

**WHY PUBLIC HEALTH SERVICES?
EXPERIENCES FROM PROFIT-DRIVEN HEALTH
CARE REFORMS IN SWEDEN**

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Market-oriented health care reforms have been implemented in the tax-financed Swedish health care system from 1990 to 2013. The first phase of these reforms was the introduction of new public management systems, where public health centers and public hospitals were to act as private firms in an internal health care market. A second phase saw an increase of tax-financed private for-profit providers. A third phase can now be envisaged with increased private financing of essential health services. The main evidence-based effects of these markets and profit-driven reforms can be summarized as follows: efficiency is typically reduced but rarely increased; profit and tax evasion are a drain on resources for health care; geographical and social inequities are widened while the number of tax-financed providers increases; patients with major multi-health problems are often given lower priority than patients with minor health problems; opportunities to control the quality of care are reduced; tax-financed private for-profit providers facilitate increased private financing; and market forces and commercial interests undermine the power of democratic institutions. Policy options to promote further development of a nonprofit health care system are highlighted.

The traditional Swedish universal health care model is tax-financed with public health centers and hospitals. Certain specialist services are provided by publicly financed private practitioners. Patients have the right to choose any public or tax-financed private health center in the whole country and, with a referral, any hospital. This freedom of choice has been stated in the Swedish Health Act since 1995.

The Swedish public health care system is highly decentralized. County councils/regions are in charge of the services provided and they collect most of the tax revenue needed to provide the services. A local parliament, the county council, is responsible for most health policy decisions. The medical results achieved in the traditional public health care system are from an international perspective typically quite good. Total costs of care are at the same level as in most other West European countries (i.e., around 9% of GDP). Shortcomings of this traditional system are long waiting times for certain treatments, a fairly weak primary health care system, and poor systems for monitoring results.

This traditional system was challenged in the late 1980s by conservative and neoliberal political parties and various organizations with commercial interest in a privatized health care system. They strongly argued for a more market-oriented system with tax-financed private for-profit providers. Key words in this campaign were “increased efficiency,” “competition between providers,” and “choice.” The arguments were thus very similar to the arguments used across the globe for commercialization and privatization of public health services. The social democrats—the biggest party in Sweden—were split on the issue of privatizing public services. Prime Minister Olof Palme strongly opposed this privatization in his last speech before being killed February 28, 1986. Kjell-Olof Feldt, then Minister of Finance, on the other hand saw privatization as a natural and positive development (1). The pro-market line came to dominate Swedish health policies during the 1990s.

The first phase of this reform process was initiated in some county councils in early 1990. Public health centers and hospitals were to act as firms in an internal health care market. The organization was split into purchasers and providers, and patients were called “customers.” Health promotion and disease prevention related to groups or directed toward local health hazards were almost eliminated instead of strengthened. The focus was solely on individual patients. These neoliberal New Public Management (NPM) ideas were in some county councils, such as in the Stockholm region, developed to a level rarely seen in any other country.

The second phase of the market reform process was to privatize the provision of tax-financed health services. The NPM reforms during the first phase, calling for increased competition between providers, opened up for private for-profit providers. The number of tax-financed commercial providers increased, in particular, within the tax-financed primary health care system. One major public acute hospital (St Göran Hospital in Stockholm) was also privatized (1998). Policies promoting private for-profit providers of tax-financed health services were intensified in 2006, when conservative/neoliberal parties came into power both at the national level and in many counties. The county councils’ purchases from private for-profit providers increased between 2007 and 2012 by 56 percent and, by the end of this period, 23 percent of all tax-financed health care centers had been privatized. County councils not in favor of this privatization of health

centers were forced by the so-called LOV law (2010) to open up a tax-financed market for all private for-profit providers meeting certain criteria. Those financing these services—the county councils—were not able to determine the magnitude of services provided nor to decide where these tax-financed services were to be located. The “LOV law” gave the right to make these decisions to commercial providers of care. Profitability rather than need became the guiding principle for the allocation of public funds. These reforms were highlighted in international magazines and newspapers. A special issue of *The Economist* (February 8, 2013) praised Swedish politicians for developing welfare capitalism into a new type of Swedish model and *The Guardian* (December 18, 2012) concluded that Sweden has become a welfare laboratory for right-wing parties.

It should also be noted that Sweden’s ranking among all Organisation for Economic Co-operation and Development countries dropped in some important respects during these two first reform phases. For example, medically avoidable mortality was lower in Sweden than in almost all other Organisation for Economic Co-operation and Development countries 15 years ago. Today, Sweden is ranked in the middle. The ranking related to perceived quality of care also dropped during this period, according to the European Consumer Index. From a national perspective, trust in the health care system is also falling. According to a recent study initiated by the Swedish Media Academy and carried out by one of the leading institutes for public opinion polls (SIFO), 60 percent of all adult Swedes had a high or very high level of trust in the Swedish health care system (2011). Today (as of February 2014), the corresponding level of trust is only 41 percent. This is the most dramatic loss of trust registered in any of the many branches included in this survey.

The present level and intensity of the public debate for and against tax-financed private for-profit providers of care is also unique from a Swedish perspective. In 2013, articles focusing on this issue were the second most common in our newspapers (after articles about the war in Syria).

A third phase of this neoliberal reform process, with increased private financing of essential health services, is likely to emerge before 2020 if the present trend continues with reduced taxes, despite increasing health care needs. The increase of private for-profit providers facilitates this shift from public to more private financing.

The purpose of this article is to present the main effects of the first two phases of these reforms as reported in public evaluations, research reports, and well-documented experiences. Ten main conclusions are highlighted, followed by policy options to promote high-quality care according to need for the whole population.

1. MARKET-ORIENTED HEALTH CARE REFORMS REDUCE RATHER THAN INCREASE EFFICIENCY

A main argument for market-oriented reforms is that competition and privatization will increase efficiency. “You will get more care for the money” or “the

same care for less money.” This argument is repeated so often that many take it for granted without asking for evidence.

Market-oriented health care reforms are, however, very inefficient in reducing geographical and social inequities in health and health services. These reforms typically widen, as illustrated below, these inequities. Nor is the efficiency of profit-driven health care reforms higher than in public health care systems in general.

A major Swedish meta-study carried out by a commercially linked research institute (SNS) showed that the evidence for higher efficiency in market-based systems compared to public-based systems is very weak or nonexistent (2). An in-depth research study from the University of Lund comparing Swedish counties with different levels of market-oriented health care systems also concluded that there was no difference in efficiency between traditional public health care systems and commercialized systems (3).

International studies also illustrate that nonprofit health care providers are as cost-effective—or more cost-effective—than for-profit providers. A meta-study based on 317 peer-reviewed articles found that not a single article showed that for-profit providers were more effective than nonprofit providers (4). Other meta-studies showed that the cost for care was higher at for-profit hospitals than at nonprofit hospitals (5). One main reason is that increased commercialization usually increases the cost for administration and controls. The European Observatory also stated that it is an ideological belief rather than an evidence-based fact that market-oriented reforms improve efficiency (6).

Policy Option

Ask for evidence when claims are made that commercialized health care systems are more efficient than public health care systems. Special attention should be given to efficiency as related to the achievement of equity-oriented targets in terms of access and quality of care. It must also be observed that improved productivity is of interest only if it is related to higher efficiency related to stated health and health care objectives. If this is not the case, higher productivity simply means doing the wrong thing at a lower cost.

2. PROFIT AND CHEATING ARE A DRAIN ON RESOURCES FOR HEALTH CARE SERVICES

When the efficiency of producing tax-financed health services is the same or lower for private for-profit and public providers, it is a loss of scarce health care resources to privatize the providers. The reason is that private for-profit providers then must use part of the available resources for providing health services to pay their shareholders/owners. Profit is thus a drain on public health care resources. Public providers, on the other hand, can use

all available resources to provide health services. Surpluses are used to improve the services provided.

It must also be recalled that incentives for cheating the system typically increase in profit-driven health care systems. Experiences in Sweden and abroad show that the focus on profit, together with limited possibilities for financial controls, encourages dishonest billing and profitable, but unnecessary, services. Selling public health centers at a too-low price has also been a waste of public resources. One example is when the conservative majority in Stockholm County sold the health center Serafen to two doctors working at this center for 0.7 million Swedish crowns. Four years later, these two doctors sold the health center to a commercial health care provider (Capio) for 19 million Swedish crowns. This type of selling of public tax-financed health facilities without any external bidding was intensively promoted until 2008, when it was found illegal (7).

The debate about profit-driven health care is intense in Sweden. The conservative and neoliberal parties now in power are firmly committed to promoting market-oriented reforms in general and tax-financed private for-profit providers in particular. The opposition parties differ in their critique of these profit-driven reforms. The left party (Vänsterpartiet) and the environmental party (Miljöpartiet) have a policy to promote nonprofit care only. The main opposition party, the social democrats, is split on the issue of private for-profit providers of care. Consequently, they tend to present vague and sometimes even contradictory policies. In a recent health care policy declaration, it is, however, stated that all tax-financed hospitals should be nonprofit (while of course honoring present contracts with private for-profit providers).

Policy Options

- Develop a long-term strategy for developing the public health care system. One way of doing this can be to initiate a law that any financial surplus generated by tax-financed providers must be reinvested. Alternatively, the law could state that the profit paid to owners must be limited to a very low level.
- Public funding is thus only available for providers accepting these nonprofit principles. Private for-profit providers still have the option to sell their services at a market price to patients paying out-of-pocket or via private health insurance. Private for-profit care is thus not forbidden, but public funds (taxes) are not financing their services.
- Improve the financial controls and replace NPM payment systems with results-oriented, need-based budgets, and periodic follow-ups/professional assessments.

3. TAX EVASION BY OWNERS OF FOR-PROFIT PROVIDERS OF CARE REDUCES PUBLIC RESOURCES

Almost all major tax-financed private for-profit health care providers operating in Sweden are owned by private equity companies that buy providers of health care with primarily borrowed money (leveraged buyout). They have tax evasion as a business norm. This is achieved by complicated organizational structures, internal loans with a high interest rate, and close collaboration with non-transparent institutions in tax havens. Little to no tax is thus paid on profits made on tax-financed health services. The owners of these private equity companies—who often have an income between US\$2 million and US\$10 million per year—further avoid paying normal income tax by claiming that their earnings are revenue from capital, not income from work.

The magnitude of public resources lost as a result of this tax evasion is not known, but it certainly amounts to hundreds of millions of euros per year. This loss of tax revenue is effectively a theft of resources that could have been used to improve public health care services.

The Swedish tax authority has identified many such cases, but its claims have been appealed and brought to court by private equity company owners. Some of these companies have been forced to pay taxes, but others have escaped thanks to vague laws, resources to hire the smartest lawyers, extremely complicated tax evasion models, and the secrecy provided to money in tax havens such as Guernsey and Jersey.

Policy Option

A requirement for public financing should be that private for-profit providers pay normal business and income taxes in Sweden.

4. PROFIT-DRIVEN HEALTH CARE SYSTEMS FAVOR URBAN AREAS AND NEGLECT RURAL AREAS

A new law (“LOV”) permitted, since 2010, all private for-profit providers meeting certain criteria to decide where to locate their tax-financed health centers. The location of tax-financed health centers was then determined by the potential to make profit rather than the need for health services.

Existing geographical inequities in the supply of primary health care services thus drastically increased. A study from the Swedish Competition Authority (8) analyzed the geographical distribution of all new tax-financed health care centers established in 2010 and 2011. The main findings are:

- A total of 190 new tax-financed private for-profit health centers were established. This is a far greater expansion of primary health care services than in previous periods.
- A total of 88 percent of new centers were located in areas with an already very good or good general service level. Moreover, 58 percent were located in regions of the three main cities in Sweden where there is—particularly in economically privileged areas—a relative oversupply of health centers and family doctors.
- None of the 190 new centers was located in an area with a very low general service level.

Consequently, those living close to a health center now had two health centers that could be reached within five minutes. Those living in areas where an increasing number of patients had to travel more than 30 minutes to reach a health center did not get any new center, despite paying for health services via taxes. They were not profitable.

Policy Option

- Replace the existing law favoring commercial interests with a law requiring county councils to locate all tax-financed health services according to the need for these services. This is in fact already stated in the present Medical Health Act, but bypassed without any consequences. There is thus a need for a new “imperative” law.
- Underserved county councils with a weak local tax base should be given additional resources from the state to expand nonprofit health services.
- Local public health programs should be developed in underserved rural areas with mobile teams for home visits/care, tele-care, and additional resources for acute care provided, because the distance to the nearest hospital typically is many hours away.
- Intensify efforts to recruit qualified health staff by offering higher salaries, better research possibilities, more flexible working time, and greater opportunities to influence working routines and conditions. If this is not enough to recruit staff to underserved areas, compulsory service as part of a medical career should be considered.

5. PROFIT-DRIVEN HEALTH CARE SYSTEMS NEGLECT LOW-INCOME URBAN AREAS AND FAVOR HIGH-INCOME URBAN AREAS

The right for private for-profit providers to locate their tax-financed services according to profitability also generates major inequities between high- and low-income areas in large cities. For example, around 80 percent of all outpatient

specialists work in the northern, wealthier half of Stockholm County, in spite of the fact that the need for these services is far greater in the southern half of the county. The geographical distribution is particularly skewed for cardiologists, orthopedists, and psychiatrists. They are mainly found in high-income, inner-city areas (9). These inequities in access to tax-financed private specialists is also reflected in the fact that persons living in inner-city areas close to a private specialist were more than twice as likely to use these tax-financed health services than people living farther away (10).

Public health centers in Stockholm County, on the other hand, are typically located more according to need, but it can be difficult to recruit qualified staff to certain low-income areas. These problems were further reinforced with the introduction of market-oriented health sector reforms. The resources for low-income areas were further reduced as additional funds due to greater need were abolished. Furthermore, the new “Stockholm choice system” (“Vårdval Stockholm”) has reallocated substantial financial public resources from low- and middle-income areas to high-income areas every year since it started in 2008 (11).

Policy Options

- Paragraph 2 in the present Health Care Act, stating that public health care resources should be allocated according to need, must be made legally binding as it is bypassed today without any consequences.
- Comprehensive local programs for improving geographical, economic, and cultural access to care in low-income areas should be developed. These programs should be planned and implemented in close contact with the citizens of that area and include additional community doctors and nurses, social welfare workers, volunteers to assist in reaching hard-to-reach individuals/families, and qualified interpreters. The funding of these programs should be based on a results-oriented budget that is periodically reviewed.

6. FEE-FOR-SERVICE-FINANCED HEALTH CARE PROVIDERS OFTEN DISTINGUISH BETWEEN PROFITABLE AND UNPROFITABLE PATIENTS AND TREATMENTS

The introduction of fee-for-service payments and NPM systems force public health centers and hospitals to act as if they were private providers in an internal health care market. In this business perspective, there is a tendency to distinguish between profitable and unprofitable patients and services. This is, for example, the case when providers are paid—as in Stockholm—a fixed amount per visit regardless of whether the consultation takes 10 or 30 minutes. It is then more profitable to treat patients with minor health problems than patients with more serious, time-consuming ones. A major study in 2012 revealed that 78 percent of

those in charge of primary health care services in Stockholm County believed that the present system for paying providers discriminated against certain groups of patients. Only 1 percent believed that the present system favored those with the greatest need for care. The corresponding figures for the entire country were 63 percent and 20 percent, respectively (12). The losers in this tax-financed health care market are, in particular, low-income groups, which typically have a 50 percent to 100 percent greater and more complex disease burden than high-income groups. Furthermore, activities that are difficult to quantify are not given a price tag. They are then neglected as they are considered unprofitable.

Many health promotion and disease prevention activities fall into this category despite being very important from a health point of view. Equally evident is that collaboration between health care providers, as well as research and education, also get a much lower priority in profit-driven health care systems. The need for quantification is much less pronounced in a public non-market health care system where the “space” for professional judgments is much greater.

These negative effects are reduced in many county councils as they base the funding of health centers on fixed rather than activity-related budgets. The approach is then to link the payments to the individuals listed at a specific health center and adjust the payment to age, disease burden, and socioeconomic factors.

Activity-based payment systems remain, however, in the NPM system applied at many public hospitals. Payments to providers are then based on the average price for treating different types of diagnosis-related groups. The same payment for a specific diagnosis is given, regardless of the length of hospital stay and the quality of care provided. Consequently, a patient leaving the hospital after two days is more profitable than a patient staying 15 days. Those with the greatest and most serious burden of diseases are then the most likely to be considered unprofitable. Only extreme cases are paid according to actual costs for their treatment. Possibilities to increase income rather than need may then influence decisions that should be based on professional medical judgments only. Certain diagnoses are also considered more profitable than others. This has influenced doctors and administrators on the provider side to classify patients in the most profitable way. This makes it difficult to rely on the information given in medical case books.

Negative effects of the NPM system seem to be quite common within the Swedish health care system (13, 14).

Policy Options

- Dismantle NPM systems, fee-for-service payments to health centers, and diagnosis-related groups-based payments within hospitals. Develop need-based block funding/budgets and payment models promoting collaboration rather than competition between providers. Develop equity-sensitive professional systems for planning and follow-up, within which patients' representatives can play an important role.

- Secure separate budgets for health promotion, training, and research when these activities are not integrated in a normal consultation between a patient and a doctor/nurse.
- Secure by law that those with greater need are given priority over patients with minor health problems. This is in fact already stated in the Health Care Act, but is frequently bypassed without any consequences. Consequently, there is a need for a new law that is binding in this respect.

7. QUALITY OF CARE IS NOT IMPROVED BY PRIVATIZATION

It is often argued that private for-profit care is of better quality than services available from public health providers. In a Swedish context, this is illustrated by the fact that the perceived quality of care, according to most surveys, is better at private for-profit health centers as compared with public providers. The Authority for Health Care Analysis (15) has, however, demonstrated that there are no differences in perceived quality of care when taking into account differences in the context in which the health centers operate. Private for-profit providers operate more often in high- and middle-income areas with a relative oversupply of health care providers. Public providers, by contrast, often operate in low-income areas with fewer health care services as related to their patients' greater need for care. The Authority for Health Care Analysis thus concluded that it is the socioeconomic context—not the type of provider—that explains the differences in perceived quality.

Typically, the NPM payment systems are linked marginally or not at all to the quality of care provided. Poor-quality care is thus paid the same as high-quality care. Investing in improved care is thus not profitable. A survey of physicians by the Swedish Medical Association (16) showed that a majority of respondents thought that present market reforms did not improve the quality of care.

It has also been argued that the ability to choose between providers should improve the quality of care. People will choose the good services and reject services of a low quality. The evidence that “choice” is an effective method for weeding out providers of poor quality is not very strong. A recent study by the Swedish Authority for Health Care Analysis (15) concluded that there are no significant links between “choice” and quality of care. This is in line with international findings (e.g., within the National Health Service in England, showing that patient choice schemes are failing to raise quality of care) (17).

It is important, furthermore, on medical safety grounds to reject a strategy for improving quality of care based on choice. Medical treatments are not like potato chips, which you test and then choose the one you liked best. First of all, it is very difficult for a patient to judge the medical quality of services provided. Second, many treatments are irreversible. When a cataract surgery is carried out,

you cannot go to another doctor to find out if he can do it better. The effects of poor-quality care can be very difficult to remedy by choosing another provider.

The only acceptable policy is to try to guarantee that all tax-financed health services are of equally good quality. If patients then find that they do not like the services provided, they should of course have the option to choose another doctor/clinic. This freedom of choice has long been far greater within the Swedish public health system than in commercialized health care systems.

International comparisons of the medical quality of hospital care clearly indicate that nonprofit providers typically offer better quality of care than private for-profit hospitals (18, 19). In Sweden, however, it seems that there are no major differences in quality between the for-profit hospital Capio-St Göran and public hospitals in the Stockholm region (14).

The opportunities to develop effective quality control systems are reduced, however, as the number of private for-profit providers grows. They, as with any commercial business, are unlikely to report shortcomings and mistakes. Private for-profit providers always have to present themselves as being “the best.” Image, then, becomes more real than reality. Private for-profit providers may even be able to reject certain quality controls on grounds of commercial confidentiality. Furthermore, professionals employed by private for-profit providers do not have the same legal protection if they report poor practice or inadequate care to the media. Staff employed in public services has, by contrast, almost a duty to report such shortcomings and they can do so without being identified and punished (20). These whistleblowers within the public health care system have often been of critical importance from a quality control point of view and have even lent their names to new laws.

8. PRIVATE FOR-PROFIT PROVIDERS FACILITATE INCREASED PRIVATE FINANCING OF HEALTH SERVICES

The present conservative/neoliberal government has changed the law to permit privately paying patients at tax-financed private for-profit hospitals. In practice, this means that the law permits queue-jumping for patients able and willing to pay the market price out-of-pocket or via private health insurance. The private for-profit providers have no ethical or economic reasons to oppose this possibility. On the contrary, privately paying patients in their tax-financed hospitals increase their profit. If, on the other hand, a patient offered a public hospital 10.000€ to bypass the queue to a certain treatment, this would be considered a bribe. If accepted, this would be described as “corruption.” Thus, increased privatization of providers in a tax-financed system facilitates a political decision to increase the share of private funding.

The official policy of all political parties at present is that health services, even in the future, shall be mainly financed by taxes. A shift toward increased private financing of the Swedish health care system is likely, despite these

declarations, given present major tax reductions and the increased need for health services. We may thus reach a point—without any major political discussion about alternatives—when increased private financing is considered the only viable option, the argument being, “We can no longer afford the same high level of funding via taxes.” Before reaching this point of no return, it is of critical importance to illustrate policy options for continued public financing and to highlight the negative effects of increased private financing.

It is outside the scope of this article to present a viable financial strategy for continued tax-financed health services. The following two main negative effects of private financing should, however, be recalled when increased private financing is suggested.

First, even fairly low user fees and other private payments for services typically reduce economic access to essential health services among low-income groups. A research report from the Karolinska Institute (21) in Stockholm showed that 34 percent of those on social welfare in Stockholm could not, at the present levels of user fees, afford to consult a doctor in spite of a perceived need for professional health care. The same report revealed that 17 percent of all single mothers with children at home could not afford to pay for prescribed medicines on one or several occasions. Low-income groups are thus paying, via taxes, for a service they cannot afford to use according to need.

Despite such findings, the government has recently increased both user fees and out-of-pocket payments for medicines prescribed by a doctor. No analyses were presented to show how this will affect low-income groups. From a health point of view, this is likely to increase social inequities in health, as those with the greatest disease burden within all age groups typically have the lowest ability to pay.

Second, an increased share of private financing at a given level of total costs and utilization implies the following redistribution of the burden of payment:

- The sick pay more and the healthy less.
- The elderly and children pay more and working-age citizens pay less.
- Women pay more and men less.
- Low-income groups pay more and high-income groups pay less.

Private financing via increased user fees and other direct private payments for care is the most regressive of all strategies for health care financing.

Policy Options

Promote public financing by:

- Illustrating the effects of increased private financing in terms of reduced access to essential health services among those with the greatest need for these services.

- Describing the distributional effects of an increased share of private financing, where those with the greatest need and least financial resources are to pay a greater share of total health care costs. The main question is not if we can afford to pay, but who should pay. The guiding principle must be that publicly financed health services should always be provided according to need and paid for according to ability to pay. Strategies for health care financing not explicitly focusing on these principles can only be described as unprofessional.
- Introducing free primary health care services at the point of delivery (as in Denmark and England) and lowering the financial ceiling for receiving free prescribed medicines at the point of delivery.
- Eliminating the possibility to “jump the queue” and pay privately for higher medical quality of care. Tax-financed hospitals should exclusively treat tax-financed patients.
- Engaging in the political dialogue on tax cuts versus securing funds for public health services. What is more important: giving tax-financed subsidies for domestic services to mainly better-off families and lowering value-added tax for restaurants or securing tax-financed health services?

9. PROFIT-DRIVEN HEALTH SECTOR REFORMS TEND TO UNDERMINE THE DEMOCRATIC POSSIBILITIES OF ENSURING GOOD HEALTH CARE FOR ALL

The decisions to promote private for-profit providers and to develop different types of market-oriented health sector reforms in Sweden are all made in accordance with formal democratic rules. The citizens, however, have had very limited opportunities to endorse or reject these major changes in the health care system. The introduction of NPM methods within the public health care system, for example, occurred without any major political debate or external information. This is remarkable as one of the objectives of NPM is to shift some health policy power from democratic institutions such as county councils to market forces and to change the ethical norms of public health services to the ethical norms of private business on a commercial market. Furthermore, pricelists determined by administrators and economists in consultation with medical professionals also replace many political decisions. This limits the democratic potential to influence the health services financed via taxes. It also makes it more difficult for citizens and patients to identify politicians responsible for shortcomings and problems experienced. Equally obvious is that responsible politicians can claim that problems experienced are due to the system, commercial laws, and/or poor providers.

From a democratic point of view, it is also remarkable that those financing the health services via taxes—the citizens—have never had a chance to choose between developing the public system or going toward the privatized market. Nor

did they have a chance to be informed about and discuss the likely effects of the market model, as no assessments were made before the change was implemented. It was even difficult for citizens to understand that the health care reforms represented a shift in ideology because words such as “privatize,” “profit,” “commercial interests,” and “market forces” rarely were mentioned.

The reason for hiding the real intent behind these reforms—to favor the interests of commercial providers of care and better-off groups—is of course that a great majority of all citizens oppose such changes and favor further development of public health services.

Periodic surveys carried out by the University of Umeå show that around 75 percent of the adult population favors public providers. This strong support for the public health care system has been the same since these periodic opinion polls started almost 25 years ago. Another major study (2012) showed that 62 percent of the adult Swedish population would favor a decision *not* allowing for-profit providers of care, while only 16 percent could accept or also wanted for-profit providers (22). Similar results are found in almost all other opinion polls.

This democratic deficit is further reinforced by an almost symbiotic alliance between certain leading politicians and representatives of different commercial interests. Commercial interests are thus increasingly influencing tax-financed health policies. This has resulted in a transfer of power from democratically elected county councils to the boardrooms of major commercial health care providers and private equity companies. One example, also mentioned above, is that the number and location of all tax-financed private health centers are decided by private for-profit providers only. Those financing these services—the taxpayers and democratically elected county councils—cannot influence these decisions. A post-democratic era is thus gradually emerging, where the sphere for political decisions is reduced and market forces are increased while formal democratic rules are intact.

Policy Options

- Present alternatives to profit-driven health care reforms based on democratic control and mainly public or private nonprofit provision of all tax-financed health care services.
- Sharpen health legislation as regards the right to high-quality care for all. Today, these laws are increasingly subordinated to market forces, commercial interests, and international free trade agreements.

10. PRIVATIZATION: AN IRREVERSIBLE PROCESS?

Market-oriented reforms and privatized health care systems sometimes seem irreversible. This is particularly the case when most providers are private for-profit

and private health insurance schemes finance most health services, but for the poor and the elderly. Commercial interests and economically privileged groups then effectively block—as in the United States—public health care reforms. Sweden has not reached this point of no return yet. The public health care system is still the base, even though NPM models and expanding private for-profit care change the ethics of tax-financed health services.

The core values of a public health care system are thus partly replaced by the core values of the commercial market. Leading representatives for the Swedish Medical Association (Läkarsällskapet) recently described this change as follows: “Our core values are science, education, quality and ethics.” The core values of NPM as applied today within the Swedish health care system are “control, top-down management of details, focus on quantitative measures only and commercialization.” “The health care system is managed by principles used for production of goods.” “NPM represents logic foreign to the work within the health sector” (23). NPM and for-profit privatization can also seriously limit the clinical freedom of medical professionals.

There is no magic bullet to stop this commercialization, which mainly is driven by forces outside the health sector. These reforms are an integrated part of neoliberal policies that, as expressed by Carl Tham, a former Minister of Education, “turns the clock back” to “a pre-democratic state of affairs” (24). They are driven more by ideology and commercial interests than by evidence related to stated objectives for the tax-financed health care system. The same reform model with deregulation, market orientation, and privatization is used across all public sectors and in many other countries. “One model fits all.”

Given a political will and power it is possible, as illustrated in Scotland, to promote public health services. A long-term strategy is needed that—in addition to the policy options presented above—also includes:

- Amendments to the health care law stating that all tax-financed hospitals and all new tax-financed health centers should be nonprofit and mainly public. Present contracts with private for-profit hospitals should be honored. These hospitals become public when the contracts terminate.
- All existing private for-profit health centers must sign a time-limited contract with the county council in which the conditions for public funding are specified. A gradual shift from private for-profit to public to nonprofit care is then to take place when these contracts terminate. These “new” public health centers are moved to underserved areas if they are located in areas with a relative oversupply of health services.
- Special service contracts should be signed with private for-profit providers if there is not sufficient capacity to replace private providers with public or private nonprofit providers. A prerequisite for a nonprofit policy for tax-financed health services is that potential negative effects from the perspective of patients/citizens are reduced or eliminated. If this capacity does

not exist at a certain location or for a certain type of service, the private provider should be offered a special service contract enabling continued provision of services. In a Swedish context, this may, for example, be the case for certain publicly funded private for-profit specialists and dentists. Ideology must never create negative effects for those who are supposed to benefit from this ideology.

This public health reform should be developed within a participatory, open democratic process in close cooperation with labor unions, organizations for medical professionals, associations for the elderly, and different groups of patients. Potential private nonprofit or cooperative providers of care should also be invited to contribute to further develop a nonprofit “Swedish health care model.”

The attacks against this public health care reform from conservative and neoliberal political parties, commercial health care providers, and private insurance companies will be intense and well-organized. One counter-argument, when they claim that the government forbids private for-profit care, is that this is not a policy against private for-profit providers. They are of course free to continue their business on normal commercial terms. It is a policy where those financing health care services also decide how their resources should be used. Private for-profit providers can never claim to have a right to have their services financed by public funds.

This is an issue to be decided within the democratic political process. The present conservative neoliberal government strongly favors tax-financed for-profit care. Only two political parties—the left party and the environmental party—are today promoting a nonprofit health care system. They have around 15 percent of the “votes” in recent polls. The social democrats, with around 30 percent to 35 percent of the “votes,” have at their latest congress (2013) decided to accept for-profit care if it is of good quality. Public opinion and pressure from many party members have since led to a recent decision not to allow profit-driven tax-financed hospitals. The leader of the party (Stefan Löfvén) has also recently stated that they will—if in power—abolish NPM methods within the tax-financed health care system that reduce the time doctors and other medical personnel can spend with patients.

The differences between the “red/green parties” now in opposition are thus diminishing, but major differences still exist related to for-profit outpatient care (i.e., the type of care where the privatization process mainly has been implemented). If the present opposition parties win the election in September 2014, it is thus likely that the regulatory framework and quality controls will be further developed, while the number of tax-financed private for-profit providers of outpatient care will continue to increase, albeit at a slower pace. No public hospitals are likely to be privatized. Political pressure from within and from the left party and the environmental party may, over time, change the policy of the social democrats toward a nonprofit policy. Labor unions, organizations for

the elderly, and an increasing number of medical professionals, together with other organizations and pro-public networks, will also continue to try to convince the more right-wing leaders among the social democrats to move toward a nonprofit tax-financed health care system.

If, on the other hand, the conservative/neoliberal parties now in power win the election, intensified efforts will be made to privatize the health care providers and gradually to increase the share of private financing. Sweden will then drive faster than most other West European countries on the international autostrada designed by Milton Freedman toward a commercial health care market.

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