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Future directions

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Summary

In this final paper, we summarise briefly the principal conclusions to emerge from the conference. We also review possible future directions in the light of the contributions of different authors and discussions at the conference. The paper argues that changes in the Swedish health services are both inevitable and desirable. The challenge is to maintain the strengths of the existing system while tackling widely acknowledged weaknesses. It is not yet clear what will emerge from the process of reform but the probable outcome is a period of innovation and experimentation leading to greater diversity in service provision. We argue that diversity is most likely to develop within the context of a continuing commitment to equity and comprehensiveness in the delivery of health care.

Key words: The Swedish model; Health care; Reforms; Private sector; Competition

The papers presented in this issue testify to the strengths of the Swedish health services. As a number of authors argue, Sweden has a deserved international reputation as a country which has made a major commitment to the funding and delivery of comprehensive health services. These services are available to all citizens on an equal basis and are delivered to a high standard. As comparative data demonstrate, Swedes enjoy good health by international standards. Not only have hospital and primary care services been extensively developed, but also government has committed itself to the 'Health For All by the Year 2000' strategy promulgated by WHO. This includes support for inter-sectoral action to bring about further improvements in health.

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Notwithstanding these achievements, the Swedish model has come under increasing challenge in recent years. There are a number of reasons for this. At the most general level, the commitment in Swedish society as a whole to a policy of high levels of public expenditure financed through high levels of taxation has started to weaken. In the face of declining national economic performance, Social Democrat politicians have sought to reduce public expenditure and to shift the burden of taxation from direct to indirect taxes. This has been associated with measures to increase the efficiency with which public resources are used. The health services have been significantly influenced by these developments and have gone through a period of tight expenditure control.

A second important factor has been the opening up of Eastern Europe and the consequent questioning of traditional methods of running public services. The transition from state ownership to private enterprise in Eastern Europe, and the gradual replacement of command and control systems with mixed economies and market principles, has important implications for Sweden which has sought in the past to find a middle way between the economic and social systems of Eastern and Western Europe. This has been reinforced by the interest shown in Sweden in membership of the European Community. The consequence has been to stimulate debate about new ways of organising public services, involving acceptance of a greater degree of pluralism than has previously been the case.

Alongside developments at the macro level have emerged a number of more specific concerns about the performance of public services. During the 1980s this was manifested in a programme of action initiated by the Social Democrats concerned with the renewal of the public sector. A range of initiatives were undertaken designed to refashion public services to enable them to better meet the challenges of the private sector. In parallel, Conservative politicians showed increasing interest in encouraging the role of the private sector as a provider of services and in introducing competitive principles. In the case of the health services, concern that service providers were not sufficiently responsive to patients and the public and lacked real incentives for efficiency were important considerations in supporting the search for alternatives. These considerations were reinforced by lengthening waiting lists for non-urgent surgery and the limited choice available to patients.

Options for reform

As the movement to reform health services gained momentum, attention focused on a number of options for change. Given the strong emphasis in the past on planning and administration as control mechanisms, one school of thought was that priority should be given to strengthening management arrangements to tackle the weaknesses that existed. Ham's paper in this issue

represents this approach to reform and suggests several ways in which changes might be taken forward. These include:

- clarifying the role of the Ministry of Health and Social Affairs and the National Board of Health and Welfare in relation to the county councils
- strengthening management in the county councils to clarify the respective roles of politicians and managers and to support the development of general management
- developing management arrangements in hospitals to consolidate the part already played by doctors in management and strengthening the role of general managers
- separating responsibility for purchasing and providing health services within county councils in order to increase the accountability of service providers.

As Ham emphasised at the conference, these proposals were not designed to perfect command and control systems within the health services. Rather, they were intended to move the health services from an administered system to a dynamic management culture. Drawing on best management practices across a range of public and private sector organisations, the proposals seek to give politicians and managers space in which to be creative and innovative. The aim is not to constrain local initiative through tight central rules and regulations but to establish a clear and agreed national policy framework and to hold county councils responsible for delivering higher quality services within the context of that framework.

A second option for reform is to build on the growing role of the private health care sector in Sweden. Rosenthal's paper in this issue highlights the expansion of the private sector in recent years and indicates that a mixed market already exists, albeit on a limited scale. If the constraints on public expenditure continue to be tight, it can be anticipated that an increasing number of Swedes will take out private insurance and make use of private providers. The growth that has occurred to date has taken place without any official encouragement or tax incentives. In view of this, expansion has been remarkable, and any move to introduce incentives would provide a clear signal for future, rapid growth. It remains unclear whether this will act as a spur to efficiency and productivity in the public sector, or serve to undermine the commitment to equity.

A third possibility is to encourage the emergence of competition within the public system. Saltman and von Otter's paper in this issue sets out the arguments for public competition or what they refer to as planned markets. As Saltman and von Otter note, there is increasing interest in this path of reform within the county councils. The approach that is most widely discussed in Sweden is the Dalamodel initiated in Kopparberg County Council in 1991. This seeks to devolve budgets to primary health care boards and charges these boards with both providing primary care services and purchasing secondary care from hospitals. Key features of the Dalamodel are the emphasis placed on patient choice and the use of competition as an incentive for providers to improve their performance. A number of other county councils have initiated similar experiments.

Those attending the conference emphasised that these three options were not mutually exclusive. Indeed, it was argued that a real strength of the decentralised nature of the Swedish system was the opportunity it created for reform to proceed along a number of paths simultaneously. As several speakers and participants argued, it was vital for the experiments and innovations that were taking place to be properly monitored and evaluated to enable the lessons to be learned and assimilated.

Strengths and weaknesses

In relation to the options that were identified, a number of participants doubted that improvements to management arrangements would in themselves be sufficient to achieve real changes in service delivery. Indeed, it was argued that strengthening the role of the centre in relation to county councils would be a retrograde step, out of keeping with a trend towards greater devolution of responsibility to local government. In the view of many of those present, a better alternative was to seek to enhance the accountability of county councils to the populations they served. Questions were also raised about the potential for strengthening management in the absence of competitive incentives. It was suggested that only through the operation of a market or quasi market would managers be faced with the need to genuinely increase efficiency and respond to patients.

As far as the role of the private sector was concerned, it was recognised that the growth that had occurred during the 1980s gave an important indication of public dissatisfaction with the public system. The emergence of a more informed and educated generation of patients with high expectations of service standards meant that lack of choice and long waits for treatment were unlikely to be tolerated. If the county councils did not act to address these issues, then further growth of the private sector was inevitable.

Two important questions were raised about the growth of the private sector: is it part of the problem or part of the solution? And does private medicine increase public efficiency or challenge equity? The principles of a comprehensive Welfare State are to promote high-quality standards, with equity and access, so that, theoretically, everyone shares the best in universal solidarity. This should have eliminated the need for private alternatives.

It remains unclear whether the growth of the private sector, under the Social Democrats, was a reflection of some failure of the Welfare State, a response to central government's need to quietly shift some of the economic burden of health care to the private sector, a reaction to the growth of individualistic ideologies, or all of these. Now that the Social Democrats have lost the 1991 election and a Conservative coalition is governing the country, it is likely that some official forms of privatisation will be promoted in health care. Most likely, this will be in the primary care sector, but may include hospital specialists as well. The issue of equity will remain, however, since the

Conservative parties have shared that commitment with the Social Democrats for a number of decades.

As many participants at the conference pointed out, the growth of the private sector could result in a two-tier system. Not only would private patients receive faster treatment, but also private providers might attract better trained staff. Over a number of years, this could result in the private sector offering higher standards of care than the public sector.

In respect of the third strategy of reform, the development of public competition and planned markets, it was recognised that significant change was already taking place. The popularity of competitive approaches had led to major innovations in a number of county councils and in this sense reform is well underway. Nevertheless, some participants at the conference pointed out that there was little empirical evidence that competition produced the results claimed by its proponents. What evidence there is suggests that competition tends to lead to quality competition not price competition. Maynard and others warned that competitive reforms such as those under way in the UK, Holland and parts of the Swedish system may bring benefits but they require careful experimentation and monitoring. Equally important if not more so was the need to produce the missing data on the cost and effectiveness of services which would enable better decisions to be made about the use of resources.

Developing this theme, it was argued that although experiments in competition had already been initiated and were unlikely to be reversed, they ran the risk of introducing changes that were more radical than might be necessary. If, as most participants agreed, the Swedish health services performed well on many criteria, then it was essential that the process of reform did not undermine what had already been achieved. The advocates of management changes contended that their proposals ought to be tested out in advance of a more widespread application of market ideas. In Sweden, as in other public health care systems, effective management of services had not failed because it had not been tried. In view of the uncertain impact of competition on efficiency, access and equity, there was a strong case for seeking to improve management arrangements before embracing more far reaching changes.

The crossroads project

The conference took place during the middle of a review of Swedish health services initiated by the County Councils' Federation, the Ministry of Health and Social Affairs and the National Board of Health and Welfare. Known as the Crossroads Project, the review drew on experience both within Sweden and outside to identify options for reform. The project was completed during 1991 and the report was released to the congress of the County Councils' Federation in June 1991.

The report takes the form of a discussion document outlining the key

features of the Swedish model in the context of experience in other countries. Rather than choosing a particular path of reform, it outlines three scenarios for change. The report takes the form of a discussion document outlining the key features of the Swedish model in the context of experience in other countries. Rather than choosing a particular path of reform, it outlines three scenarios for change. All scenarios assume that there will be integration of social insurance sickness benefits and health insurance. High priority too is attached to increasing the choices available to patients and stimulating competition between providers. Against this background, one scenario suggests a move towards national responsibility for health services, another describes how health services might come under the control of regional parliaments, and a third combines national responsibility for the health care of people of working age and local responsibility for the health care of children, youth and elderly people. The congress of the County Councils Federation welcomed the report as a basis for debate. The replacement of the Social Democrat government by a Conservative coalition at the September 1991 election increased the likelihood that reform would be radical rather than incremental.

Conclusion

As the papers in this issue demonstrates, the conference provided a unique opportunity for Swedish politicians, managers, health professionals and researchers to review the strengths and weaknesses of their health services from the perspective of foreign observers. The papers presented by the analysts from outside Sweden acted as a catalyst in bringing together key actors with responsibility for guiding health services into the future. If there was no consensus as a result of the ensuing debate, then this is as much a reflection of the current state of discussion in Sweden as a commentary on the diversity of the contributions made by the speakers and participants. At a time when health services in many developed countries are undergoing a process of review and reform, Sweden continues to offer lessons to others. In this sense, the papers in this issue should be of interest not only to Swedes but to policy makers seeking to understand more clearly the direction in which change might occur.