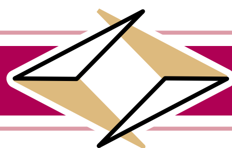
ECONOMIC  NOTE

Montreal Economic Institute

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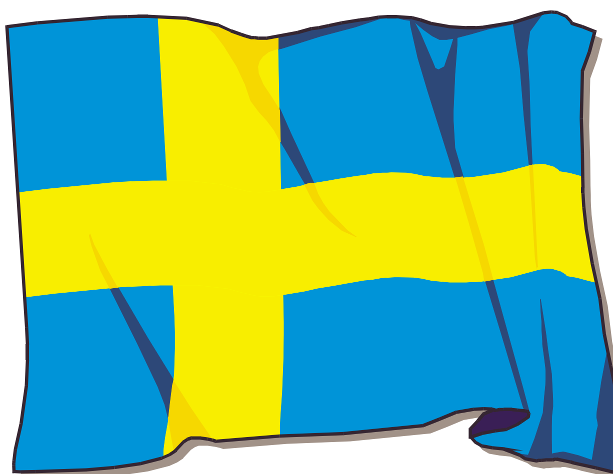
Turning to the private sector in health care: The Swedish example

Hardly a week goes by without headlines proclaiming a crisis somewhere in the Canadian health care system. Unfortunately, even though health budgets are the public spending item with the largest increase in the last few years, most of the people at the centre of this debate seem incapable of viewing the problem through anything other than a budgetary or bureaucratic scope. Reform proposals that grab the attention of politicians invariably involve the injection of fresh public funds or the creation of new monitoring and planning structures such as the Canada Health Council that is about to emerge.

Sweden's recent experience shows us that it is possible to increase the efficiency of the system by means of market mechanisms while maintaining universal care. Despite broad fears that turning more to the private sector would lead to a two-tier system, notions of profit and competition are not incompatible with the idea of health care for everyone. The existence of a parallel private system is seen as the norm in nearly all OECD countries.

In the 1980s, the Swedish health care system experienced enormous problems similar to our own today. There were long waiting lists for essential services. Hospital employees had low salaries and poor working conditions. It seemed impossible to meet growing demand merely by increasing taxes and spending — and this was in a country known everywhere for the generosity of its social programs.

In Sweden, local governments are largely responsible for managing the health care system. Stockholm, the capital and largest region, is where the reforms were undertaken first, which is why we hear today about the "Stockholm model".



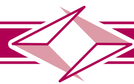
Raising the number of suppliers

In a centralized public system, the patient is a source of *spending* for managers. They have broad budgets to administer, and each additional patient digs into these budgets. There are few incentives to become more productive since this has no impact on an institution's income or on its employees' salaries. It is simpler to demand budget increases. When demand exceeds the system's financial capacity, services have to be rationed, resulting in overworked staff and long waiting lists.

The basic logic underlying the introduction of market mechanisms is that, for a private administrator (or the administrator of an independent institution competing with others inside the public system), the patient becomes a source of *income*. The more patients an establishment attracts through the quality of the care it provides, the higher the demand for its services and the better its business. Reducing costs by means of greater efficiency becomes a priority since this has a direct effect on the institution's surpluses and profits. Maintaining attractive salaries and a work climate that motivates employees is also necessary. Otherwise, they will go elsewhere.

This is what the Swedes have understood. To improve the efficiency of their health care system, they began over a decade ago to break up the state monopoly on the distribution of services by allowing entrepreneurs to compete with an overburdened public system.

In 1992, the Stockholm regional government set up a program through which public sector employees could take control independently by managing certain units. To attract offers, the government provided entrepreneurs with training and legal support to start their companies. In 1998, all medical services other than emergency services were put on the market through public bids.



There are now more than 200 small and medium-sized health care suppliers in the process of replacing the single provider. Among them are a number that were created by nurses who were unhappy with poor working conditions and mediocre salaries and who jumped at the opportunity to set up their own businesses. While unions in Canada are viscerally opposed to any privatization of the system, the nurses' union in Sweden actively supported new businesses and even created a body devoted to research on novel forms of entrepreneurship. The new suppliers run local health care centres, general practitioners' clinics and centres specializing in postnatal care as well as laboratories and psychiatric clinics. Praktikertjänst, the largest supplier in the private sector, operates as a production cooperative owned by doctors, nurses, psychiatrists, dentists, physiotherapists and support staff.

Since competition began in the area of nursing care, salaries have gone up much more quickly in Stockholm than elsewhere in Sweden. This is a crucial element in hiring and keeping skilled staff. A remuneration system based on performance rather than age or years of service also encourages medical staff to be more productive in the private companies that have applied it.[1]

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In 1994, the Stockholm county council went further and converted one of the capital's seven hospitals handling emergency cases, St. Goran's Hospital, into an independent corporation with the aim of privatizing it. Four years later, the hospital was sold to a private Swedish company called Capio AB, listed on the stock exchange. It is important to understand that, despite its status as a "private" hospital, St. Goran's continues to operate within the public system, and its patients are not expected to pay for the care they receive there. The purchase and financing of care are guaranteed by the county council while Capio looks after providing medical treatment.

Since being converted to a private company, St. Goran's has become the capital's most efficient and least costly hospital, achieving yields 10% to 15% higher than those of other hospitals.[2] This greater efficiency enables it to run at a profit. Other hospitals have been converted to commercially viable limited council-owned companies and are thus saleable, even though a moratorium has been imposed for the time being on their sale.

More efficient public management

The separation between buyer and supplier of services is a notable characteristic of the Swedish model. Until the 1980's, these two functions were combined at the county council, which was in effect the only employer and the only producer. The same local politicians who determined what was needed and who voted on the overall budgets were involved in decisions concerning the production of services. The suppliers (hospitals and clinics) received overall operating budgets that took little account of each institution's real costs nor of the quality of care provided. Setting these budgets involved internal lobbying and administrative diktats. The institutions had no incentive to analyse sources of inefficiency or to reduce costs.

A series of administrative reforms resulted in a decentralization of management power. In addition to the privatization of certain units and greater autonomy for units that remained in public hands, this separation led to financial decentralization. In 1990, the Stockholm county council set up a new health care financing system. The costs of nearly 1,000 medical procedures were analysed and evaluated on points based on Diagnosis Related Groups. This system provides for measurement of resources needed to produce treatment. Each hospital is paid for medical procedures according to the cost of DRG points. For example, cancer treatment is reimbursed differently from cataract treatment. A system of contracts based on the number and type of medical procedures that the institution provides has replaced overall budgets.

The DRG system works for the public as well as for the private sector. All providers are reimbursed at the same price, a reference price defined by spending at the most efficient hospitals (of which St. Goran's is by far the least costly), to which a margin is added if a hospital can justify higher costs.

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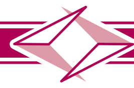
[1] Lofgren, 2002, p. 43; Hjertqvist, 2002, p. 27.

[2] Hjertqvist, 2002, p. 22.



The least productive hospitals thus have to improve their efficiency to avoid chronic deficits. This is a flexible and dynamic form of planning since the reference price can be adjusted with the advance of technology.

The DRG system increases the efficiency of the system while encouraging cost reduction. It offers a clear advantage for hospitals and for the doctors themselves: the handling of each case represents a sum of money, in other words, income. The more patients a hospital treats, the more the system pays. This gives hospitals an incentive to do so as efficiently as possible since all expenses falling below the reference price generate a surplus (that goes back into the system in the case of public hospitals) or a profit (in the case of private hospitals). In Stockholm, hospital productivity rose 19% in the year following the system's implementation.[3]

Individual choice

Individual choice has been a major theme in reforms to the Swedish health care system. Patients have the right to choose not only their family doctors but also their specialists at any stage of treatment. They are thus patient-consumers. The idea of choice forms the basis of competition in the market, which in turn leads to increases in the quality and efficiency of service. Patients' choice is also important in the sense that it guides government financing. Public funds follow patients wherever they decide to go. A hospital or clinic that fails to satisfy the needs of its patients loses customers and income.

The Stockholm county council has established a system of guarantees under which patients can receive treatment at another hospital in the city or even in another region where services are available if they are unable to obtain required treatment at the hospital of their choice within three months. To help patients make these choices, a Web site offers detailed information on waiting times.

Today more than half of Stockholm's primary care is provided by private companies that do business with the county council. Taking account of all services (primary and emergency care, long-term care for the elderly, and psychiatric care), more than a quarter of services were provided by private companies in Stockholm in 2002, compared to 7% on average for the country as a whole.[4]

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Table 1

The Stockholm model: a few key dates in the reforms

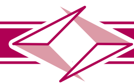
Year	Event
1990	A financing system based on Diagnosis Related Groups is established.
1992	Management of certain service units is turned over to private suppliers.
1992	A guarantee is provided to patients, who can go for treatment to another hospital or region if waiting time exceeds three months.
1994	St. Goran's Hospital becomes an independent corporation.
1998	St. Goran's Hospital is sold to Capio AB, a private company listed on the stock exchange.
1998	All public medical services (except emergencies) are put on the market.

Conclusion

The reforms instituted in Stockholm do not constitute a miracle cure for the deficiencies of a public health care system. Even today, Sweden faces shortages of medical staff, long waiting lists, and insecure financing. There are still certain incoherencies, and the system encounters some failures. But up to now the experience has been generally positive. Employees are better paid and have voted with their feet by choosing to work for private companies or even to set up their own companies. If polls can be trusted, patients are more satisfied with the services offered by the private sector than by the public sector.

[3] Hjertqvist, 2002, p. 17.

[4] Hjertqvist, 2002, p. 26.



The existence of a competitive market in the supply of health care has allowed for cost reductions in various services ranging from 10% (for ambulance care, for example) to 40% (for X-rays or laboratory services).[5] Waiting lists in Stockholm have also become much shorter (by 22% between 1992 et 1993) and are no longer a topic of political concern.[6] They are much shorter than in the rest of the country. For example, outside the metropolitan area, it is often necessary to wait up to a year to obtain a hearing aid (compared to four weeks in Stockholm), up to two years for a knee operation (10 weeks in Stockholm) or 10 months for a hernia operation (two to four weeks in Stockholm).[7]

The lesson for Canada is clear. It is possible to go much further in decentralizing and privatizing services while maintaining a universal system financed by public funds. Nothing in the Canada Health Act prevents such a change if a provincial government chooses to go in this direction. Since it is the mixing of public and private financing that is forbidden by the Act, we can follow the example of Swedish reforms without getting caught up in this. (See *Health Care Reforms: Just How Far Can We Go?,* Montreal Economic Institute, April 2003).

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With the explosion of costs and of anticipated demand with the accele-rated aging of the population, increases in health care budgets cannot stop the crumbling of the system for very much longer. The public has become more broadly aware of the challenges ahead and of the required solutions. According to a recent poll published in *L'actualité* magazine,[8] 57% of Canadians support turning to the private sector for subcontracting in the provision of health care.

Sweden has long been a model in social democratic management. Can we follow its example now that its experience shows the advantages of market mechanisms?

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[5] Hjertqvist, 2003, p. 8.
[6] Lofgren, 2002, p. 15.
[7] Hjertqvist, 2002, p. 31.
[8] Chantal Éthier, « Santé : Vive le privé ! », *L'actualité,* July 2003, p. 48-9.

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