by the regional conservative government but it was taken away by the social democrats when they returned. Now, it's effective again and today I would say it's also very efficient. You see the same king of guarantees on other parts of Sweden but they're more "showcases", they're not very efficient. They're more ambitions than real standards.

Dr Abel Assaf

I'm from the Montreal General Hospital and I'm also interested in the Stockholm standard. How does the population accept - if I understand right - that the Stockholm standards are only for Stockholm and not applied in the rest of Sweden? How does the population accept that 50 kilometres from Stockholm they can wait for two (2) years for a hip replacement while in Stockholm they get it in three (3) months?

Johan Hjertqvist

It's a good question. An increasing number of people don't actually, meaning that they turn to their own council and say "Now I want to use my freedom of choice, I want to go to Stockholm to get my hip replaced." So, there's an increasing flow of patients coming to Stockholm to get treatment. Of course, the Council of Stockholm is quite happy to charge the other councils for this service. It's a fairly good situation as you now have surplus of production capacity in Stockholm. People in general are quite conservative in this respect I would say. They prefer to get treated in their neighbourhood, closer to their home. And I guess that's the same thing in Canada. But as people are getting more aware of their rights or these opportunities, I'm quite sure that you will have increasing mobility among patients. In fact you have a national health care market in Sweden. You can move around, optimizing the access if you need treatment. Still very few people do but I'm sure that in a couple of years you will see that kind of mobility.

Belinda Hall

I work in a CLSC in the government of Quebec health system. I wanted to know what was the reaction of your unions, specifically about the privatization of services.

Johan Hjertqvist

This is one of the most striking things to foreign observers. The traditional attitude of trade unions, at least in health care, is to oppose and block any kind of change. That's my impression. But in Sweden one of the strongest advocates for reform - for the kind of reform I described - has been the chair of the nurses union. She's been travelling around… Her attitude, reflecting the attitude of most of her members, is quite rational to me. As I said before, as a nurse or a doctor, you just had one potential employer, if you didn't want to move to other parts of Sweden, and that was the county council. And we know that most monopoly employers are not very engaged in developing the working conditions of their staff, why would they? Today you have dramatically different conditions in Stockholm. You can make an active choice among a couple of hundreds of employers. That has improved the working conditions quite strongly and raised the salaries. So the attitude of the unions has been quite positive from the beginning and today that also goes for the trade unions intimately linked to the social democratic party. They had a referendum just six weeks ago among all their members and they now accept the role of private producers within the public system. So I would look upon the unions as advocates for change. Without their support, the whole transformation would have been complicated.

Dr. Edwin Coffey, Associate Researcher, Montreal Economic Institute

I'm very interested in your data and your outcomes. And certainly the data on waiting lists - decreasing the waiting lists for patients waiting for bypass, cataracts, hip replacements and so on -

are very impressive. Also the acceptance by health care unions. This is something we can hardly envisage and yet it's happened and I think the message we're all getting is that there must be something valuable in the Stockholm experience as far as unions are concerned.

My question, if your jetlag is not catching up with you, is from the patient standpoint, and this is what we always come back to when trying to emphasize as you did the importance of having the patient at the centre. Whatever changes occur must be satisfying to the patients and to the outcome of their illness and so on. In Stockholm, have you had the opportunity to survey the population and particularly the people who have experienced both the old and the new system with greater application of private sector forces to see if in fact the patients are more satisfied, less satisfied…? Are they looking for private providers versus public ones? I'd like to hear your comments on that.

Johan Hjertqvist

That's of course a very important question. What we notice in the whole of Sweden is that people are gradually becoming more critical of health care as such. But if you look upon the patients who are used to or made active choice, you notice that their response to the new system is positive. You will also notice from a number of polls in Stockholm that you get better rating when you turn a primary health care facility into a doctors/nurses coop or co-workers owned company. Then you get an improved rating. The people, the patient, evidently appreciate that kind of change. We also know - there was a large survey just a couple of weeks ago covering almost all county councils - that people in general are more satisfied with the private producers, the private general practitioners, the private specialists, etc. They get better ratings regarding access, the way patients are treated, information, and so on, than public ones. The differences are not dramatic but significant anyhow. You can also notice among the co-workers that they appreciate working for the privately owned producers who, I want to stress again, work within the public system with public funding. Evidently co-workers look upon the private producer as more competent when it comes to handling personnel. They have better access to middle management. They are more aware of the conditions going on in the organization. I would say that in general people appreciate this.

Then you have a general criticism of the way the health care works, and that goes also for Stockholm. People in Stockholm are I guess very satisfied with the waiting lists. You would have a very strong reaction if you said that today you can get a hip replaced or a cataract surgery in a couple of weeks but next year it will take two years. You would get a strong reaction. But when you're in Stockholm you don't compare the situation with other parts of Sweden, you compare with other parts of the region.

Jean David

I'm very interested in the approach that you took about the perception of the system itself or what the system is for. Something that surprises me a lot in Canada right now is that we're talking more about the health of the system than the health of the people. So I really appreciate the fact that there was a different perception in Sweden. Can you develop a little bit on that?

Johan Hjertqvist

To me it's one of the basic things and I would like to quote you on that. It's not the system that you should safeguard, it's the health of the consumers, the satisfaction of the people. And to me it's quite evident that you must put the reform you see in Stockholm into this broader perspective. If you try to isolate health care, if you try to maintain the pressure for yesterday's conditions, then you will never be successful. You can't force people to be satisfied! You can't force workers to feel enthusiastic about a system sending the wrong signals. Again, if you look upon change this way, the traditional left and right perceptions are of very limited value. You notice a long-term development when you leave a taylorisic system moving to a new one. We don't know exactly what it will look like. If you try to isolate health care from these long-term changes, you will never be able to meet people's demands and requirements.

Michel Kelly Gagnon, Executive Director, Montreal Economic Institute

One thing that I would like you to do is to tell us about the biggest hospital in Stockholm that is the property of a private company listed on the Stockholm stock market. It was interesting to me to see a large hospital being owned by a private company listed on the stock market and yet we don't

see Swedish rivers filled with dead people. So, I'd like you to elaborate on that but before we'll go to Mrs. Sandra Wilson.

Sandra Wilson

You told us about the "before" and the "after". What I'd like to know is: what was the impetus? What started the reforms? Is it a group of doctors who got together and said this is not good enough? Was it a group of people who formed a lobby group and said it's not acceptable? How did it start?

Johan Hjertqvist

A number of politicians were instrumental in these reforms: social democrat as well as conservative politicians who were quite fed up with their lack of influence in the late 1980s. They noticed that they were putting more and more money in the system while the waiting lists kept increasing all the time. So they got together behind closed door, decided that something dramatic needed to be done about the fundamental way the system worked, or didn't work. So that was why, I would say. They got support of course from some senior professionals. Some others, evidently, didn't like what was happening in the beginning. But you can say that the politicians really made a difference. That was the origin.

About the St. George (St. Goran) hospital, that's quite right. One of the emergency care hospital in Stockholm (we have seven in total) was sold by the council in 1999 to a big listed health care production company. And that's been quite successful. This hospital was the first one in 1994 to become a limited company. So it was mature for selling in the late 1990s. This hospital is, and by far, the most efficient. It's roughly 15% more efficient, if you look upon the compensation system. They do certain treatments with 15% less funding than most of the council owned hospitals. They are reinvesting their profits, the co-workers are quite satisfied working there, and they deliver supreme quality. And in the contract with the council there's no room for "creaming", in other words they can't turn away complicated cases. They also accept insurance funded patients, but that's less than 1% of the total income. So they're basically operating on behalf of the council and that's been quite successful. You evidently have a couple of other councils planning to do the same thing. But there's currently a moratorium imposed by the national parliament to see how you can prevent such transactions in the future. And we'll see whether it will be an import from Canada or some Sweden invented idea. But something will happen there evidently.

Pierre-Jean Dion

I'm mostly involved in primary care groups pilot projects and performance measurement studies. I'm impressed with the features and benefits but I'm wondering about the costs! Unions are happy, patients are happy, workers are happy. Who's unhappy?

Johan Hjertqvist

Taxpayers! I wouldn't say that everybody is happy… Trade unions are never happy but they are much more satisfied than you could imagine, at least if you imagine an alternative scenario. The health care costs are increasing quite rapidly in Stockholm, just like they do in unreformed "old style" councils in the rest of Sweden. Good question…

To me it's not realistic to believe that you can make reforms in health acre and reduce the total cost. That will not happen. You see increasing demand, you have a shortage - at least in Europe - of health care personnel, you have scientific development driving costs, and so on. Of course you must always think of the alternative scenarios. To me it's quite unrealistic to believe that you could keep the old system and still deliver better access, better working conditions required by personnel, and so on. The costs will certainly be a challenge but what's the realistic alternative? To me you must accept that the share of health care spending will increase. Again, reflecting tayloristic values, we've been chasing percentages… And don't read me as being sloppy when it comes to cost but to me it's the wrong starting point to say "We use only 8% of our GNP compared with your 9%, we're better, we're more efficient".

Caroline Barbir

Talking about percentage of health care spending in relation to GDP, how should industrialized nations be looking at health care spending in terms of percentage of GDP and what's the situation in Sweden?

Johan Hjertqvist

In Sweden we went down from 8.5% to roughly 7.5% in the mid 1990s after reducing costs heavily. We had to as Sweden as a nation was an economic mess. Now we're returning to the 8.5% level and the national government declared that according to demography, increased demand, etc., it's realistic to imagine that in ten years from now we will reach the 10% level or around that. But that kind of perspective looks like planned economy to me, to say that we should reach 9, 10 or 11%. But there's no doubt it will increase. What's the appropriate perspective to answer your question? For long the idea has been that health care is a cost problem, if you reduce the percentage in relation to GNP then you're quite successful. And if the share increases than you failed. To me that's a strange way of looking upon it. I mean you deliver very important services. People gradually appreciate these king of services related to quality of life. To look at putting a priority on better health rather than other kinds of consumption as a problem is a strange way of looking at the issue to me.

But then of course you must build into the system reasonable and efficient incentives to make the consumers realize that they're not "free of charge". You must have a mix between private out-of-pockets spending and public spending, so you get the information. That's one of the reasons why the Swedish system included user fees. I know that's controversial in Canada but in Sweden you add a small amount yourself. And user fees in health care and pharmaceuticals are a powerful information system telling patients or the consumers that there's no such thing as "free" health care.