The major focus on private care concerns cost containment, budget control, targets and manpower, the reduction in the length of hospital stays and budget for doctors. Institutional changes are furthermore driven by new technology, cost efficiency, highly specialised staff and cost transferred to the community, etc.

Within the EU area there are three issues of major common concern. First, regarding the common actions toward infectious diseases and non-antibiotic management. Second the treatment of diabetes and diseases related to the central nervous system, to age and to factors of a psychosocial character. Third, problems related to diet, habits and lifestyle are considered very relevant.

In terms of a European perspective, health-care services in the near future will be generally available cross-border in the European market. But they have so far been excluded from the EU Service Directive, soon to become law. The EU Health and Consumer protection Commissioner Markos Kyprianou has declared three important things for the future. First, there will be legal regulation of cross-border care (reimbursement limits, matters of responsibility, etc.). Secondly, patient mobility is now a given and will grow with volumes and range of treatment. Third, there is the dimension of “health tourism” (cf. Hjertman 2006).

Consequently, the European Commission has the ambition to increase cross-border collaboration between highly specialised medical services and within areas for ICT and control of infectious diseases (cf. Vårdkonsumentindex 2006).

2. THE PROCESS OF LIBERALISATION AND PRIVATISATION

In its annual report on the finances and activities of the Swedish counties/regions, the Federation of County Councils (FCC) has collected statistics regarding private physicians and physiotherapists in outpatient departments reimbursed from public funds. In 1994, the responsibility for costs, including reimbursing private actors, was decentralised from the state to the counties/regions. In 2003, 1,151 private physicians (out of 26,873 in total) were reimbursed according to the national standard for 2.4 m. medical visits, and 1,509 physiotherapists with 3.4 m. visits. The majority of private physicians and physiotherapists are to be found in the county of Stockholm.

From June 2000, under the National Health-Care Plan, the Social Democratic government opened the health-care sector to liberalisation. According to the plan, multiple variations of management were to be encouraged. The then Social Minister, Lars Engqvist, drew the line at acute and emergency hospitals, which were not to be privatised. The “Stop Law” emergency care constituted an important part of total health care, and the government considered that those in need of immediate care should not have to decide on a hospital in the ambulance on their way to the hospital.

In Stockholm, where the privatisation is most extensive, one subsidiary of Praktikertjänst is responsible for parts of Löwenströmska hospital, and another subsidiary has been running a
major part of Nacka sjukhus since 1999-2000. S:t Göran’s hospital was bought by the international health-care company Capio (former Bure) in 1999.

2.1 The private care sector

The turnover in the health-care sector is about 260 m. SEK. Excluding elderly care activities in the municipalities, it still amounts to 164 m. In 2006, 85% of providers are still public, but this will certainly change when the government opens the doors to private actors (cf. SvD 2006-10-11).

Table 1: Private health-care companies

<table>
<thead>
<tr>
<th>Name</th>
<th>Owner</th>
<th>Yearly turn over (2005), billions</th>
<th>No of employees</th>
<th>National and international activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capio</td>
<td>Company on the stock market</td>
<td>SEK 2</td>
<td>2,500</td>
<td>The Nordic market, but also 20 highly specialised hospitals and one of the major providers in France, 12 hospitals in Spain + clinics for outpatient care</td>
</tr>
<tr>
<td>Aleris</td>
<td>High risk company EQT</td>
<td>SEK 1.5</td>
<td>1,500</td>
<td>One of the major private providers in Sweden, Norway and Denmark</td>
</tr>
<tr>
<td>Carema</td>
<td>High risk company 3i</td>
<td>SEK 2.8</td>
<td>5,500</td>
<td>Sweden, Norway and Finland</td>
</tr>
<tr>
<td>Praktikertjänst</td>
<td>Cooperative Minor providers</td>
<td>SEK 9</td>
<td>13,000</td>
<td>The Swedish market funded in 1960</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Svenska Dagbladet 2006-10-11.

2.1.1 Praktikertjänst AB

Praktikertjänst AB, in Stockholm, is the major private group and the oldest within Swedish healthcare. It covers nearly 50% of the outpatient care within primary care and more than 45% of the dental care within Sweden (cf. Konkurrensverket 2004). The group is run in the form of a producer cooperative and was founded in 1960 (then Medical Service, i.e. Läkartjänst AB). Praktikertjänst AB acquired its current name in 1977 after a merger with its counterpart, Dental Service (founded in 1966). The activities are described as entrepreneurial driven dental, health and personal care. The concept is based on small, local practices combined with the resources of a large company. Praktikertjänst provides the external conditions of a commercial enterprise, but the driving force is said to come from within; from the producers themselves. The practitioners managing the practices are entrepreneurs and they are responsible for running their own operations. This includes responsibility for the odontological and medical aspects as well as finances, human resources, business development, and ensuring that the practices are properly staffed and equipped. The entrepreneurs are employed by Praktikertjänst, as are the staff members at the practices. Wages and benefits are based on the practices’ results and linked to part of the
group's overall wage policy. Praktikertjänst is particularly important within dental care because of a reform of dental care since 1999, with 1,400 dentists connected to the group. 70% of the group’s overall turnover derives from dental care. However, one third of the total 2,200 practitioners within Praktikertjänst (about 770 people) are physicians, physiotherapists, occupational therapists, psychoanalysts/therapists, nurses, midwives, certified social workers, chiropractors and dieticians, who develop and run their own practices throughout the country. Most of the businesses are operated under healthcare agreements with the local/regional authorities or through the national health system. The turnover in 2004 amounted to SEK 1.9 million (cf. Homepage for Praktikertjänst AB 2006).

2.1.2 Aleris

Aleris was founded in March 2005 and today is among the major healthcare companies, with activities in Sweden, Norway and Denmark operating in areas such as specialised care, audiology, physiological laboratories, radiotherapy medilab, elderly care and psychiatrics (www.aleris.se).

2.1.3 Carema

Carema is one of the other leading producers within medical services and social care in the Nordic Countries. It manages polyclinics, smaller local hospitals, specialised clinics for outpatient care, homes for the elderly, disabled and mentally ill on behalf of the counties and the municipalities. Carema is also the main actor regarding manpower and manning of healthcare staff on the market. It operates in Sweden, Norway and Finland (www.carema.se).

2.1.4 Capio

Capio has approx. 18,000 shareholders. The foreign-owned proportion of the share capital was 44% (2006). In June, the shares on the stock market were based on high risk companies and minor posts on Swedish insurance, risk and pension funds (such as the Second Swedish AP Fund 6.3%, Fourth Swedish AP Fund 5.3%, Orkla ASA 5.1%, AFA Insurance 3.7%). The Nordic healthcare market is Capio’s home market, especially the healthcare sectors in Sweden, Norway and Denmark. Their market share accounts for approximately 9% of each country’s GDP. On their homepage, Capio says that “despite strained public finances and a partially unclear political direction, Capio’s view is that there are considerable opportunities for further development in the Nordic countries”. Besides the Nordic market, Capio also refers to itself as a leading actor in European healthcare, for instance in the UK, Spain, France, Portugal and Germany (www.capio.se).

2.1.5 S:t Göran

S:t Göran is one of the private hospitals under the portfolio of Capio. Jan Öhrling and Mats Sverke (2003) have analysed two hospitals in Sweden with a focus on all (management) employees. One of the hospitals, S:t Göran’s Hospital Inc., was made a non-profit public stock company in 1994 and a for-profit private stock company in late 1999. The other
Södertälje Hospital remained a non-profit public administration unit over the course of the study. Both hospitals are a part of Stockholm county council, which is also the most privatised region in Sweden. The process started with S:t Göran in 1994.

However, apart from this longitudinal research study (1994-1999) carried out by a business economist and a psychologist, few studies of privatised Swedish hospital care have been undertaken. Their aim was to explore the private owners’ organisation, the insecurity of health-care management and service provision and how problems were dealt with within this context (cf. Öhrming and Sverke 2001).

3. PROVISION, PLANNING AND FINANCING OF HOSPITALS

In Sweden, distributive justice was a leading vision in the 1970s and 1980s. According the fundamental Health and Medical Service Act of 1982, the overall aim of Swedish health and medical service is for the entire population to have equal access to good care service. In Sweden (as well as in other Nordic countries and in the UK), the emphasis is on equal access as opposed to freedom of choice (as, for instance, in the Netherlands).

A general overview furthermore exemplifies how the focus was on cost containment in the late 1980s and on efficiency in the early 1990s. The efficiency issues such as prospective payment schemes, purchasing-organisations and increased rights for patients came to the fore as a result of the introduction of new management systems and new organisational structures. In the latter part of the 1990s new delivery systems and new ways of organising healthcare were in focus. More recent reforms of the 2000s are again addressing a renewed concern about cost containment (WHO 2005, 95ff). Dalarna, Stockholm and Bohus were the first county councils to introduce reforms (using methods referred to as the Dala Model, the Stockholm Model and the Bohus Model) that included most issues discussed in the 1980s, i.e. resource allocation according to the needs of the residents, per-case payment schemes, total cost liability for departments, and interdependent transfer pricing systems (cf. WHO 2005, 65).

Accordingly, several county councils introduced solutions in which separate purchasing organisations were established. The hospitals became more independent in relation to political bodies and, in some cases, have been transformed into county-council-owned limited companies. In some county councils (Stockholm and Skåne), some of these companies were transformed back to county council boards after the 2002 general election. By 1994, 14 out of (at the time) 26 county councils had introduced the purchasing-provider models. The purchasing organisations vary among as well as within the county councils. Some county councils have introduced one large central county council purchasing organisation, while others have introduced purchasing organisations at district level (cf. WHO 2005, 50).

Contracting in practice is based on the purchasing organisations negotiations with the hospital healthcare providers in order to establish financial and activity contracts. These contracts are often based on fixed prospective per-case payments (based on diagnosis-