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INTERNATIONAL HEALTH CARE SYSTEMS

The Public–Private Pendulum — Patient Choice and Equity in Sweden

Anders Anell, Ph.D.

Decision making in Swedish health care is decentralized — 21 elected county councils own and operate almost all hospitals and a majority of primary care facilities, and most physicians are salaried employees of these institutions. There is universal access to high-quality medical services for all citizens at reasonable expenditure levels (see table and case histories). But the picture is more nuanced than those general facts might imply. Waiting times for consultations and treatment and lack of patient-centeredness are persistent problems, and services are not always distributed equitably, to name a few common concerns.[1] The types of organizational reforms undertaken to address such problems depend in part on the ideologies of both the national and local governments — a factor that has been most evident in recent policies related to patient choice and the private provision of care.

An interactive graphic is available at NEJM.org

The current Swedish health care system is largely the product of past national governments led by the Social Democrats, which strongly emphasized equity and reliance on the public sector. Since 1990, however, both center-right and center-left governments have turned to competition and consumer choice as ways to increase efficiency in areas previously dominated by public monopolies. Together with tax-policy reforms and liberal labor-immigration policies, these changes have substantially transformed the Swedish economy over the past 25 years.[2]

When it comes to health care, social services, and education, however, political opinions in Sweden have been more divided. The center-right government that was in place from 1992 to 1994 introduced changes that created opportunities for private providers of outpatient care. But these changes were reversed by a later government led by the Social Democrats, which also introduced a so-called stop law in 2000 to prevent county councils from contracting out the operation of emergency hospitals to private

PREGNANCY AND CHILDBIRTH

A healthy 23-year-old woman is pregnant for the first time.

Although the organization of services for prenatal, delivery, and postnatal care in Sweden varies among county councils, when Ms. Andersson becomes pregnant, she knows she will receive publicly funded services without having to make copayments. In a neighboring county, pregnancy services are offered by the primary health care center that a woman has chosen, but in Ms. Andersson's county, she can choose, before week 12 of her pregnancy, to register with a separate center offering maternity and child care.

At that center, clinicians monitor Ms. Andersson's pregnancy and identify any risk factors for poor outcomes, and she and her partner are offered counseling and support. Early in her prenatal care, she has a motivational consultation with a specialist nurse about use of alcohol, tobacco, and drugs; diet; existing medications; and physical activity. When she is offered prenatal tests, she is given relevant information about ethical dilemmas involved in testing — and the clear indication that tests are voluntary.

At week 24 or 25, her biweekly visits with a specialist nurse begin. Counseling and support are offered to both Ms. Andersson and her partner, often in group activities, to inform and prepare them for childbirth and early parenthood. In principle, Ms. Andersson can choose the hospital in which she wants give birth, but if there is no room for her there, she may have to go elsewhere. She is likely to deliver the baby vaginally, since the proportion of cesarean births in Sweden is on average below 20%. Sixteen weeks after delivery, Ms. Andersson will have a follow-up visit with a specialist nurse. At this time she is also offered a gynecologic consultation.

providers. This law was, in turn, reversed by a center-right government that held office between 2006 and 2014. In practice, only one acute care hospital in Stockholm has been contracted out since the early 1990s. But more visible changes have been implemented outside hospitals.

The model of primary care that was put in place in Sweden in the early 1970s, in which publicly owned health centers employ a multidisciplinary workforce, is rather unusual from an international perspective. Typically, a Swedish primary care center employs four general practitioners (GPs), as well as nurses with triage responsibility, physiotherapists and occupational therapists, social workers and cognitive therapists, and specialist nurses in areas such as diabetes or asthma and chronic obstructive pulmonary disease. The proportion of GPs is lower than that in most other comparable high-income countries, as are investments in other primary care resources. Because of the lack of a gatekeeping role for primary care, a 2010 report from the Organization for Economic Cooperation and Development classified Swedish health care in the same category as the systems of Iceland and Turkey, rather than with its Nordic neighbors.[3]

A wave of primary care reforms involving increased patient choice and the privatization of providers was initiated by county councils starting in 2007. Important objectives behind these reforms were to strengthen the role of primary care in general and to improve access for and responsiveness to patients. Inspired by these local initiatives, the center-right national government developed a new law, and freedom of establishment for private primary care providers with public payment to an individual's chosen provider became mandatory for county councils in 2010.

Nationally, the number of primary care providers has increased by 20% since this reform was implemented, but the private–public mix varies, with more private providers in urban areas than in rural areas. Several studies show an increase in the number of people who have contact with primary care providers and in the number of physician contacts per person.[4] In the few counties where studies have been conducted, results indicate that the population at large may have benefited more than the subgroup of patients with serious disease, and people with above-median incomes may have benefited more than their lower-income counterparts. There is no evidence that the quality or efficiency of private providers differs systematically from those of public providers — nor should such differences necessarily be expected, since providers' responsibilities and payments are the same irrespective of their ownership. Most new private providers are located in densely populated areas, however, and the national regulation of freedom of establishment for providers means that county councils have limited options for influencing private providers' decisions about where to set up their practices.

The organization of pharmacy services in Sweden has also changed in recent years. Until 2008, both community and hospital pharmacies were owned and operated by a single state-owned corporation formed in 1970, when the formerly private pharmacies were taken over by the public monopoly. Sale of over-the-counter medicines was restricted to pharmacies. In 2009, the pharmacy markets were deregulated in terms of barriers to entry and ownership, and selected over-the-counter medicines became avail-

MYOCARDIAL INFARCTION

A 55-year-old man with no serious health conditions has a moderately severe myocardial infarction.

Since the acute management of myocardial infarction varies with the type and severity of the event, when the emergency medical technicians arrive at Mr. Johansson's home, they begin administering diagnostic tests, pain management, and antiischemic treatment, using electrocardiography to determine whether he requires primary percutaneous coronary intervention (PCI). If he does, he can be transported directly to a hospital with primary PCI capacity, distance permitting. Since Mr. Johansson does not require it, when he reaches the hospital, he undergoes coronary angiography within 24 to 48 hours, and then PCI or coronary bypass surgery if appropriate. Before the intervention, he's given dual-antiplatelet therapy plus an anticoagulant, antiischemic therapy, and a high-dose statin.

Mr. Johansson remains in the hospital for 3 to 5 days. Echocardiography is performed to evaluate his left ventricular function and to determine the recommended intensity and type of long-term medication and further interventions. After discharge, Mr. Johansson is offered a follow-up visit at the cardiovascular clinic and, if suitable, participation in a rehabilitation program before being referred to primary care.

Secondary prevention in primary care should ideally reduce Mr. Johansson's risk factors, such as smoking, high blood pressure, high cholesterol levels, and lack of physical activity — although he is unlikely to reach his designated targets in all four areas within a year (only 12% of patients do so, though there is substantial geographic variation). All the services Mr. Johansson receives are publicly funded, but he must pay fixed copayments per visit with a ceiling of 1,100 SEK ($150 U.S.) per year and copayments for prescription drugs with a ceiling of 2,200 SEK ($300) per year.

able outside pharmacies. The state-owned pharmacy corporation still exists, but most of its pharmacies were sold to new competitors as part of the reform. Despite political intentions to allow individually owned pharmacies, which existed before 1970, most pharmacies are now part of four dominant national chains, owned by pharmacy wholesalers and capital investors. Studies show that reforms have increased the number of pharmacies by 40% and improved access for most people. There is some concern, however, that pharmacies may have gone too far in reducing their inventory and deliveries from wholesalers, thereby reducing their capacity to deliver all medicines to customers within the 24 hours required by law.[4]

These reforms in the pharmacy market and primary care have been described as a clear break with Swedish traditions. From a historical perspective, however, it is rather the period of full public ownership beginning in 1970 that represents the exception. Important changes were made in the early 1970s, when formerly private pharmacies were taken over by the public monopoly and when physicians, who had previously provided outpatient services independently, became fully salaried. In a 1973 *Journal* article, Shenkin described the latter reform as not very rational — but nevertheless a strong indicator of the Swedish commitment to equality.[5]

With the return to private ownership, the Swedish pharmacy market faces more liberal regulation than its counterparts in several other European countries. In France, Germany, and Denmark, for example, private pharmacies have strongly opposed deregulation of ownership and formation of national chains. Similarly, Sweden now has more liberal rules for market entry and private ownership of primary care providers than do many European countries with long traditions of regulated private markets.

On an ideological level, there are public concerns about the impact of recent privatization, not only in health care but also in education and social services. Studies show that the Swedish public wants choice but is more skeptical about profit incentives in tax-funded markets and about the payment of dividends by health care providers to owners. These concerns have been fueled by media reports that some health care corporations that are owned by venture capitalists have had quality problems in nursing home care and are using offshore companies to avoid paying taxes. There is no evidence that skimping on quality is more or less common among private providers than among publicly owned ones, but quality problems may be perceived as worse when they're linked to profit incentives. Since 2006, it has been possible for a private provider to register in Sweden as a limited company with restricted dividends, similar to a community interest company in the United Kingdom or a low-profit limited-liability company in the United States. So far, however, there has been no interest among Swedish private health care providers in pursuing this option.

Although it will be difficult to reverse reforms, the center-left national government that was elected in September 2014 may find popular support for halting the privatization of care. The new government has made early promises to propose a new stop

Selected Characteristics of the Health Care System and Health Outcomes in Sweden.*

Variable	Value
Health expenditures	
Per capita ($ U.S.)	5,319
Percentage of GDP	9.6
Public sources (% of total)	81.7
Health insurance	
Rate in population (%)	100
Source of funding	Local and state taxes
Average annual base salary for senior physician in 2013	858,000 SEK ($92,511)
Generalist–specialist balance in 2011 (%)	
Generalists	16
Specialists	54
Access	
No. of hospital beds per 10,000 population in 2011	27
No. of physicians per 1000 population in 2010	3.8
Total government health expenditures spent on mental health care in 2011 (%)	10
Primary care physicians using electronic medical records (%)	88
Life and death	
Life expectancy at birth (yr)	82
Additional life expectancy at 60 yr (yr)	24
Annual no. of deaths per 1000 population	10
Annual no. of infant deaths per 1000 live births in 2013	2
Annual no. of deaths of children <5 yr of age per 1000 live births in 2013	3
Annual no. of maternal deaths per 100,000 live births in 2013	4
Fertility and childbirth	
Average no. of births per woman	1.9
Births attended by skilled health personnel (%)	100
Pregnant women receiving any prenatal care in 2004 (%)	100
Preventive care	
General availability of colorectal-cancer screening at primary care level	No
Children 12–23 mo of age receiving measles immunization in 2013 (%)	97
Prevalence of chronic diseases (%)	
Diabetes (% of 2013 population 29–79 yr old)	4.7
HIV	<0.1
Prevalence of risk factors (%)	
Obesity in adults >20 yr of age in 2008	16.6
Overweight in children <5 yr of age	8.0–13.5
Smoking in 2011	24.0

* Data are from the World Bank, the Swedish Medical Association, the Organization for Economic Cooperation and Development, the Commonwealth Fund, the World Health Organization, and the Public Health Agency of Sweden as of 2012 except as noted. The percentages of generalists and specialists are for physicians who have completed additional training and taken a specialist exam within a chosen medical field (which may be a generalist field); the remaining 30% include physicians engaged in such advanced training programs, those trained in other countries who are pursuing qualification in Sweden, and newer physicians who have not yet chosen a specialty. GDP denotes gross domestic product, and HIV human immunodeficiency virus.

law preventing the contracting out of the operation of hospitals responsible for tertiary care, to reverse the law mandating freedom of establishment for private primary care providers, to create a committee focused on equity in health, and to launch an investigation regarding regulation of for-profit health care providers. It is less clear how the new government is going to address persistent problems related to patient-centeredness and waiting times. The government's suggestions, like the policy changes that were criticized in this journal in 1973, may not be totally rational, given the evidence of the effects of recent reforms, but they once again reflect Sweden's strong commitment to equality in health care services.

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Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Lund University School of Economics and Management, Lund, Sweden.

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