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