

Recent health policy initiatives in Nordic countries

by Richard B. Saltman

Health care systems in Sweden, Finland, and Denmark are in the midst of substantial organizational reconfiguration. Although retaining their tax-based single source financing arrangements, they have begun experiments that introduce a limited measure of competitive behavior in the delivery of health services. The emphasis has been on restructuring public operated

hospitals and health centers into various forms of public firms, rather than on the privatization of ownership of institutions. If successful, the reforms will enable these Nordic countries to combine their existing macroeconomic controls with enhanced microeconomic efficiency, effectiveness, and responsiveness to patients.

Introduction

This article reviews current reform experiments and proposals that reflect the search for a new, specifically Nordic planned market approach to the delivery of health services. It examines both the intentions and the potential complications that accompany the present reform process. Finally, it considers a series of future factors that can be expected to affect the long-term implementation of Nordic planned market models.

Searching for a new paradigm

Health care systems in Sweden, Finland, and Denmark¹ are well reputed for their commitment to values of equity and social justice (Anderson, 1972). Access to comprehensive health services has been a fundamental pillar of the welfare state approach articulated in the post-World War II period throughout the region by Social-Democrat-led governments (Einhorn and Logue, 1989). Countries like Finland and Sweden were among the first (1972 and 1973 respectively) to acknowledge the limitations of hospital-based care and to make explicit national commitments to strengthen the role of primary care and preventive services (Köhler and Jakobsson, 1987). Partly as a result of these efforts, Finland was selected as a model country for the World Health Organization's Health For All program as defined in the 1978 Alma Ata Declaration, which identified a primary and preventive care strategy as the way forward for developed as well as developing countries (World Health Organization, 1984).²

The central mechanism by which these Nordic systems sought to achieve their objectives was through

public ownership, operation, and accountability of the health care financing and delivery systems. Although arrangements varied among the different countries and political cultures, with differing degrees of operating and/or financing responsibilities at the national, regional (county or provincial), and municipal levels, and differing degrees of political tension among these several levels of government, the core operating framework was much the same. In Sweden and Denmark, a regionally elected council, and in Finland a municipally elected council hired both an administrative staff to plan the necessary services and professional providers to deliver them. The result was a tax-based, publicly operated health system organized on a regional or municipal, democratically accountable, command-and-control basis.

Based on their performance, health care systems in these three Nordic countries have been among the most successful in the industrialized world. On measures of health status like infant mortality, all three countries are among the lowest in the world, while life expectancy in Sweden and Denmark is among the highest (NOMESKO, 1989). Although life expectancy in Finland is significantly shorter, particularly for males, the rate of improvement in the last decade has been significant, in part because of public policy toward health promotion (World Health Organization, 1991). On financial measures, similarly, the Nordic countries have had stable (or, in Sweden, declining) aggregate measures of health expenditure as a percent of gross domestic product (Schieber and Poullier, 1991).

During the 1980s, however, a series of new circumstances brought the long-term viability of the traditional Nordic planning approach into question. Among other factors, one can point to changes in demography (for example, 18 percent of the Swedish population is 65 years of age or over compared with 11 percent in the United States), technology (rapid advances in both invasive and non-invasive procedures, with a concomitant need for additional resources), and economy (constraints on public sector spending reflecting economic convergence either inside [Denmark] or in parallel with [Sweden and Finland] the European Community as well as strong competitive pressures from the growing globalization of the world economy). In terms of social culture, traditional Nordic stoicism toward one's personal lifestyle (in Sweden and Finland) as well as belief in the importance of solidarity with one's fellows began to erode, in part because of a

¹The absence of Norway and Iceland reflects the author's lack of empirical research experience in these two countries.

²In Europe, the World Health Organization Regional Office developed 38 specific targets as the basis for implementing the Health For All program. These stressed improvements in mortality and morbidity, health-related lifestyle changes, enhanced environmental monitoring and controls, and more comprehensive access to and participation in health services. The European Regional Office has established a Working Party on Health Care Reform in Europe to help incorporate a Health For All emphasis into current financial and organizational reforms.

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growing realization among the citizenry that they had in fact become well-off. The prior social ethic based on self-effacement was increasingly challenged by new forms of individualist behavior that included demands for more responsiveness to direct patient influence and treatment preferences within health care systems. However, health planners and policymakers, in their continued commitment to population-based objectives, tended to belittle the population's perception of a rising problem with queues for certain elective procedures (typically tied to new technologies for conditions that afflict elderly patients) and for some outpatient specialist visits, and to ignore the growing feeling among the citizenry of individual powerlessness in the face of the health and medical care establishment (Petersson et al., 1989).

These conflicting pressures came together in the late 1980s in a general perception that, although traditional command-and-control planning systems had succeeded admirably in advancing social objectives in the area of equity, there was considerable room for improvement in these health systems' level of organizational efficiency and responsiveness to patient preferences. What made this perception different from those that stimulated prior reform efforts, for example, decentralizing operating responsibility to county (Sweden and Denmark) or provincial (Finland) levels—was the shift in emphasis from continued commitment to command-and-control planning and its concomitant central administrative control to a widespread desire to establish a locally autonomous, incentive-driven, decisionmaking environment. The fact that this shift took hold in Sweden and Finland, with their then Social-Democrat-led governments (Denmark, which has been something of a laggard in this process, has had a Conservative-led coalition administration since 1982), and at roughly the same time as did the initiation of a similar reform process by a Conservative government in the United Kingdom, suggests the extent to which the fundamental pressures triggering this reform process in publicly operated health systems involved predominantly pragmatic rather than ideologically-driven criteria (Saltman, 1991).

The new wave of reform in these three Nordic countries can be traced to a 1987 decision by Stockholm County to allow pregnant women to select whichever of eight maternity clinics they preferred, and to link those decisions directly to clinic budgets. In January 1988, Stockholm County created a single fixed-price market in which maternity clinics were paid the estimated operating cost of an uncomplicated delivery. Although this experiment was not comprehensive (the payments did not, for example, include personnel salaries or capital costs), it successfully introduced the twin notions of patient choice and money following the patient (Saltman and von Otter, 1992), both of which represented a radical departure from the prior command-and-control framework.

A parallel inception in Finland was the introduction of capitation for general practitioners in the 1985-90 Personal Doctor Program (Vohlonen et al., 1989). In a series of experiments around the country, citizens could

choose to be on the list of a particular health center physician who would then be paid a three-part compensation predominantly determined by the size of his or her list (60 percent) and the degree of population coverage. Although this experiment was subsequently transformed into the considerably less patient-responsive Small Area Population-Based Responsibility Group Program (Saltman and von Otter, 1992), the same seminal issues—patient choice inside the public system and money following the patient—had been raised.

Starting in 1989, what began as a trickle widened into a flood of major reform experiments and proposals. Sweden and Finland are now making fundamental changes on the production side of their health systems. In Sweden, the new Conservative-led coalition government is also raising questions about how health care is financed. Although Denmark has been slower to take up the challenge, perhaps because of its weak coalition government, there are signs of movement there as well (Organization for Economic Cooperation and Development, to be published).

What began as an exercise in reformist reform, in an effort to mitigate problems of efficiency and responsiveness within Nordic health systems, has emerged as a full-fledged search for a new strategic model (Gorz, 1964). Viewed functionally, the present approach combines longstanding social objectives (equity of access to clinical services, population-based responsibility for preventive care, and better continuity of care among different service subsectors) with more recent financial objectives (increased efficiency of organizational performance, better management of existing institutional resources) and an increased concern for enhanced patient influence over services received. Viewed conceptually, Nordic health policymakers have begun to select specific mechanisms from a neo-classical market model of health delivery—consumer choice, negotiated contracts, performance-linked pay—and inject them into existing command-and-control planning structures in an effort to develop a new hybrid health system model that can best be termed a planned market (Saltman and von Otter, 1992).

Although planned market frameworks can be configured in a number of different ways, their central characteristic is that they are intentionally designed markets, constructed by public sector officials in a manner that maintains public accountability over institutional behavior and that will achieve explicitly public sector objectives. This new hybrid paradigm extends beyond the Nordic Region to include current reforms in the United Kingdom (in a more completely mixed market, contract-based format) as well as proposed reforms to the production side of health care systems in Southern and Eastern Europe.

Current reforms

The present profusion of health reform projects and proposals in the Nordic countries can be grouped into two basic categories—changes taking place

predominantly inside the existing publicly operated systems, and changes concerning predominantly the private finance or delivery of health services. Although activities in these two subsectors are largely independent of each other, in both instances they reflect the current level of organizational ferment in the health sector overall. Moreover, as will be noted in a later section, certain initiatives involve the development of cross-boundary relationships between the health and social welfare sectors which had not occurred previously.

The most active reconfiguration is taking place in Sweden, which started on the reform path earlier (Saltman, 1990) and which has had a long standing tradition inside the publicly operated system of small-scale change and renewal (*förändringsprocess*). Finland began its reform process rather more cautiously (Vohlonen et al., 1989) and in a top-down, centrally directed fashion consistent with the broad character of Finnish health planning (Saltman, 1988). The present pressures in Finland, however, have forced the national government's hand such that, although the standard Nordic policymaker's rule of thumb that "Sweden reforms first" remains true, the 5- to 10-year period Finland typically has required to introduce similar reforms is being compressed into a substantially shorter timeframe. Denmark, consistent with its long-term political as well as geographical posture of locating itself between the other Nordic countries and continental Europe, has only recently begun to move down a parallel health care reform road.

These dual patterns—public as much as private subsector changes, and Swedish leadership in the reform process—organize the discussion of reform initiatives that follows. Predominantly public sector initiatives will be presented first, followed by private sector and joint activities, and Swedish examples will be followed by Finnish and Danish experiences as appropriate.

Contracts

Perhaps the most striking change in these three Nordic health systems is the growing emphasis on contracts inside the public sector. Traditionally, publicly operated institutions in these health systems received a global budget on an annual prospective basis, determined incrementally upon prior years' service levels and newly approved activities. Personnel salaries, including those of physicians, typically were included in these institutional budgets. Although this financing approach created macroeconomic discipline (Schieber and Poullier, 1991), it has not been very successful in encouraging microeconomic efficiencies inside or between individual institutions.

Triggered by the announcement of the *Dalamodel* in June 1990, the 23 county councils and 3 municipalities that operate the Swedish public system on a largely independent basis (Saltman, 1990) are now almost without exception developing various types of contract-based payment systems for their hospitals and specialist physicians (Bergman, 1992a). These new contract systems all involve some form of separation of

financing from provision inside the existing county council structure. Two counties, Sörmland and Östergötland, have made this split at the county level, creating one political board (i.e., made up of elected county council members) responsible for purchasing services and a second board responsible for managing the county's organizational infrastructure of primary health centers and hospitals. Another county, Bohuslän, has established three separate districts each with its own purchasing and administrative boards. In a similar but arguably more radical reform, Stockholm (9 districts) and Dalarna (15 districts) counties have created local political boards which combine financial and administrative control over local primary health centers with the responsibility for purchasing hospital care for their districts' inhabitants. In the Stockholm and Dalarna approach, local boards are expected to utilize their control over hospital funds to closely monitor primary care referrals to hospital, and to encourage primary health physicians and centers to provide an increased proportion of necessary services themselves (Saltman, 1990).

In all these reform models, individual hospitals and primary health centers will be transformed from dependent administrative units to something approaching public firms. They will no longer be funded through an automatically allocated budget, but will be expected to support themselves partially or entirely on the revenues each provider institution can generate within this new public market (Saltman and von Otter, 1992).

In Sweden, the shift to a contracts-based payment structure has been accompanied by a continued strong commitment to the patient's recently introduced ability to choose a physician, health center, and hospital. As of March 1992, none of the existing or emerging contracts restricted patient choice of provider inside the publicly operated system (Bergman, 1992b). This combined emphasis on patient choice as well as contracts is fundamentally different from the reforms put in place in 1991 in the United Kingdom, which curtailed patients' already minimal ability to influence where or from whom they received hospital services (Green et al., 1990). Moreover, the current contract approach in Sweden has a rather different meaning than has a contract-based approach in the United States' health care system.

At present, the evolving structure of contracts in Swedish counties is not based on a detailed statement regarding price, quality, or volume (Bergman, 1992b). Rather, it is an agreement to enter into an open-ended arrangement to provide care for a specific period. In effect, Swedish contracts establish a care relationship rather than specify the precise content of that relationship. They thus resemble the contracts that previously existed within the Dutch health care system between the sick funds and the hospitals (Saltman and de Roo, 1989). That is, the financing board behaves more like a financial intermediary, rather than acting as a prudent purchaser, as is the case in the selective cost-based contracting undertaken by preferred provider organizations (PPOs) in the United States. This raises

interesting questions about what the new Swedish contracts actually accomplish. They don't act as hard contracts that restrict patient options or define precise care characteristics. Instead, they define a general but short-term rather than permanent relationship between purchaser and provider. The implication of the Swedish contracts is that potentially, sometime in the future, the purchasing board could decide to change the contract conditions to specify cost and volume or to place the contract with a private provider instead. Thus, although existing revenue flows haven't changed, anticipation has been created among hospitals and physicians that they could change in the future, especially if the financing board were not satisfied with a particular provider institution's performance.

In turn, although the new contract structure has not changed revenue flows, it has influenced the balance of power within the Swedish health care system. This shift involves two components. First, where local boards control both primary health centers and the purchasing of hospital services, hospital physicians must pay more attention to the desires and concerns of the primary care doctors. Second, worried about future changes in the contract structure, all physicians feel they must pay more attention to the politicians and managers who run these boards. As a consequence, the introduction of contracts has generated a shift in the prior distribution of power within the health sector: Hospital specialists have lost some of their leverage over hospital decisions, whereas general practitioners (GPs) (in Sweden, as elsewhere, less respected in physician circles) and managers have gained. Hospital specialists are still far from powerless, of course. However, the use of contracts may help Nordic hospital administrators and politicians achieve their long-term goal of making hospital specialists more managerially accountable (Saltman, 1985).

The present approach to contracting in the Swedish system is thus not explicitly (at least not yet) about reducing costs. In practice, it is about changing the balance of power and, in the process, encouraging hospital specialists to become more productive and more organizationally compliant. Increased efficiency and overall value for money are a byproduct of the contract process rather than specified within the contracts themselves. This shifting balance of organizational power as well as anticipation of further change explains why Stockholm County in 1991, despite the introduction of contract-based reforms in only one out of five operating districts, experienced an increase of 10 to 20 percent in hospital productivity throughout the whole county (Könberg, 1992).

In Finland, the development of the contracting process and of a new planned market model for the publicly operated health system are currently in the design stage. The tightly controlled national planning process, instituted in conjunction with the 1972 Primary Care Act, has been weakened considerably, however, its legacy remains in that decisions about the structure of the new contract-based framework are being determined by national government agencies. Although the cabinet and Parliament have decided in principle to

replace most of the national plan with a block-grant system known as the Hiltunen Plan (named for the Finance Ministry official who devised it), the date of implementation was delayed from January 1992 to January 1993 as the complexity of this transformation became apparent.

Under the Hiltunen scheme, the 461 Finnish municipalities which formally own and operate the public health centers and hospitals but in practice have had little to say about their management would gain practical control over the flow of public health care revenues (Saltman and von Otter, 1992). Subsequently, at least in theory, each municipality will be able to decide how to use formerly hospital-designated revenues, including whether to expand existing municipally-run primary health centers and which of Finland's 22 central hospital districts to contract to provide care for their referral patients. (Each of the central hospital districts is already free to contract with any of the five university hospitals for tertiary or subspecialty services.) Moreover, current controls which limit municipalities to expending no more than 7 percent of their total revenue outside the public sector (in 1990, these expenditures totaled 6 percent [Organization for Economic Cooperation and Development, to be published]) will be abandoned in January 1993, allowing municipalities to contract at will with privately as well as publicly capitalized providers (Jansén, 1992). At present, however, the municipalities have no experience in writing such contracts and little or no basis on which to monitor or evaluate hospital performance. Although central hospital districts have some experience sending patients on a contract basis to the small but growing private hospital sector in Finland, municipalities have little background in contracts between the public and private sectors.

In preparation for the coming changes, the national Finnish League of Cities, the League of Municipalities, and the Hospital Association have agreed to merge into a more politically powerful representative of municipal governments in the health sector (Vohlonen, 1992). One possibility is that lack of municipal experience, combined with substantial 1992 budget cuts necessitated by the collapse of trade with the former Soviet Union and the historical trepidation of national officials about local officials' judgment concerning social expenditures, could result in a further postponement of the implementation date while a pilot project is conducted. Another alternative is that, as in Sweden and, at least for the first 2 years, in the United Kingdom, the contracts themselves will be structured as soft statements of service relationships rather than hard agreements about price, volume, and quality (Saltman and von Otter, 1992). The pressures for reform have become sufficiently great, however, that it seems likely that Finland will in some fashion follow the United Kingdom and Sweden in their learning-by-doing approach.

In Denmark, there has been considerable interest at the county level in the contract-based restructuring under way in Sweden and Finland. The governing Conservative-led coalition in the national Parliament

has put forward (for the second time) the necessary enabling legislation. However, as of June 1992 its passage appeared unlikely (Vang-Nielsen, 1992).

Cross-boundary initiatives

As fully articulated welfare states, Nordic societies provide their citizenry with a wide range of social as well as health-related benefits. However, many of these entitlements were developed independently of each other, and there often is little or no effective cooperation among different programs. Under recent pressures to reduce total public sector spending, a variety of proposals have been made to combine or coordinate certain benefits so as to reduce overall social sector costs.

As they have with contracting, the Swedes have taken the most visible initial steps in cross-boundary integration. Two major initiatives are under way, one in the care of elderly, the other in disability payments and rehabilitation. Although both initiatives were begun by the then-governing Social Democrats, they have been continued by the new Conservative-led coalition in a demonstration of the pragmatic agreement that undergirds much of the current health care reform process.

The ÅDEL reform (from *Äldredelegation*, the working party that wrote the proposal) is an attempt to partially fulfill a longstanding commitment to integrate primary health and social services, in this instance for the elderly. As of January 1992, the overall responsibility for providing elderly citizens with residential and associated medical and nursing care was shifted from Sweden's 23 counties to its 289 municipal governments (DIR, 1992:30). In so doing, one public entity now budgets and administers the full range of nursing home, sheltered housing, old age home, and home care services that elderly patients require. This consolidation is expected to improve coordination and continuity of care while at the same time reducing unnecessary medical and custodial expenditures. To finance this change, over the next 5 years the counties will transfer a portion of their own revenues to the municipalities, utilizing a complex series of population-weighted formulas (Pettersson, 1991).

The second cross-boundary initiative involves utilizing both general disability insurance and workman's compensation funds to speed up clinical treatment and rehabilitation of injured individuals. Although formally separate, what is called workman's compensation is in practice administered by the national insurance system in Sweden. Beginning with a 500 million SEK (\$90 million) contribution in 1992 (to be raised to 700 million SEK in 1993), this rehabilitation initiative hopes to reduce what have been rapid increases in the total cost of disability payments and early retirement pensions by increasing the available funds for elective surgery and physical therapy. Drawing on research which indicates that a higher percent of injured individuals can be successfully rehabilitated if they receive intensive treatment immediately after being injured—and thus will not

enter into a destructive personal development cycle nor require long-term income support (Federation of County Councils, 1991)—this initiative is expected to substantially reduce overall social expenditures.

A third cross-boundary program, originally Danish but now under way in Swedish counties as part of the ÅDEL reform (DIR, 1992:30), deals with the dilemma of what Nordic policymakers euphemistically term *bed blockers*—elderly patients who have finished their inpatient treatment but are forced to remain in the hospital because municipally run home care services have inadequate staff to accept new clients. In a demonstration project in North Jutland, municipalities were required to accept such patients within 5 days, beyond which the municipalities had to pay the (county-run) hospital for each extra day of care. This application of incentives to what was as much a cross-budget as a cross-boundary dilemma was deemed sufficiently successful (Organization for Economic Cooperation and Development, to be published) that it has been introduced elsewhere in Denmark as well as in Sweden. (In Finland, both social services and primary care are administered directly by the municipality.)

Patient choice

A third set of reform initiatives in publicly operated Nordic health systems concerns the introduction of patient choice of physician and treatment site. In the traditional command and control planning model, patients were assigned to a primary health center (in Sweden and Finland) and to a hospital (in all three countries) based on the system's ability to provide coverage. Moreover, where the clinic approach was adopted, patients often had little or no influence over which doctor treated them.

As Nordic societies became more affluent, however, individuals increasingly wanted to have some measure of control over this as in other aspects of their lives (Saltman and von Otter, 1992). As previously noted, the first demonstration project was in Stockholm County in maternity care (January 1988), followed 1 year later by open annual choice of one's primary health center. Subsequently in April 1991, the Federation of County Councils adopted a statement in principle that all Swedes should be able to choose their physician and facility (Federation of County Councils, 1991). The importance of patient choice in the current Swedish context is underscored by its continued role in a reform environment increasingly dominated by contracts for health care services—quite opposite, by comparison, to current efforts to reduce patient choice in the United States through contract-based managed-care programs.

In Finland, patient choice was incorporated into the Personal Doctor Program, although choice of primary health center or hospital was still not allowed. Increasingly, however, patient choice in Finland at both GP and outpatient hospital specialist levels has come to mean utilizing the national insurance system (a separate public revenue stream) to receive subsidized private services from physicians, particularly as public primary

health centers have had difficulties attracting and retaining GPs (Saltman and von Otter, 1992). Consistent with the overall pattern of Nordic reform, the Danish Federation of County Councils announced that in October 1992 Denmark would, like Sweden, lower the administrative barriers that required patients to receive hospital services within their county of residence (Reimer, 1992). Because the costs of this out-of-county care will be paid from the home county to the provider county, the effect will be to create a patient-driven public market for hospital care in Denmark (Vang-Nielsen, 1992).

Public sector physicians

Reforms in the status of physicians in the Nordic countries reflect frustration with compensating doctors on a 100 percent salaried basis. Although driven by an explicit desire to increase productivity and performance, the changes have the effect of granting both general practitioners and specialists increased degrees of administrative autonomy (clinical autonomy was never restricted) to build a practice inside the boundaries of the public operated system. With regard to primary care physicians, there has been movement away from a fully salaried framework in Denmark, Finland, and Sweden. In 1988, the only Danish county which had 100 percent salaried general practitioners, Copenhagen, shifted to the part capitation, part fee-for-service framework utilized by the other 13 Danish counties (Groenewegen et al., 1991; Flierman, 1991). During 1985-90 in Finland, as already noted, the Personal Doctor Program was conducted on a demonstration basis, in which GPs were paid on a 20/60/20 percent basis for, respectively, base experience, list size (capitation), and percent of total list seen annually (Vohlonen et al., 1989). With the October 1991 appointment of a Swedish Minister of Health from the Liberal Party (Folkpartiet), county councils have been pressured to shift from 100 percent salaried GPs to a family doctor (husläkare) approach, which in Stockholm and most likely other counties will involve placing GPs on a part capitation, part fee-for-service status similar to that of private GPs in Denmark, the United Kingdom, and The Netherlands (Calltorp, 1992).

This transition will be a complicated one for Swedish primary care personnel. It requires a shift away from the current team approach in primary health centers, necessitating increased numbers of physicians and fewer auxiliary personnel (Öhrming, 1990). The extent to which the existing health center structure will survive is unclear. Further, given the independent administrative character of the counties and municipalities, the national government can use only indirect means to achieve its objective—resolutions in the National Parliament, media publicity, and, by far the most potent, specific conditions in the annual national and county negotiations over the rate of payment by the national insurance system to the counties for ambulatory services (the so-called Dagmar process). Although some counties may resist this policy initiative,

the positive clinical and financial results achieved by one primary care district in Stockholm which underwent an equivalent transformation in the late 1980s are well-known in Sweden (Öhrming, 1990).

With regard to hospital specialists, numerous reforms are under way to link physician compensation to physician performance or the performance of their clinic or hospital. In Stockholm, Dalarna, and elsewhere in Sweden, hospitals, and in many cases departments within them, will be expected to generate their budgets through the per-episode-of-care revenues they attract.³ This development reinforces a pattern that emerged in Swedish hospitals during the late 1980s, in which fully salaried physicians were allowed to establish private companies to provide elective services, often in hospital facilities, at night, on weekends, and other off-duty time (Saltman, 1990). Whether physician payments will be tied in some manner to the DRG-payment structure for hospitals that Stockholm, Bohuslän, and other counties intend to introduce has not yet been determined.

A similar set of changes is under way in Finland's publicly operated hospitals, which, when the Hiltunen Plan is implemented, also will be expected to support themselves on income generated by municipally-let (for university hospitals, central-hospital-district-let) contracts. Although changes of this type in Denmark must await legislative passage of an overall program of system reform, it is likely that eventually Danish hospitals and specialists eventually will adopt this emerging Nordic pattern.

These changes from fully salaried to various performance-tied payment systems for physicians are not without strong opponents, particularly in Sweden and Finland. A generation of commitment to building up a physician corps expected to respond to clinical and social rather than financial incentives, and the emphasis on population-based and preventive rather than individual curative medicine, is seen by some to be at risk (Didricksen, 1990). Moreover, it is not yet clear how increased financial incentives for hospital specialists will be structured by the counties so as to guarantee that abuses associated with volume-tied fee-for-service and DRG-based payment mechanisms in the United States do not develop in the Swedish context.

Private finance and provision

The private sector has played only a very minor role in these three Nordic health systems for more than a generation. Through to the end of the 1980s, private insurance existed only at the margins of the system—in Sweden some 15,000 insurees who were predominantly business executives, in Denmark a single private insurer covering 26 percent of the population, used primarily for outpatient prescription drugs (Organization for Economic Cooperation and Development, to be published); and in Finland, a widespread practice by

³In Stockholm County, for example, a maximum price will be set for each diagnosis-related group-tied category for all 10 hospitals, however, hospitals can compete by providing services at less than these fixed ceiling prices (Essinger, 1992).

middle-class families of purchasing extra coverage for their children (in 1991, 16.4 percent of all children 0-14 years of age carried private insurance [Piiirainen et al., 1992]). Private provision at the hospital level was similarly constrained. There were two small 40-bed hospitals in Sweden, one larger (100-bed) and three small hospitals in Finland, and several 5 to 10-bed clinics in Denmark. At the practitioner level, there was somewhat more activity, however: All GPs in Denmark are technically independent (although paid almost exclusively by county funds), and Sweden had a small number of private GPs and specialists, as well as publicly employed hospital specialists who worked in private clinics during their off-duty time. Finland had the largest private physician group, including not only substantial numbers of specialists working in private polyclinics (7 percent of all physicians work exclusively in private practice) but also nearly one-third of all publicly employed GPs and specialists conducting private practices on evenings and weekends (Organization for Economic Cooperation and Development, to be published). Finnish public hospitals also have a small number of private beds for specialists' private patients (Saltman and von Otter, 1992).

In the last year or two, there has been a noticeable increase in activity in these countries' private sectors, primarily in the establishment of small new ambulatory and inpatient clinics. In Finland, a number of small, private hospitals have been established, typically near university hospitals by specialist physicians with funds borrowed from banks. In the small city of Kuopio, for example, two 15 to 20 bed surgical hospitals have been built. In Sweden, there has been a noticeable increase in the number of small private inpatient facilities, and the national newspapers now carry a weekly page of advertisements for them (Rosenthal, 1992). More tellingly, according to the responsible official at the National Board of Health and Welfare, a number of these new operations have not obtained the few legal permits currently required. This breakdown in regulatory responsibility led a leading Swedish newspaper to speak of a "Wild West" in the Swedish private health sector (*Dagens Nyheter*, 1992b). Although most new activities appear to be started by physicians, at least one has a foreign multinational corporation (American Medical International) as part-owner (*Dagens Nyheter*, 1992a). In Denmark, a new private hospital with 69 beds was established in 1989 (Reimer, 1992).

In private insurance, similarly, there has been continued growth in the last several years. In Sweden, where 41,000 private policies are currently in force, mostly with small corporations, one insurance company (Skandia) recently developed a lower-priced product that it hopes to market to individuals (*Dagens Nyheter*, 1992d). In Denmark, the private insurer of outpatient pharmaceuticals has expanded its coverage to include 85 percent payment for elective procedures in Denmark's new private hospital (Kolind, 1992). However, private health insurance premiums are not tax deductible for individuals or companies in Sweden, Finland, or Denmark (as of January 1992, personal

expenditures for private physicians were no longer tax deductible in Finland (Vohlonen, 1992). They have not been deductible in Sweden for some years). Given all three countries' high marginal tax rates, it is unclear how much near-term growth in private policies is likely.

An intriguing aspect of the current picture is that alliances are developing between the public and private sectors. In the past, the public county councils (Sweden and Denmark) and central hospital districts (Finland) have purchased certain elective surgical procedures (particularly coronary bypass operations) from the private Nordic hospital sector (Saltman and von Otter, 1992). Although this volume may well grow in the new contract-based purchasing environment, a converse but complimentary trend also has begun to emerge. In Sweden, private insurers who want to expand their underwriting business have begun to negotiate contracts with publicly operated hospitals to provide inpatient clinical services for private patients (*Dagens Nyheter*, 1992e). At least initially, the public hospitals expect to offer better amenities—private rooms, better food—but insist that they will maintain the same clinical services for public and private patients alike. Swedish hospitals, particularly in over-bedded Stockholm, appear to be interested because of the likely end of queues for elective procedures coupled with their need, as public firms, to attract additional revenue in order to remain open. However, the current Minister of Health, Bo Könberg, has stated that the introduction of private beds into publicly operated hospitals is a "principled question" which should be decided "at least at county council level" and which, if it were to occur, runs the risk of patients beginning to think that private patients were getting better clinical care as well (*Dagens Nyheter*, 1992e).

Future issues

Current movement toward planned market models in the Nordic countries, although impressive in design, has yet to be fully tested in application. As the dates for implementation of several key proposals suggest, and the present soft character of many contracts further underscores, the final outcome of this reform process may not be known for some years. In particular, the extent to which the pursuit of heightened efficiency and performance is compatible with continued maintenance of social values like equity and comprehensiveness remains to be seen. The capacity of contracting within publicly operated health systems to achieve efficiencies greater than the added transaction costs that accompany them also has yet to be demonstrated (Saltman and von Otter, 1992; Bartlett, 1991). Whether unrestricted patient choice of physician and hospital can be maintained, should the contracting process evolve from soft to hard agreements, is another unknown. Further, insufficient regulation of private providers in Sweden suggests that some policymakers have not yet recognized that greater reliance on private health care providers will require much the same level of direct governmental oversight (although different in focus) in order to maintain acceptable standards of

service. As a partial response to the growing diversity of both public and private providers, the Swedish National Board of Health and Welfare has proposed that it should undertake intensive efforts to monitor and evaluate service quality and outcomes (Örtendahl, 1992). Major new initiatives also will be required to develop and disseminate information sufficiently detailed to enable patients to utilize their freedom to choose their provider effectively (Saltman, 1992). The shift to contract-based or privately provided hospital inpatient services may affect the current high level of patient trust of physicians in the Nordic region and the consequent low level of malpractice suits.

Several additional factors loom on the policy horizon. Recent decisions in Sweden (July 1991) and Finland (November 1991) to apply for membership in the European Community may have a variety of financial and organizational implications for their health sectors, reflecting an expected macroeconomic convergence concerning tax levels (i.e. less public sector revenue for Nordic social services) and an acceptance of European Community competition policies (i.e. entry of non-Nordic commercial health insurance underwriters). These externally generated pressures will likely be exacerbated by the current Northern European recession, particularly in Finland where a substantial structural adjustment following the loss of Eastern trade is expected to result in a 15 to 20 percent reduction in the 1993 national budget for health care (Jansen, 1992).

Another factor is the growing interest by fiscally hard-pressed Nordic governments, like national governments elsewhere in the industrialized world (Organization for Economic Cooperation and Development, to be published), in off-loading a portion of current health care spending onto lower-level governments and onto private business and individual budgets. This trend can be seen in recent Dagmer negotiations in Sweden and the projected 5-year phase-out of part of the Hiltunen block grant system in Finland, in increased copayments for primary care visits in Sweden and the current revisiting of this subject in Finland, in the 1993 elimination of occupational health subsidies to industry in Sweden, and, more long term, the establishment in Sweden of a national government inquiry to explore the feasibility of establishing a social insurance based financing system for health care.

Finally, it should be noted that the changes under way in the health sector also are beginning to be felt in other sectors of the social welfare system. Discussions about making the Swedish day care and educational system more responsive to parents also are taking place, and are likely to be replicated in Finland as well (in Denmark, private schools and day care facilities already are administered as one part of the public system). Thus, the conceptual issues under consideration in the health sector should be seen as part of a broader debate about renewing the entire social sector of the Nordic welfare state.

Viewed in international context, emerging Nordic health care reforms are equally as important for what they will not change. In contrast with the ongoing

debate about market mechanisms among policymakers in the United States, all mainstream health sector actors in the Nordic Region explicitly accept the highly delimited degree to which competitive forces can be appropriately applied to health care systems (Saltman and von Otter, 1992). Among the elements of these three Nordic countries' health systems which will remain as before are the following:

- *Universal access*—All major political parties continue to be committed to the right of every citizen to receive comprehensive health services, and to do so independently of personal ability to pay for care.
- *Predominantly public ownership*—Despite rapid growth in some areas of private sector activity, the service delivery structure remains overwhelmingly public (well over 90 percent, for example, in Sweden), and several reforms currently under way are intended to strengthen and reinforce the publicly operated system.
- *Single source financing*—The introduction of competitive forces has been confined to the production side of the delivery system. What little interest exists in changing financing arrangements (in Sweden) is focused on developing a uniform social insurance system (Federation of County Councils, 1991), not a United States (Enthoven and Kronick, 1989) or Dutch Dekker-style (van de Ven, 1991) competitive financing structure.
- *Expanded primary and preventive services*—All national and regional (Sweden and Denmark) governments remain committed to expanding primary, preventive, and social care services, a commitment which will be reinforced by recent changes in the financial responsibilities of local political boards (in Stockholm and Dalarna counties, and in Finland's emerging municipally-based contracting system).

The continued commitment to a socially responsible health system can be summarized by the following overview included by the Swedish Ministry of Health and Social Security in its proposal to establish a national commission:

"In Sweden, which has a budget-controlled system, a process of change is now under way in many county councils and municipalities, with the aim of deriving benefit from the positive elements of market mechanisms but without compromising on the qualitative level of activities and the overriding aim of health services and health care, via good care and care on equal conditions for the whole of the population." (DIR. 1992:30).

The Nordic reform process is very much in the initial phases of development. How present changes will play out and what final shape these new planned markets will take are yet to be determined. What is clear, however, is that major reform is under way, fundamental principles are by-and-large being preserved, the existing publicly operated systems are beginning to respond to the pressures they confront, and the outcome could well be stronger, more flexible, and more responsive publicly operated health systems in the Nordic region in the not-too-distant future.

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