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 health-care 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-