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SWEDEN

INTRODUCTION

This paper presents an analysis of the Swedish health-care sector focusing on hospital care, concerning the change of market structures, regulations, actors and ownerships before and during the liberalisation/privatisation process.

The hospital/health sector is a complicated one because of the issues of financing, national/regional government control, role of primary/secondary care, etc. A reform within health care is embedded in a complex context shaped by the interchange between actors, content and process. This means that the results of a reform vary according to the settings, the period of time, different stages of monitoring and execution and the actions of different stakeholders (cf. Walt 1998). To summarise, it appears that a broad policy is not enough to change practice in health care; attention has to be paid to the macroeconomic and micro-economic factors as well as quality issues.

1. THE SWEDISH HOSPITAL SECTOR BEFORE LIBERALISATION

Post-war health-care development in Sweden followed the general enlargement of the Swedish welfare state. The period from 1945 to the 1980s was characterised by a rapid expansion of somatic hospitals and primary health care. The peak of the wave of nationali-sation took place during the 1960s. In combination with compulsory national health insurance for all citizens, the “Seven Crowns” reform eliminated private practitioners, as the private alternative became too expensive for patients. Thus, no private practice was carried out within the walls of public hospitals (cf. Immergut, 1999).

During the 1960s and the 1970s, Swedish health-care expansion showed a strong belief in big hospitals and the rational treatment of patients.[1] However, in the 1970s, as a result of the economic recession, there was a great divide in public administration that subsequently led to the first crisis of the welfare state. By this time, different levels of care had been introduced in order to keep up with the pace of technological development and attempt to eliminate increasing health costs. From the 1980s onwards, primary health care (the polyclinics) was formally considered the base of Swedish health care. After the peak year of 1982, Sweden was one of the OECD countries with the most vigorous cost-containment programmes built on cost-saving campaigns, wage freezes and cuts in budgets for equipment and buildings. These were followed by efforts to monitor and control clinical activities and to rationalise services by structural changes and mergers between units at

[1] The supply of medical service ranged from primary health care with general practitioners and district nurses to the highly specialist hospitals in the seven Swedish regions.

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county-council level (cf. Harrison and Calltorp 2000). In the Göteborg and Stockholm areas, private providers of emergency and outpatient care were expanding their services under the name of “Cityakuten”, as well as Sophiahemmet and Carlanderska for in-patient care.

The wave of deregulation and introduction of competition for public services such as electricity, air transport, postal services, telecommunications and the railways started in the 1990s. Increased competition and the privatisation of previously public organisations, goods and services in general in order to increase efficiency naturally also had an influence on the health-care sector. Health care, however, was only partly privatised. With the right wing holding power in the government and in county councils from 1991 to 1994, a range of reforms was introduced concerning new payment schemes, internal markets, etc., and the focus was on decentralisation, efficiency, transparency and freedom of choice. Quasi-markets were created for both public and private actors. From 1990 onward, health-service providers and purchasers were split into different roles. Because of self-governance, different models of financing were developed, for instance the Stockholm, the Dala and the Bohus model.

Between 1992 and 1995, three major reforms took place, namely the ÄDEL reform (focusing on long-term elderly care), the handicap reform and the psychiatry reform, with the common aims of changing the institutional organisation of health care. As a result the accountability for patients with high caring needs (such as elderly, handicapped and patients with mental disorders) were transferred from hospitals, provided by the county councils, to the municipalities. As pointed out by Wärvik (2005), it is important to note that the reforms concerned people in great need of nursing care and/or rehabilitation, demanding supplementary medical treatments, but whose medical treatmentwas outsourced. S:t Görans is one of the oldest hospitals in Sweden. In 1994 S:t Göran was first converted into an independent subsidiary company (bolagisering) before it was sold to the Swedish private health-care multinational Capio in 1999.[2] Several hospitals, predominantly within the county of the capital of Stockholm, have followed the path taken by S:t Göran. Huddinge Hospital, Danderyds Hospital and S:t Erik’s hospital for ocular care are recent examples of conversions into independent subsidiary companies (cf. WHO 2005). However, these companies are still (2006) owned by the county council. Söder hospital and Karolinska Hospital were also scheduled to become independent companies in 2000, but the trend was reversed by the “Stop Law” of 31 December 2002 prohibiting the selling of emergency hospitals to commercial for-profit compa-nies. The main purpose of the Stop Law has been interpreted as halting the rising trend in priva-tised hospitals, but keeping already established agreements with private actors (cf. DI 2005-03-09). However, with the election of a conservative government in 2006 it remains to be seen what direction health-care reform in Sweden will take in the future. The new Minister of Health and Social Affairs, Göran Hägglund, has stressed that “it is the quality that has to guide, not the ownership of the providers” (SvD 2006-10-11).

1.1 Drivers of change and determinates of pace and directions

In the mid-1970s, a halt in a long phase of economic growth paved the way for the Thatcher

[2] Apart from Sweden, Capio operates hospitals in Norway, Denmark, Finland, France, Portugal, Spain and the UK. The company has recently also expanded its business to Germany. It has more than 14,500 employees a yearly turnover of 1.3 billion euro. It was recently bought by the British finance investor Apax (cf. Rümmele 2007, 43).

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and Reagan era in the late 1970s and a wave of privatisation in Europe as well as in the entire Western world. The first step of marketisation in Sweden came about with the right-wing government in 1976.

The second step followed in the shadow of repeated problems (deflation, unemployment, loss of credit) caused by the major recession of the early 1990s. A political change from a Social Democrat to a right-wing majority government (1991-1994) led to a major shift in ideology.

The contemporary debate concerned alternative solutions and hence a shift towards regulation based on rules, directives and bureaucracy, to focus on operations based on competition. The main reasons for internal markets were the aim of increasing competition in order to improve access, cost-efficiency and maintaining high quality standards.

The drivers of change have been discussed in terms of a shift in the positions taken by powerful policy-makers, not only governmental level but also, and particularly, with the county councils. During the years between 1989 and 1996, the elections moved liberal and conservative politicians, who were the most enthusiastic supporters of competition, in and out of control of most county councils (cf. Harrison and Calltorp 2000). Their major concern was controlling health expenditure during a period of recession, at the same time as politicians were resisting taking measures to fix prices and distribution. Additionally, health-sector employment was considered a sacred cow and a very delicate issue (cf. Harrison and Calltorp 2000).The reforms in Sweden from 1989-1996 went from uncritical support by a broad spectrum of stakeholders to gradually escalating tensions over the goals, reform programmes and fundamental social and political values, unrealistic assumptions of the effect of competition as well as technical and organisational obstacles to implementation and the threats from interest groups. According to Harrison and Calltorp (ibid.), Sweden entered another stage of experimentation of market-oriented reforms in 1997.

The liberalisation and outsourcing debate continually comes back to the limited resources of 20th-century society. The lack of resources is described as putting bounds to the possibilities to directly and fully respond to the overwhelming needs and hopes of an ageing population.

In Sweden as well as elsewhere, the state seeks different ways to control public spending. According to Saltman et al. (1998), there has been a general perception since the 1980s that resources are not always deployed in an optimal fashion. In Sweden this has been linked to a desire to enhance patient choice and to make providers more responsive to patients as “consumers”. The background to these discussions can be related to the fundamental developments in society: rapid medical-technical development brings help, but these increased possibilities also raise people’s expectations. Demography is changing as well as health conditions (with an older population, multi-functional needs increase. At the same time as we are physically “healthier” we feel psychologically poorer). Different generations have different values; young people are much more used to rapid communication, autonomy and individual treatment (according to Ham’s analysis of the critical challenges for the future (1998). The old dilemma where the population’s needs seem limitless must again be set against society’s limited resources.

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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 a main driving force for change in health care in the early years of the 21st century is the idea is 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.

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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 publicfunds. 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

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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

Name	Owner	Yearly turn over (2005), billions	No of employees	National and international activities
Capio	Company on the stock market	SEK 2	2,500	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
Aleris	High risk company EQT	SEK 1.5	1,500	One of the major private providers in Sweden, Norway and Denmark
Carema	High risk company 3i	SEK 2.8	5,500	Sweden, Norway and Finland Also a personnel agency
Praktikertjänst	Cooperative Minor providers	SEK 9	13,000	The Swedish market funded in 1960

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

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group's overall wage policy. Praktikertjänst is particular 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 out-patient 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 Öhrming 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

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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-

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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 cincludes 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

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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.

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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 gather peoples experience and attitudes:

- 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. Vårdkonsumentindex 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

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versus decentralisation and privatisation, the role of the state professionals and the market, etc. While centralisation is at the centre of the Social Democratic vision, the centre-right argues for a decentralisation of responsibility and for privatisation. Another great divide concerns state employees, entrepreneurs in their own practice versus healthcare companies, driven by high-risk funds on the stock market. Considering access as one of the major problems of Swedish healthcare, a reviewed and strengthened version of the Guarantee Act came into practice in 2005 (cf. WHO 2005). Unsatisfactory access to healthcare has also been discussed in terms of primary care centres/polyclinics versus family doctors. The Social Democrats' are in favour of primary care close to the residents (and close emergency department), while the right wing emphasises the need for family doctors and possibilities of visiting patients in their homes.

In Sweden, political changes in the various county councils and the government in power have affected the measures taken. The presence of various administrational levels in a decentralised model provides the opportunity for different political parties to hold power at municipality, county council/regional and national level, with large variations in the large geographical area of Sweden.

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