Privatisation of Hospitals – Swedish experiences

AEHM Conference
Brussels 7 May 2009

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Perspective

- Health services ”production methods” are increasingly becoming international – medical technology for example
- Health services delivery and system is still shaped very much by culture, tradition, social and economic context
- It is important to develop methods to compare between countries for learning and understanding of the issues

Europe - and North America

- Within Europe more detailed comparisons of health systems begin to develop due to the dynamics of the European Union.The European Observatory on Health Systems and Policies is an important actor
- Also ”integration” between the European systems will increase – but the pace is slow because of ”cultural” conditions
- It is also of great interest to develop methods to compare health services between Europe and North America. USA under president Obama is refocusing internationally

Dimensions for comparisons (The ”iron triangle”)

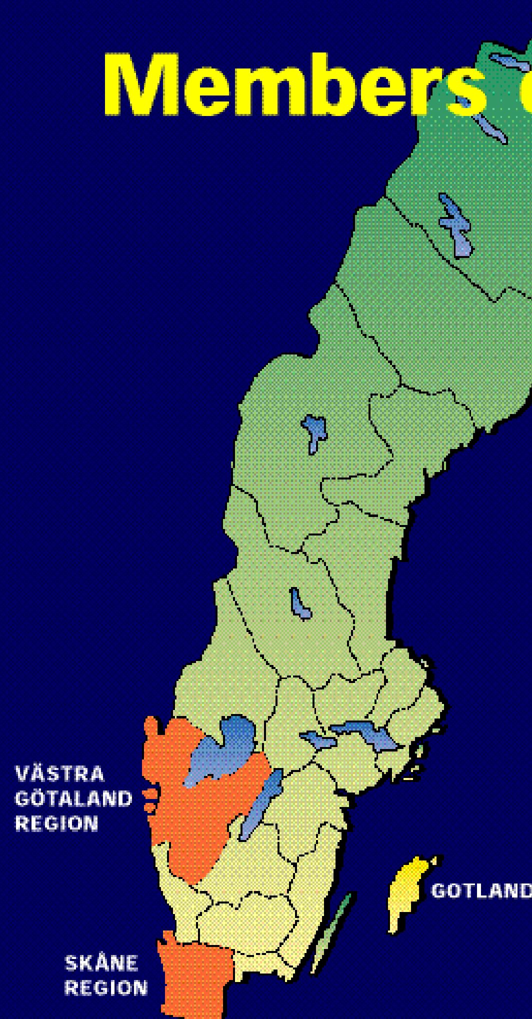
- Financing – who pays?
- Structure and organization – who delivers and how ?
- Quality – who get´s what, when and with which result ?

- The role of the medical profession – becomes increasingly important to understand dynamics and functions of the health systems

The Swedish health system

- Dominantly public regarding financing, ownership and delivery of services
- Minor “private” elements integrated in the public financing – mostly working on contracts from the county councils
- Local strong base for the delivery of services with 21 county councils responsible for financing (80 % of total), planning and delivery of services - “monolithic”
- A regional planning regarding highly specialized care since the 1960´s

Members of the Federation



The Federation has 21 members:

- 18 County Councils
- Skåne Region
- Västra Götaland Region
- The Municipality of Gotland

The Swedish health system,cont.

- Physicians salaried since 1970 – relatively small differentials between specialities and parts of the country
- The system is mainly budget based and controlled, little “incentive” thinking
- A public health perspective in planning and well developed intersectorial cooperation has been important for health results and outcome

The Swedish system, cont.

- A strong hospital orientation
- Traditionally weak primary care - no “gate keeping”
- “Consensus” politics. A tradition for co-operation between physicians, managers and politicians
- Much “governing” of the system is performed through “informal” interaction

A division of responsibility for care of the elderly and chronic patients

- County councils are responsible for all needed medical care – inpatient and outpatient specialized care and primary care
- Municipalities are responsible for “nursing care” in the home and “sheltered living”
- Advanced home health care is developed quite rapidly but unevenly over the country

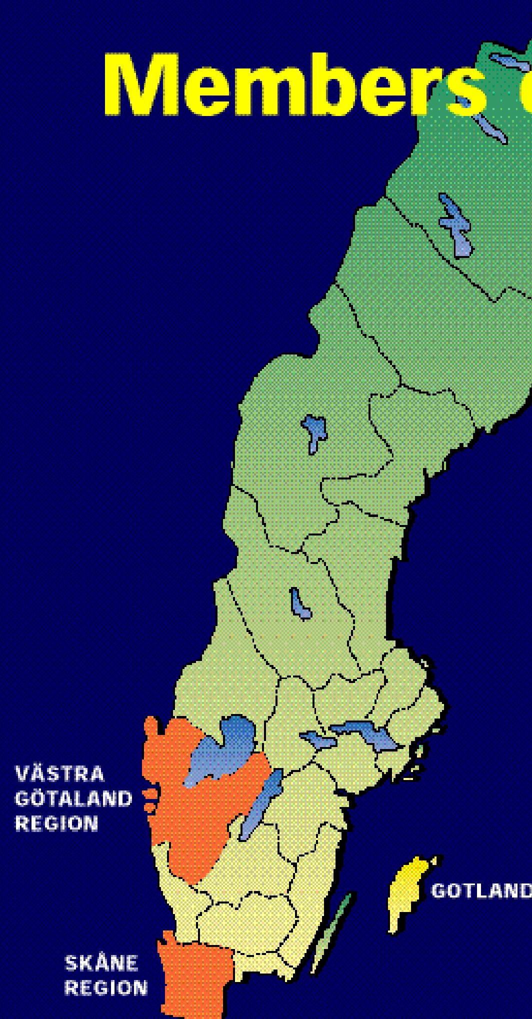
Decentralization, but still national coordination and steering through many formal and informal mechanisms

- Legislative and economic control by gvnmt.
- Supervision and control by authorities (medical, pharmaceutical, disciplinary)
- Well developed patient data bases (based on "personal numbers")
- Technology Assessment (SBU), QA focus in several national bodies
- Quality registries developed by medical specialty societies (over 60 disease specific registries)

Local/regional/national dynamics

- Budget resource constraints during 1990´s "triggered" a wave of structural reforms - hospital mergers, closures and integration of services ("seamless care)
- Spending presently approx 9,5 % of GD
- The process that county councils merged to regions had a resource and quality drive – but have now come to a "standstill"

Members of the Federation



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Structural changes from 1995 and onwards (to beginning of 2000)

- Mergers between hospitals
- Structural changes within hospitals and between the levels in the system ("chains" of care, "seamless" care etc)
- Co-operation over county council borders (selective parts of the health services spectrum)
- Forming of bigger regions (in West Sweden and in the south, "Skåne")

How will the present financial crisis affect health care ?

- Health financing directly linked to taxable income (a year later)
- County councils will move into deficit
- A pressure for change – as last “crisis” during the 1990´s
- It can go two ways – renewal, innovation, change, new ideas <u>or:</u>
- “Rapid cuts”, “stand still”, “no new actors”
- An open issue………. ?

Strength in the Swedish approach and tradition

- Cost control is working
- Structural changes of the “production machinery” are developing at a reasonable pace
- A gradual development towards greater “diversity” ?
- Equity is maintained - both as an ideal and a practice

Strength in the Swedish approach and tradition cont.

- Multisectoral co-operation for health gain is maintained - and good results are still achieved
- Excellent possibilities for combining population approach, cost containment and a rational production system

Weaknesses and threats in the Swedish approach

- Access and queue problems
- A relative lack of integration between hospital care, primary care and municipality care and services
- Willingness and loyalty among doctors and nurses towards the “system”?
- Incentives for production and productivity?

Weaknesses and threats in the Swedish approach cont.

- Roles of professions, politicians and managers?
- The combination of population expectations, unstable political coalitions, resource demands
- Future health funding in a globalized world?

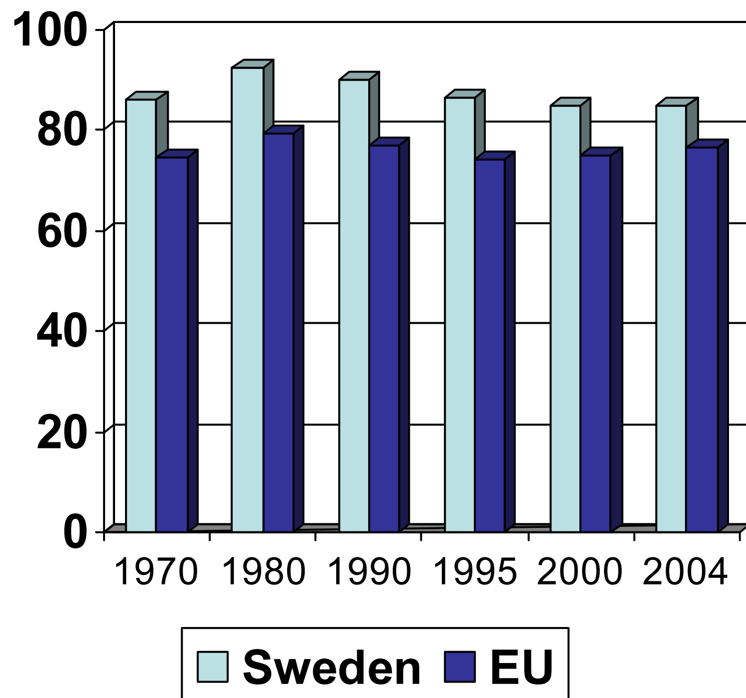
A new agenda in Sweden ?

- Political shift in October 2006 to a liberal coalition government
- A focus on diversity, innovation, ”renewal”, access
- Change of law to allow for-profit companies to own and to operate health facilities – if county councils want
- Allowe a mix of public and private financing from the same provider
- A gradual diversity regarding delivery of services is evolving ?
- For profit ? Not for profit ? Long term role of the County Councils ?

Policy steps so far

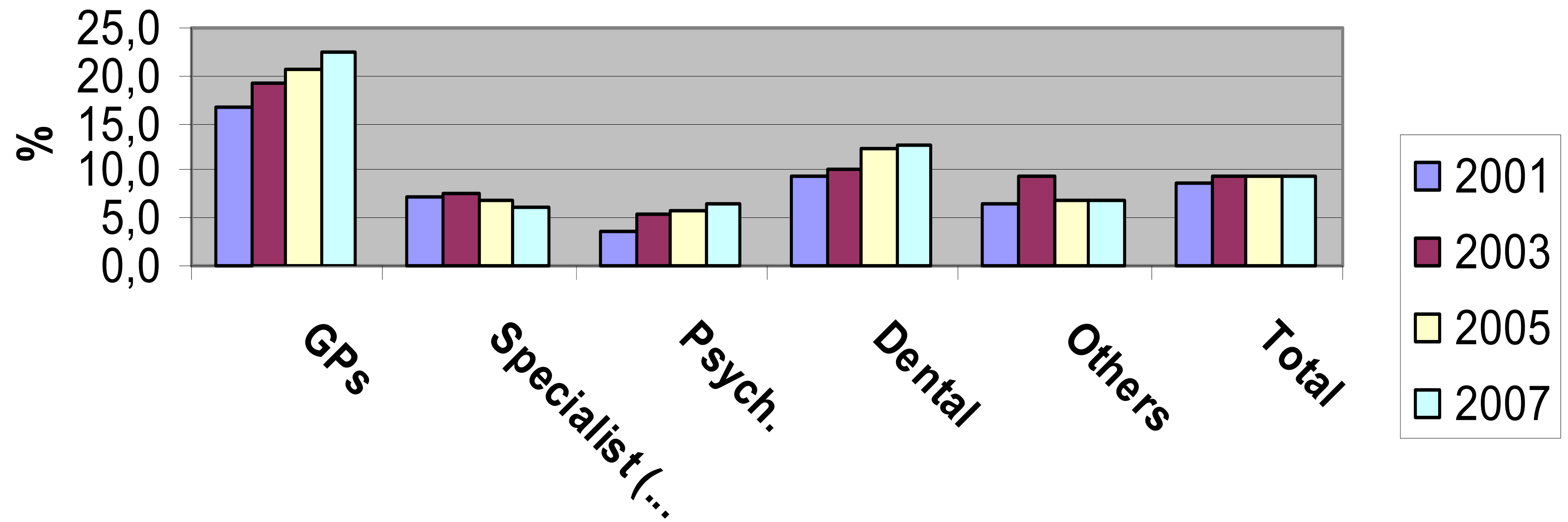
- Implementation of a GP-system (UK, Danish, ”European” – style) with patient choice among providers and freedom to establish a GP-practice given certain certification requirements
- Pressure on county councils to increase contracting with private providers
- Pharmaceutical monopoly challenged – more than half of the pharmacies are put on a process of sale to private actors

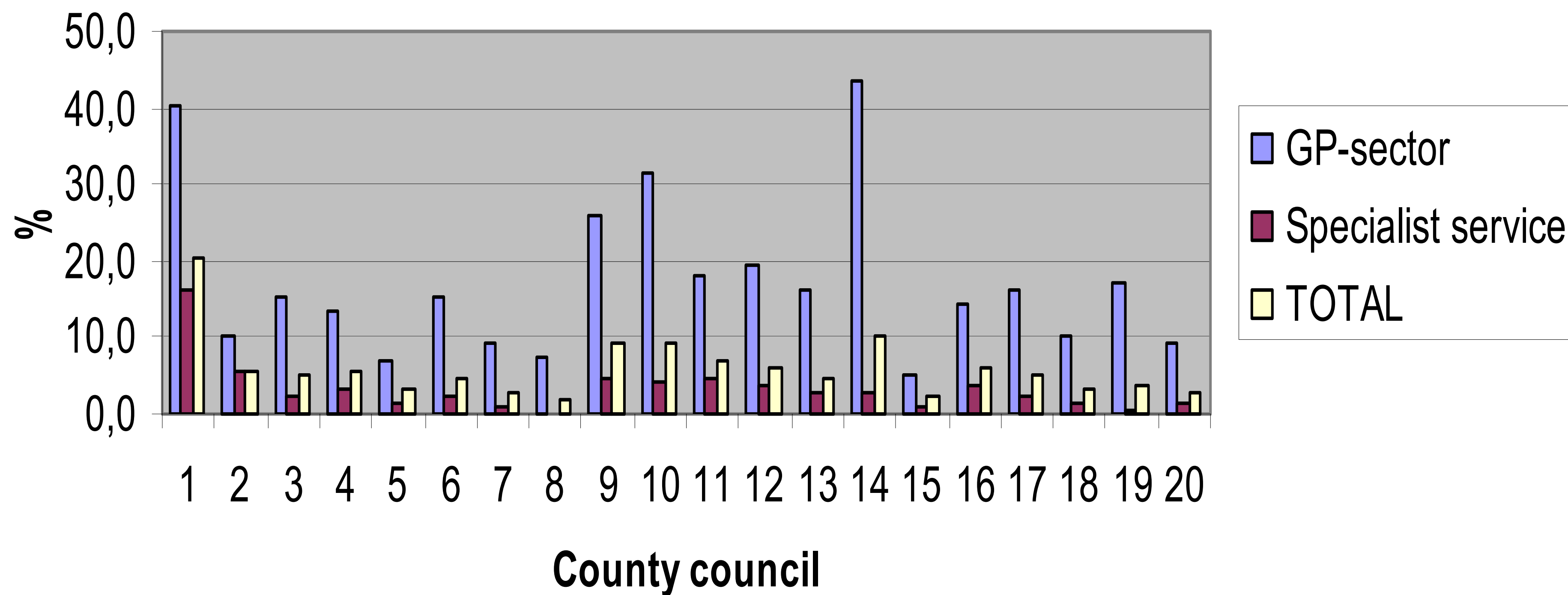
Sweden: financing of health services



- Stable share of public financing
- Small segment (3%) of private health insurance (some increase)
- Monopoly power by the county councils/regions

Contracted services per sub-sector, Sweden 2001-2007 (%)




Purchase of health service by county councils, 2007 (% of net costs)
50,0
40,0
30,0
20,0
10,0
0,0
%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
County council
GP-sector
Specialist service
TOTAL

Private ownership mix, Sweden

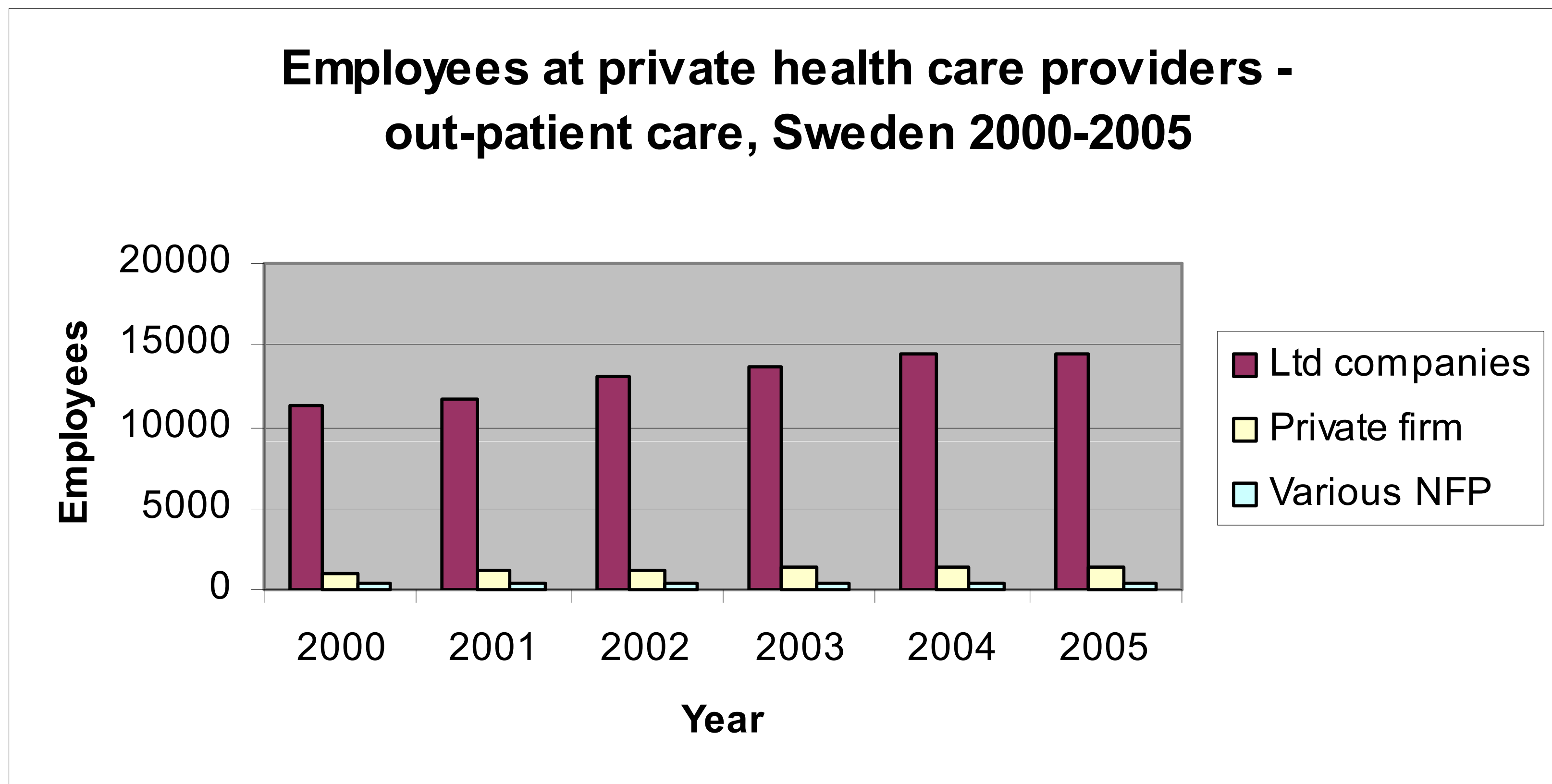
For-Profit:

- Out-patient specialty care
- Private specialists
- Elective procedure hospital
- GPs
- Home help agencies

Not-for-profit:

- Elective procedure hospital
- Hospice hospital (palliative care)
- Specialist (out-patient care)

Employment – private out-patient providers



Contracting private providers

- National tariff-system (FFS) for private specialist (FP?)
- Public procurement (elective surgery, rehab,) – FP more successful than NFP
  - EU-directives
  - NFP – access to capital
- Patient choice (voucher-model) – FP (small business dominates)
- Hospital sector - bilateral monopoly (‘lock-in’ effects)

Challenges

- How to move towards a ”needed” (unavoidable?) diversity without losing for example cost control ?
- How to ”decide” on limits and coverage ?
- How to use ”entrepreneurial spirits” among health professionals for innovation ?
- How to maintain ”equity in spirit” within services, how to increase equity in outcome and access ?
- How to enhance macro and micro management of the system – given the heavy political influence structurally ?

Challenges for future health services management

- To handle the most complex ”knowledge system” – rapid change, professional drivers, pride and wish of autonomy
- To meet expectations – from public, politicians, professionals
- To balance - resource use, technology, demands, outputs, values
- To use professional driving forces and let different groups act independently within agreed limits (physician ”self-governing”)

The future health management

- Works more adaptive and quick
- Uses more precise ”tools” designed for health services purposes
- Uses new powerful ”tools” that builds on today´s quality methods, medical technology assessment, evidence based knowledge base (Cochrane etc)
- To implement and to act on best available knowledge will be important

Thank you – looking forward to your comments!