1.2 Future challenges

As a result of demands for increased productivity (efficiency and effectiveness), new methods of public administration such as New Public Management, and new financing models have come into being. The patient is supposed to be more empowered. The meaning of empowerment, however, is very hard to define bearing in mind that health care is a service characterised by asymmetric knowledge and high levels of uncertainty. Furthermore, the main driving force for change in health care in the early years of the 21st century is the idea that health care should be carried out at an adequate level, and consequently cost-efficiently as possible. A strong economic incentive is that the municipalities have to pay for patients’ hospital care when the medical care is completed. This is expected to eliminate the risk of “over-caring” in expensive hospitals and a lack of beds, transferring patients to the cheaper municipality care. Many county councils, embracing their health-care providers, have more or less changed their economic control systems since the 1990s to be able to follow up care paths and to in a position to handle the situation as a question of rational decision-making.

The most important factors in the privatisation of health care seem to be the ideology of the government in power, followed by the political composition within the county councils and the local authorities. Between 1991 and 1994 the right wing introduced internal markets and the split between purchaser-provider into a model equally bearing the names of the actors in question. It was an entire range of concepts new to the health-care sector, involved with the changes concerning decentralisation, quasi-market efficiency, transparency, freedom of choice, public and private actors, etc. In Stockholm and in Malmö, (the third Swedish city by size), the right-wing majority has pushed privatisation in the area surrounding the capital and in the south of Sweden, whereas the left-wing majority in Göteborg has had a restrained attitude towards private actors in the west of Sweden. Different attitudes towards privatisation have provoked different liberalisation patterns within health care. According to the authors of the 2005 WHO report the reforms within the Swedish health-care sector have very much been targeted towards addressing unique and limited problems. For example, the transition of care for elderly people, the disabled and those suffering from psychological disorders from responsibility of the county council to that of the municipality relieved acute-care hospitals from so-called bed blockers. The elderly no longer stay in hospitals when their treatment is considered to be complete, and institutional nursing homes and long-term hospitals have therefore been created. But some problems have remained unsolved and new ones have appeared: the lack of physicians and their involvement in municipal care, poor access to nursing homes, poor coordination between county councils and municipalities necessary for ensuring patients’ care and rights within the division of responsibility (cf. WHO 2005:98).

1.3 The European dimension

The European Union has indirectly been an important driver in the process of liberalisation.

Policy priorities have included the control of inflation and the pursuit of macro-economic stability, and thereby put a pressure on the nations concerned to implement a drastic reduction of fiscal deficits and overall government debt levels.