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 Görans 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-
related groups) and complemented with price or volume ceilings and quality components. Prices are determined by historical costs and negotiations between purchasers and providers. The use of diagnosis-related groups and other classification systems, however, varies among regions and county councils. Per-case reimbursements for outliers, such as complicated cases that grossly exceed the average cost per case, may be complemented by per-diem payments (cf. WHO 2005, 51).

The fundamental law for Swedish healthcare is the Health and Medical Services Act. In the following, the overall framework regarding aims, scope and ethical considerations will be outlined. The three basic principles for public health and medical care are: the principle of human dignity, the principle of need and solidarity and the principle of cost-efficiency. These are also the terms for prioritisation of healthcare, meaning that it is most important that all individuals are treated with dignity and have the same rights, regardless of their status in the community. Second, those in greatest need should take precedence. Third, if a choice has to been made regarding different healthcare options, “there should be a reasonable relationship between the costs and the effects, measured in terms of improved health and improved quality of life” (WHO 2005, 1). These guiding principles have then been converted in four priority groups: The first group includes persons with life-treating diseases, palliative care and care for chronic diseases. The second group concerns prevention and rehabilitation. The third group includes those with non-acute and non-chronic diseases is included. Finally, the fourth group covers care for reasons other than illness and injury, e.g. cosmetic surgery, which is not financed by public funds (cf. WHO 2005, 101).

Contracting out is an example of a general liberalisation practice. However, scepticism among practitioners has been important. Accordingly, the Swedish purchaser-provider split was adopted with an incremental approach. Instead of a national reform package as in the UK, the Swedish counties have chosen different ways of provision and financing. In health care, the control over operations is important. One way to combine competition with the state government is based on tender procedures. The county or municipality in control have a procedure for bidding that is open to competition, i.e. in order to make it possible for private actors to provide a service within the framework of a subcontracting organisation. The state seeks to use the bidding process to guarantee the lowest cost.

There are small direct fees for medical attention to be paid by patients in the form of flat-rate payments. In 2003, the county councils received SKr 5,130 million in patients’ fees and other fees (including those for dental care), which accounted for 2.8% of the county councils’ total revenues (cf. WHO 2005, 45-46). The parliament has however set ceilings on the total amount that any citizen must pay in any two-month period. In 2004, the fee for consulting a physician in primary healthcare varied from SKr 100 to SKr 150 (approximately €11–€17) between county councils. In the same year, the fee for consulting a specialist at a hospital varied between SKr 200 and SKr 300. For inpatient care, normally a fee of SKr 80 per day is charged, but reductions are possible for pensioners and those in low-income groups (Federation of Swedish County Councils 2004). The government’s ceiling for out-of-pocket payments means that an individual’s total charges on healthcare for a period of two months, i.e. for visits to physicians, district nurses, physiotherapists, etc., cannot exceed SKr 900 (€100), not including inpatient care. After this cost ceiling has been reached, the patient pays no further charges for the remainder of the two-month period, which is calculated from the date of the patient’s first visit to a physician. The exemption scheme is included in national
health insurance, financed by the Swedish Social Insurance Board and administered by the county councils.

Swedish citizens pay taxes to the local authority and to the counties/region, which accordingly have a great deal of freedom to organise the activities in their area. Supplementary grants from the state are provided in general and for specific targets. The general grants are paid per inhabitant, while target grants are provided to finance specific activities, and sometimes for a limited period of time (The Swedish Association of Local Authorities and the Federation of Swedish County Councils 2005). In addition, health care may be procured from public organisations as well as private companies. Only a minor part of healthcare is privately run. But private health centres and practitioners are relatively common in major Swedish cities and in urban regions. In 2002, 27% of all physician consultations in outpatient care with public funding were conducted at private facilities (Federation of Swedish County Councils 2004).

Private companies that carry out activities on behalf of the local authority, the county or the region are financed though public funds, i.e. as an outsourced department. Using the tax revenues, the private actors have to offer service equal to public service in terms and conditions, i.e. “citizens pay the same for a service irrespective of whether it is provided by the public sector or by a private company” (author's translation from SALAR 2005, 7). The market for voluntary health insurance is growing in Sweden. However, it is still small in comparison with other European countries. In 2003, about 200,000 people (2% of the Swedish population) had some kind of supplementary insurance (cf. Swedish Insurance Federation 2004). It should be noted that the number of surgical operations that are privately financed is quite low. Even in the few private hospitals, an overwhelming proportion of the activities are financed by public money, i.e. they are purchased and contracted by county councils (cf. WHO 2005, 47). One of the reasons behind the growing market for voluntary private health insurance is the long waiting lists for elective treatment within the county councils. The main benefit of having supplementary insurance is the possibility of obtaining rapid access to a specialist in out-patient care when needed. Another benefit might be the chance of jumping waiting lists for elective treatment.

The private insurance company IF has reported that they believe there is a boom in private care. More and more Swedes are willing to spend money on their health. According to the IF CEO Torbjörn Magnusson, they want better and quicker access to healthcare. More people are exercising in gyms, signing private healthcare insurance and going to the Baltic countries for treatment. But it is still the employers and not the citizens who are driving this development, because employers are concerned by absences from work for health reasons and are thus signing up to private insurance schemes (cf. IF 17 Nov 2005).

3.1 Standardisation and instruments for comparisons

The possibilities of standardisation within the health-care sector are limited (despite TQM, medical audits, clinical guidelines, etc.) and the medical knowledge is ubiquitously in the hands of the medical professions. The Swedish system so far includes no national performance indicators for healthcare, no overall quality registers or private information systems (cf. Dr Foster) as it does in the UK or in the Netherlands.
The National Quality Register of intensive heart care and stroke care is the nearest equivalent to a national quality register concerning a national ranking of public care undertaken by the Swedish state. There are also guidelines, for example regarding diabetes (cf. Swedish Diabetes Index 2006). Both the national quality registers and the guidelines are made public and so one can note distinctive differences from one hospital to another as well as differences between counties. They also point to inequalities and weaknesses in Swedish diabetes care county by county. Not one single county follows the National Board of Health and Welfare’s guidelines stipulating bi-annual eye check-ups. The following initiatives have been adopted:

- Information provided to the public on queues mainly for surgical treatment. This information about queues to all Swedish hospitals and special clinics is provided by the federation of county councils and municipalities (SKL).

- A Consumer Index has been developed by the EuroHealth company network in response to the demand for performance indicators for Swedish healthcare. The need is described to consider national, authorised, regular repetitive, multi-dimensional evaluations on healthcare quality and efficiency with the possibility of comparing healthcare nationally within different counties and internationally with other European and international performance indicators. The EuroHealth Consumer Index is a tool for ranking and comparing national healthcare systems across the EU from the consumer/patient’s viewpoint.

- The Swedish Health Care Consumer Index (VKI) compares the 21 Swedish county councils with each other, showing the extent to which consumer aspects have been taken into account in the design of publicly funded healthcare. Every county council in Sweden constitutes a regional healthcare system with extensive liberty to decide emphases, priorities and service according to its own needs and values. Accordingly, the degree of consumer adaptation says a good deal about the policy pursued.

- One continuously on-going survey is Vårdbarometern, which seeks to collect experiences with and attitudes towards healthcare without any rankings. However, there has been criticism that the respondents are “residents”/”citizens” rather than health-care consumers. Consequently, interviewees may have little experience of the health-care provisions. The public has taken first steps towards creating an information system similar to Dr Foster’s. The Swedish Board (Socialstyrelsen) has a mission to collect and design users’ information, although the consumer perspective is still lacking (cf. Vårdkonsument-index 2006).

**CONCLUSIONS**

This section seeks to summarise the description and analysis of the Swedish health sector with a focus on hospital care. Finally, the paper concludes by presenting some empirical findings and studies, where other researchers have attempted to answer the question of the impacts of liberalisation and privatisation on productivity, quality of service and employment. There is a lot of ideological disagreement concerning healthcare, such as centralisation