Beyond Equity: Swedish Health Policy and the Private Sector

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THE PRIVATE HEALTH CARE SECTOR HAS GROWN steadily in Sweden in the last five years. This is a surprising development. The public health care system has been the centerpiece of Swedish Social Democratic welfare policy and has received full funding and broad-based support. Furthermore, the Social Democrats have been in national office for almost fifty years, providing a unique opportunity for long-term and consistent evolution of health care policy. A number of factors have now come together, in the last five years, to challenge both social welfare policy development, in general, and the public health care sector, in particular. The recent growth of the private health care market represents a serious threat to the Social Democratic ideology of equalitarianism, social class solidarity, and equity of access to health care.

What are the forces that have produced this challenge to the Social Democrats and how are they responding?

Precipitating Factors

Explanations can be found in four quarters: increasing economic constraints in the public sector; a growing pool of physicians; a new tide of emphasis on individual freedom and choice; and mounting criticisms of public sector health care.

The Milbank Quarterly, Vol. 64, No. 4, 1986

TABLE 1
Average Annual Growth in Health Care Budget, Stockholm

Period	Percentage of growth
1965–1970	8.5%
1970–1974	3.0
1974–1977	4.9
1977–1978	6.7
1979–1980	4.7
1980–1982	2.5
1983–1988	0.5–0.9

Sweden, like other western nations, is facing new economic constraints. After decades of steady and impressive economic growth, the oil crises and a large national debt have eroded the financial underpinnings of public spending. Although innovative public financial management and programs have cushioned unemployment, the pension system, and other welfare programs, the rate of health care funding has slowed considerably. This is reflected, for example, in the annual rate of growth in Stockholm County's health budget (U. Zetterblad, director of planning, Stockholm County Council Health Board, personal communication, September 27, 1985).

A great deal of effort has also gone into developing less costly alternatives to the expensive hospital, high-technology and specialist-oriented system developed since World War II. This has included an emphasis on primary health care centers. The urgency for cost constraint in the health care system is underscored by the increase in life expectancy and the growing proportion of elderly in the population (15 percent nationally; 25 percent in Stockholm). The pressures, then, to control public spending in health care come from several sources. Even if economic conditions should improve for Sweden, the growing demands on health care resources by their aging population will be unremitting.

In an effort to obtain a better distribution of doctors geographically and by specialty, the Swedish government has been increasing admissions to medical school since the 1970s. Since there is considerable (but not full) government control over official positions for doctors, this was conceived as a strategy to encourage young doctors to move to the underserved rural areas of the country and to take up specialties

in short supply, particularly general practice. While the numbers of physicians demonstrably increased, the medical profession has been able to circumvent government intentions (Rosenthal and Frederick 1984).

For example, the contract negotiations between the Swedish Medical Association and the Federation of County Councils in recent years reduced doctors' working hours—thereby creating the need for more doctors–and permitted compensation for overtime (night and weekend duty) with time and a half off (Rosenthal and Frederick 1984). Doctors in the major cities of Sweden, with more free time, have looked for private spare-time practice opportunities. (According to a personal communication from Prof. Edgar Borgenhammer of the Nordic School of Public Health, many Swedish surgeons work only twenty-eight hours per week in the public sector.) The high standard of living and disposable income in the cities have proved a responsive environment. Furthermore, new jobs in the rapidly growing primary health centers have provided additional opportunities to remain in the large cities.

Like many of the western socialist democracies, Sweden has also experienced a growing public attraction to more conservative and individually oriented political philosophies. While the conservative political parties have become more aggressive in challenging socialist ideology, the Social Democrats have staved off the rise to national power that has occurred in Britain and Norway. Nonetheless, it has had to recognize that a significant proportion of young voters are attracted to conservative philosophy and that the issue of individual choice is a deep-seated one.

It has, in fact, picked up the rallying cry of "individual freedom" and tried to reshape it to fit its own brand of socialist ideology, searching for ways to promote individual choice and freedom while still maintaining a strong commitment to class solidarity and equity. A recent example of this is expressed in a speech by now Prime Minister Ingvar Carlsson (1983) who speaks about socialism as a "freedom movement" which stresses individual freedom and freedom from starvation, ignorance, injustice, and exploitation. "Let me stress that by freedom we mean individual freedom to try new things, to get a good education, to search for happiness." Carlsson goes on to say that individual freedom includes freedom from "powerlessness" and the freedom to take more individual responsibility.

In this atmosphere of more individual assertiveness, consumers have

also been increasingly critical of the public health care system. A recent study of public complaints (Swedish Planning and Rationalization Institute 1984) reflect public concerns about poor service, waiting times, long waiting lists, and impersonal care and little continuity of care.

The diminishing rate of public spending on health care, more doctors looking for private part-time practice, increased interest in freedom of choice, rising criticism of the service in the public health sector, and a growing segment of the Swedish public able to pay for private care have combined to stimulate the private market in Sweden.

A Close Look at the Nature of the Private Sector

When the privately owned and financed City Akuten drop-in clinic opened its doors in downtown Stockholm in the spring of 1983, the impact was immediate. Its waiting room was filled and the newspapers provided extensive and laudatory coverage. With typical Swedish forthrightness, administrators at the Stockholm County Council Health Board admitted that City Akuten's success reflected failures in the public health care system.

It is located close to many business offices, in contrast to the public primary health care centers built in the residential neighborhoods. It remains open late, until 7 p.m., and on Saturdays. Its personnel have received special training in consumer relations and it guarantees a shorter wait than the public hospital outpatient clinics. It provides quick, courteous, efficient care in a convenient location. While it is not equipped to deal with serious problems requiring elaborate hospital technology and sends these to the nearest public hospital, it is a symbol of much that is criticized in the public sector.

The success of the Stockholm City Akuten clinic emboldened the private organization and individuals that established it. It was capitalized by Praktikertjanst, a private, nonprofit physicians' cooperative which operates other facilities and provides various medical-related services as well (K.E. Mosten, director, medical division, Praktikertjänst, Stockholm, personal communication, August 21 and 27, 1985). Praktikertjänst was organized originally by the Swedish Medical Association in 1959 and is now an independent company and an important component of the variety of elements that compose the private sector for health care in Sweden.

TABLE 2
Private Medical Care Sector in Sweden

Three types of private practitioners	Numbers in 1971	Numbers in 1984/1985	Percentage of total physicians (20,000 in 1984–1985)
1. Full-time (devote all practice time to private patients):			
A. Affiliated with social insurance	1,069[a]	(See no. 4 below)[b]	
B. Nonaffiliated (charging fee-for-service or other arrangements)		175[c]	.008
C. Holders of private, full-time risk insurance (SALUS + 500 Humana Care and Medi-Care physicians)		1,200[d]	5.7
D. Estimate by NBHW		1,050[e]	5
2. Part-time (working in another medical sector part-time; offering private medical care part-time):			
A. Affiliated with social insurance	2,200[d]	(See no. 4 below)[b]	
B. Nonaffiliated (charging fee-for-service)		1,100[f]	5.5
C. Holders of private, part-time risk insurance		3,917[d]	19.6
D. Part-time practice in other sectors		1,050[a]	5
1. School doctors			
2. Industrial doctors			
3. Military doctors			
4. Pharmaceutical industry			
5. Insurance industry			

3. Spare-time doctors (work on full-time contracts with county councils and "moonlighting")		
A. Affiliated with social insurance: affiliated	3,254[g]	16.2
(pre-Dagmar) affiliated + active	1,987[g]	9.9
B. Nonaffiliated (charging fee-for-service) or tied to private insurance plans	Unknown	
4. Combination of full-time, part-time and spare-time physicians affiliated with social insurance		
A. Affiliated	5,509[b]	27.5
B. Affiliated + Active	3,765[b]	18.8

[a] In 1971 the system was such that the patient paid the entire out-of-pocket fee and applied to the social insurance for reimbursement. In 1975, the system was changed so that private doctors signed contracts with the social insurance and were paid directly by the insurance fund. Dagmar changed this procedure again.
[b] Statistisk Rapport 1985. See appendix table 2. "Affiliated" means they have signed up with the Social Insurance. "Active" means they actually submitted claims for fees during 1984.
[c] An estimate by the president of the Private Physicians Association, a division of the Swedish Medical Association.
[d] Figure provided by SALUS.
[e] Figure provided by the Health Planning and Prevention division of the National Board of Health and Welfare.
[f] Figure provided by Praktikertjänst.
[g] *Statistisk Rapport* 1985; See appendix table 3.

The private sector can be described as an overlapping combination of (1) practitioners, (2) facilities, and (3) insurance. Each segment has experienced growth in the last five years either through expansion or the emergence of new forms. Components of the small, long-standing private sector of practitioners and facilities are expanding, and altogether new forms of private care are emerging. Both the expansions and the emergence are summarized in tables 2 to 4.

Practitioners

Private practice is now offered by an increasingly complex array of full-time private doctors, part-time private doctors (who may have regular part-time jobs as physicians in industry, the military, or in schools), and the newer "spare-time" doctors (who are full-time employees of the county health care systems and now moonlighting spare-time). Traditionally, a small and static number of physicians (full- and part-time) have practiced privately and have been linked to the national social insurance fund, which also pays a portion of the public health care bill. They receive standard out-of-pocket fees from their private patients and are compensated by the fund according to predetermined rates for selected services. They also have had no public hospital privileges. Full-time private physicians have been limited to 3,000 patient visits every 6 months. The general attitude toward these private doctors was that they would gradually fade away as they aged and retired and that younger doctors would have no interest in private practice. This has not happened.

It is now clear that growing numbers of younger physicians want to offer some sort of private care and have sought affiliation with the social insurance fund. There is also evidence that medical care is being offered completely outside of the fund on a strictly fee-for-service basis or tied to private insurance arrangements. In the last several years, groups of physicians have formed private group practices, some of which appear to be patterned after American HMO models (J. Paulsson, assistant executive director, SALUS, personal communication, June 13, 1986). These include Humana Care, a group of 500 specialists all over the country who couldn't get spare-time practice contracts from their counties and so decided to offer private care through their own insurance sold by two small companies, Valand and Vegete;

TABLE 3
Insurance Industry: All New Patterns

	1974	1986
I. Skandia (International Corp.)*	25–30	
1. Executive health & accident insurance "Sjukvardsforsakring" (in cooperation with Sophiahemmet) (purchased by large corporations and family businesses)		4,500 individuals covered by June 1986; projected market 50,000
II. Trygg Hansa* Executive and individual health insurance (announced August 1985) (in cooperation with Praktikertjanst doctors; discussing construction of new private hospital) (cooperates with the 2 Swedish private hospitals and 4 foreign hospitals)		1,000 individuals covered by June 1986; 3,500 projected by December 1986
III. Other insurance companies entering the private medical insurance market:		
Länsförsäkringar		
Wasa Insurance		
Valand and Vegete		
IV. SALUS: Private risk insurance for doctors (originally an SMA division)		
Doctors buying part-time risk insurance		3,917**
Doctors buying full-time risk insurance		1,161**

* Figure provided by Skandia and Trygg Hansa, June 1986, Stockholm
** Figures provided by SALUS: Läkarnas Forsäkringsanstalt Doctors Liability Insurance

TABLE 4
Private Facilities*

	1974	1984
I. Owned and/or operated by Praktikertjänst (Doctors' Cooperative):		
A. Lakarhuset (group practice centers) (*old pattern and new growth*)	122	350
B. Small offices	160	350
C. Out-patient facilities (*new pattern*)		
City Akuten clinics	0	8
Stockholm, Gothenburg		
Norrköping, Mälmo (1987)		
Wasa Vaccination (Stockholm 1984)		1
D. In planning stage:		
Pain clinic (1986)		1
Mammography clinic (1986)		1
E. Alcohol abuse center (1985)		1
F. Other	0	150
II. Private Hospitals:	2	2
Sophiahemmet (Stockholm)		
Carlanderska Sjukhemmet (Gothenburg)		
Scandinavian Heart Center (Gothenburg-1985) Carlanderska		1
III. Diagnostic laboratories (Praktikertjänst)	40	80
(Other-large with important share of market)		2
*V. Nursing Homes		240–260 (in Sweden)
V. Other: Ambulatory Eye Clinic (Stockholm, 1984)		1

* All figures provided by Praktikertjänst AB

Medicare AB, with 300 doctors which is owned by the Swedish steel company Ahlsell; three smaller companies called Mepraco, Hemläkarjour, and Academy Groupen; and assorted other groups of physicians of various sizes. A small percentage of these doctors are full-time and the rest part-time, some tied to the social insurance fund, with an estimated 40 percent working through totally private insurance schemes or fee-for-service. These activities represent the beginnings of an heterogeneous pattern of medical practice.

Estimates of numbers are sketchy because of a fluid situation, but

TABLE 5
Doctors with Part-time Private Practice Risk Insurance

	1983	1984	1985
	3,304	3,409	3,917

Doctors with Full-time Private Practice Risk Insurance

	1983	1984	1985
	654	672	1,161
Totals:	3,958	4,081	5,078

one useful source of information is SALUS, an insurance company for physicians that has managed to stay in business even though Swedish Patient No-Fault Insurance (started in 1975) make their malpractice policies for doctors unnecessary. However, physicians in various forms of private practice must still cover themselves for liability. SALUS claims to have 98 percent of this market. The figures provided by SALUS, recorded in Table 5, indicate what they have sold (I. Holmberg, executive director of SALUS, personal communication, April 1983; J. Paulsson, assistant executive director of SALUS, personal communication, June 13, 1986).

These figures indicate how many physicians are buying private risk insurance for some degree of private medical practice. It is likely that some of these doctors are positioning themselves for private practice but are not yet offering medical services. They are preparing for future opportunities.

Statistics from the 1985 "Report of the Social Insurance Fund" provide an accurate picture of private practice that is officially compensated (see tables in appendix). Appendix table 1 records the growth in affiliated doctors between 1975 and 1984; they increased by almost 300 percent. Appendix table 2 records the growth of private visits. In 1984, 18.8 percent of Swedish doctors were getting compensation for private visits. Appendix table 3, the evolution of spare-time practice between 1981 and 1984, records that 16.2 percent of Swedish doctors are affiliated for spare-time visits. It is clear that spare-time practice

has jumped dramatically both in terms of numbers of doctors and as a proportion of all private visits. Finally, appendix table 4 indicates that the recent cohorts of affiliated doctors are young, between 30 and 49. Other data from the report indicate that 45.7 percent of spare-time doctors practice in the three largest cities of Sweden.

There is considerable difficulty in determining exactly how many physicians are offering private medical care of all types in Sweden. However, it is possible to draw from these various sources of information to make a reasonably well-informed estimate for the year 1985.

1. The SALUS figures of doctors purchasing private risk insurance are important. From this source, 5.8 percent of Swedish doctors were paying risk insurance to cover full-time practice, 19.6 percent for part-time practice, for a total of 25.4 percent. The unknown factor is whether all are, indeed, offering care or just covering themselves for eventualities.
2. The Social Insurance Statistics Report indicated that 27.1 percent of physicians were affiliated with them (in their register); 18.8 percent actually made claims of various sizes in 1984. These were the figures just before the Dagmar reform after which these physicians will no longer register with Social Insurance but sign contracts with their counties.
3. There are no firm sources of information on all physicians offering private care strictly on a fee-for-service basis. Humana Care advertises that it includes 500 specialists, and Medicare AB includes 300 physicians. However, it could be reasoned that the difference between those making claims to Social Insurance and those holding private risk insurance reveal the percentage of physicians offering private care, fee-for-service, or in conjunction with private plans. That figure would be 6.6 percent (25.4 percent minus 18.8 percent equals 6.6 percent).

Overall then, this current collection of data from various sources indicates that from 18.8 percent to 27.1 percent of Swedish physicians are offering private medical care through Social Insurance (see appendix note B). They could be doing this on a full-time, part-time, or spare-time basis. It is possible that as many as 6 percent are offering care strictly in the private market. It would be of great interest to know what percentage of all outpatient and all inpatient care this represents.

However, those figures would be very difficult to establish until the number of private visits outside the Social Insurance plan can be accurately and fully recorded.

Facilities

A large proportion of the full-, part- and spare-time doctors are members of Praktikertjänst (K.E. Mosten, director, medical division, Praktikertjänst, personal communication, August 21 and 27, 1985) and are housed in facilities provided and managed by this company. Praktikertjänst has also helped open City Akuten clinics in two other Swedish cities (Gothenburg and Norrköping), with plans for a fourth one in Mälmo, as well as a special vaccination clinic and ambulatory opthalmology center in Stockholm. It has recently opened an alcohol abuse center, now turned over to a private foundation, which will buy Praktikertjänst management services. It also has a pain clinic and mammography center in the planning stages. Furthermore, it negotiates all the Social Insurance contracts for spare-time practice in Stockholm County.

There are two private hospitals in Sweden, Sophiahemmet in Stockholm and Carlanderska in Gothenberg. Sophiahemmet is now planning to expand in conjunction with new private health insurance initiatives. A new cardiac center has opened in Gothenburg attached to Carlanderska. In addition, private diagnostic services have existed in the large cities for decades, as have private nursing homes. Both of these services have recently expanded.

Insurance

The most provocative developments are taking place in the private insurance industry (G. Akerlund, executive health and accident insurance department, Skandia AB, personal communication, June 18, 1986). In 1985 the international insurance consortium and largest insurance company in Sweden, Skandia, began offering private executive health insurance. This has been purchased both by large Swedish corporations and smaller family businesses for top executives. Sophiahemmet is the Swedish cooperating hospital. By June 1986, 4,500 individuals were

covered by this insurance. Skandia originally thought only large corporations would be interested in purchasing the insurance for their key executives. However, 80 percent of the purchases to date are from small and middle-sized companies. Skandia projects the sale of the insurance at 6,000 to 10,000 individuals a year. The current capacity of the two cooperating hospitals (Sophiahemmet in Stockholm and Carlanderska in Gothenburg) is thought to be 50,000 individuals. Both facilities are now expanding, however, in conjunction with these new private health insurance initiatives.

In August 1985 (*Dagens Nyheter* 1985; U. Jerner, section head, Trygg Hansa, personal communication, June 13, 1986) Trygg Hansa, Sweden's second largest insurance company, announced it would sell private executive medical insurance and private individual medical insurance as well. By June 1986 about 1,000 individuals were covered, with 3,500 projected sales by the end of 1986. Trygg Hansa cooperating hospitals include Sophiahemmet, Carlanderska, one hospital in Finland, and three in London. A small market research study conducted by Trygg Hansa suggests that 6 percent of the population might be interested in individual private health insurance. However, Trygg Hansa, like Skandia, feels the most responsive market will be through corporations and businesses. Close to 12 percent of the Swedish population own private pension insurance (National Association of Swedish Insurance Companies, personal communication, August 30, 1985), and some analysts feel that at least this proportion of the population will be interested in private individual health insurance. The key to the individual private medical insurance market is whether the tax code will permit individual tax deductions for health insurance premiums as it now does for corporate health insurance.

The Social Democrats have a history of buying selected items of medical services, like diagnostic work and nursing home beds, in the private sector, based on pragmatic considerations. Other political parties, as they have dominated various county councils, have not hesitated to do this as well. Such practices have accelerated in recent years, as counties deal with growing economic constraint. Mälmo County, where private practice has always been extensive, is a heavy purchaser of private care. Örebro and Gothenburg Counties are now buying hip joint replacements from the private sector. Increasing numbers of counties are also negotiating private contracts for the management of their primary health care centers. In the summer of

1986 Stockholm County Council, now dominated by a conservative coalition, decided to contract out two of its new primary health care centers for private management.

Overall then, two patterns of private medical practice can be observed in Sweden: an acceleration of services purchased by the counties for the public sector; and the newer development—medical care and service offered entirely in the private market.

Initial Social Democrat Response: The Dagmar Reform

In 1984 Social Democrats, with Center Party cooperation, passed a piece of parliamentary legislation aimed at controlling and containing spare-time private practitioners: the Dagmar reform. Dagmar is also an instrument to redistribute a small proportion of the health care budget and to institute a system of prospective payment for that small proportion. Financing sources for Swedish health care have been patient fees (2 percent); national Social Insurance (8 percent); government subsidies for mental illness facilities and medical education (10 percent); county council taxes (71 percent); other (8 percent). The 10 percent from government and the 8 percent from national Social Insurance have been combined into a block grant to each county based on 1982 payments. Each county now also receives a per capita allowance for private practitioner fees based on such compensation paid out by the Social Insurance fund in 1983, when private doctors applied directly to that fund. Under Dagmar, private practitioners can no longer work in this manner but must sign private practice contracts directly with their county health care boards.

It is now up to each county to decide how much private practice they will allow or encourage. Most appear to be maintaining the same amount they have had in the last several years but limiting the number of compensable visits for spare-time doctors to 600 a year. Stockholm County, where there had been a Social Democratic majority, removed 10 million crowns from their national capitation allotment, which they decided to use for their own new, public, primary health care centers. This had the effect of reducing compensated spare-time private visits by 70,000 in Stockholm County in 1985.

The Social Democrats used Dagmar for one additional purpose: to redistribute a portion of the 18 percent of health care expenditure

under their control. They removed a percentage of these funds from the allotments to the three largest and wealthiest areas (Stockholm, Mälmo, and Gothenburg) and redistributed this money to the poorest counties in the country.

The Dagmar reform, then, is a multipurpose initial response to the growing private sector, to the problem of cost containment, and to lingering problems of inequities between various parts of the country. Just how successful it will be in limiting spare-time private practice remains to be seen. About 65 percent of the counties have Social Democratic majorities and in many of these counties there is a growing distaste for the "spare-time" private practitioners who are also full-time county employees. On the other hand, the counties with chronic physician shortages hope to alleviate the shortages by offering private contract possibilities. In the counties where conservative coalitions dominate, there has been an expressed desire to increase private contracts but Dagmar makes this difficult. The Dagmar legislation calls for a review of its impact late in 1986. At that time, it will be possible to evaluate the extent to which Dagmar has worked both as a strategy to limit the amount of private practice tied to the Social Insurance fund and as a strategy to encourage a more efficient use of funds that used to be open-ended and are now capped.

Although, in recent years, the role of the national government has diminished in health care delivery, Dagmar demonstrates that it can still exert significant influence in health policy formation. Dagmar is often described by government bureaucrats as emphasizing the latitude that counties have in local decision making. It is, in fact, a strategy for the national Social Democrats to pursue their own ideological ends. Whether it will prove effective will require some time to evaluate. Meanwhile, other points of view are gathering strength.

Points of View and Ideological Positions

For Praktikertjänst, the doctors' cooperative, new opportunities for private practice now seem limitless. It is the major investor in a number of private ambulatory clinics that are going well, and it is planning more. It is the potential partner of the private insurance companies as they move into the individual private health insurance market. Not only does it represent the interests of spare-time doctors

in Stockholm County, but it is now negotiating with 4 other counties to provide private practitioner services. One of its executives (K.E. Mosten, director, medical division, Praktikertjänst, personal communication, August 21 and 27, 1985) commented that "as the amount of money available to the public sector drops, then private care and private insurance become more attractive." He feels that if tax deductions are available, private insurance "could be attractive to 10 to 20 percent of the Swedish population. Look at the recent success of private health insurance in Finland.

"Praktikertjänst is a big company working on a small scale. We can make decisions faster and promote new services more quickly than the public bureaucracy. The counties can learn from Praktikertjänst. The success of our City Akuten clinic is the pin in the public health care balloon. Furthermore, competition will be good for the public health care system."

A Conservative Party View

A discussion in August 1985 (a month before the elections) with Blenda Littmarck, Moderate Party member of Parliament and a member of the Moderate social welfare committee, and Bengt Martensson, who is political secretary to the party, reflected both specific criticism of the current health care system and the ideological framework that informs those criticisms (personal communications, 15 August 1985). Ideologically, the discussion focused on individual freedom of choice and instilling competition into the delivery system. The specific criticisms flowed from this.

"We think Swedes should be able to choose their own doctors," Mrs. Littmarck asserted, "but they have few choices and the Dagmar reform last year has limited their choice even further. 'Down with Dagmar' is one thing we are saying during this election. Because the Social Democrats on the Stockholm County Council have limited the private contracts, 70,000 such visits have been lost to those who might choose them. We don't like Dagmar and we will break it up if we win the election."

The Moderate Party has a number of specific criticisms of the public health care system as it has evolved under the long domination of the Social Democratic Party. Mrs. Littmarck enumerated these. "Too

much bureaucracy and inefficiency; long waiting lists for nonacute services. For example, 1 to 3 years for a hip-joint operation and a year's wait for cataract removal. The system needs competition. The Moderates would like to see primary care offered in the private sector and all tied back to the Social Insurance system. Let people choose their own primary care doctor privately. Then, we can keep the proper amount of funding up to the hospitals and specialists. The big hospital system can only be maintained in the public sector, and we would not reduce resources to that sector, just not let it grow. We would like to promote home care which we were interested in a long time ago when no one paid attention. Now, of course, it's being pushed in the health care system."

The Moderates would like to reduce county tax support for health care and increase what comes from the Social Insurance fund. They would continue to maintain a significant public sector but encourage growth in the private sector as a complement. "We have no interest in total private practice.

"By encouraging primary care in the private market we could reduce public spending and increase individual choice. If you are paying your taxes you should be able to choose a private doctor. We want to increase freedom of choice. Swedes should be able to choose their own doctor."

Mrs. Littmarck said that the Social Democrats were not particularly pushing health care issues in that fall's (1985) election. "They are emphasizing family policy but for the Moderates the major issues are tax reduction and questions of individual freedom. The Dagmar reform limits individual freedom, so it is a major concern with us. Dagmar is typical of how the Social Democrats tell people what to do."

The Full-time Private Practitioner

Someone else who is critical of Dagmar, but for different reasons, is Dr. Berndt Blomqvist, president of the Private Doctors' Association and full-time private practitioner (personal communication, June 18, 1985). He feels Dagmar limits the opportunities for quality medical care on an individualized small-scale basis. Dr. Blomqvist is not too pleased, however, with the growth of spare-time private practice because it dilutes the market for the "true private practitioner,"

someone like himself, affiliated with Social Insurance, full-time, and fully responsible for an office and ancillary staff, offering "continuity of care on a family and neighborhood basis, able to provide whatever his patients require without worry as to whether they can afford it, and happy to accept the fee schedule established by the insurance fund." While he provided some statistics about private practice in Sweden, he said they were estimates only and that he would like to see a system where the amount of private practice was unfettered and unknown. "In fact, I believe a number of young doctors are in some form of private practice but don't belong to the Private Doctors' Association."

In general, Dr. Blomqvist would prefer the small private sector that there has been in the past decades, limited to the "true" practitioners like himself. "We're too small a country to support private health insurance, but it may come. The Swedish state may no longer be rich but the individual citizen is. There will soon be a doctor surplus in Sweden and the consumer will have more and more choice."

Social Democratic Points of View

Dr. Gunnar Wennstrom, for many years a National Board of Health and Welfare bureaucrat and now director of its important Health Planning Department, is philosophical and ideological about the growth of the private sector (personal communication, August 27, 1985). He recognizes that Dagmar might be inadvertently stimulating the private sector to grow as could also the growing number of doctors with shorter work weeks. "But it's not just Dagmar—it's the political winds, conservative winds talking about freedom and the individual. I've been talking to young doctors a great deal and I find them so different. There used to be a commitment to solidarity and equity—and to the public health system reflecting these values. Now, young doctors are more critical of solidarity, critical of the term itself."

He went on to describe an intense debate now going on among the Social Democrats about freedom. "The Social Democrats are working for increased freedom for the individual *within* the public system. Dagmar represents the concept of solidarity; it will encourage young doctors to leave the big cities and take up practice in the underserved areas. We aren't afraid of competition from the private sector. In this

competition the public sector will prove the best in quality, efficiency, and from the point of view of solidarity and equality. We will compete and cooperate in the name of both solidarity and freedom."

The solidarity theme is very much on the mind of Douglas Skalin as well. Mr. Skalin is the major theoretician at the Federation of County Councils (personal communication, August 30, 1985).

"The crucial question is: Can we give people in common a good health care system? Basically it's how you look at people's worth. If you think everyone has the same value with basic rights, then it's not right to pay more as a rich person and get to the head of the line. Equality is very important in Swedish society and will be even more important in the future when society will be divided between those educated for a high-tech society and those without education. We will need to protect the new 'have-nots' even more. Of course, you cannot have perfect equality. You must use some private enterprise to combine equality with development."

Skalin also discussed the complex issue of the market for private insurance and the tax code. He pointed out that the expansion or limitation of private health care would depend on varying interpretations of the tax laws and whether further efforts to ensure tax breaks for private health insurance are successful. He suggested that the new primary health care centers can provide everything consumers want: quick access, continuity of care, quality of care. "But the essential thing is to have solidarity—to offer equal care for everybody. You have to pay a high price now to keep the idea of solidarity living."

Equity and Freedom: The Challenge to Social Democratic Ideology

Over the past thirty years the Social Democrats in Sweden have built an equitable and enviable health care system. No health care system can be perfect or ideal but Sweden has been relatively successful in regionalization, good distribution of resources, good access, and reasonable quality of care. It has, until recently, emphasized hospital, specialist, and advanced technology. In the last fifteen years it has begun to question this emphasis. Economic constraints have entered the system, and there has been a push toward primary care and prevention. But continuing economic constraints in public-sector

spending, along with growing numbers of doctors and rising consumer demand and criticism, have stimulated the small private sector for health care to new and as yet unknown dimensions. The old, small private sector, tied to the national Social Insurance fund that helps finance the public care, has had the effect of controlling fees in the private sector and giving those who wish the choice of a private practitioner, although these practitioners do not have hospital privileges.

The public monopoly in health care is being challenged with more vigor and assertiveness than ever before and represents a new serious challenge to the Social Democratic commitment to equity, a commitment that has been sustained and developed during a long tenure in political office. The health care system has been the pride and linchpin of the Swedish Welfare State and a prime example of the evolution of Social Democratic philosophy in Sweden. It is, therefore, of particular interest to see how the new, totally private initiatives will be interpreted and handled.

The Social Democrats have already taken steps to limit a segment of the private sector through the Dagmar reform of 1984. But that is only a preliminary measure. There are signs of further strategies to come that include cooptation, compromise, containment, and competition. The Social Democrats have tried to coopt the new calls for more individual choice and freedom that have been raised by the opposition parties. They now are publicly discussing "freedom within the public sector" as a way of maintaining their ideology of solidarity and equity. How this "freedom within the public sector" will manifest itself in the health care system remains to be seen. Some local Social Democrats in Stockholm County suggested, in the fall 1985 elections, that it could mean freedom to choose which practitioner and which facilities one would like to use. This will certainly be resisted by the planners who prefer a more rational approach that emphasizes assigned neighborhood health centers tied to referral hospitals. This will be an important agenda item in the county health boards in the next few years.

As for the private sector, the freedom-of-choice issue will be equally salient. Coupled with the continuing need to reduce the rate of public spending, aspects of private health care will be attractive to the Social Democrats. In a mood of pragmatic compromise (which has a long tradition), they will not find it difficult to work with Praktikertjänst, which is a cooperative and, therefore, more ideologically acceptable.

There will certainly be a strong desire to keep the multinational American for-profit corporations out of the Swedish market. Swedish companies who are accustomed to well-established norms of working with government will be greatly preferred.

The pitched battle will emerge, however, over the totally private market, domestic private health insurance, and the tax code. Here, a strategy of containment will be attempted to limit that market. Too extensive a spread of private health insurance will stimulate the building of private facilities, all of which will be outside of government control, and too much of which will challenge the Social Democrats' ideology of solidarity and equity. The tax code is the key to control. There are those in the private sector who feel it contains examples of corporate and individual tax rebates that can be applied to private health insurance. There are others who dispute that claim. A little (controlled) competition for the public sector will be considered healthy; rampant competition is a threat.

All of these strategies will be put to the test in the next three years now that the Social Democrats have been returned to national power in the fall 1985 elections. The situation is further complicated, however, because the Social Democrats also lost several counties they previously dominated.

The big unknown is how much market exists completely in the private sector and irrespective of tax breaks. Just how rich is the Swedish population? And how desirous of private medical care?

The Social Democrats have helped create an affluent society in Sweden, perhaps beyond their greatest expectations. Wage policies have turned the working class into a middle class with many of its predictable values. Will growing numbers of Swedes with disposable income choose to spend it on individual and private health care?

It will be of great interest to see Europe's most successful socialist party grapple with these issues. From an American point of view, it will be important to see if a model of public-private cooperation can promote and preserve an equitable health care system, in contrast to the recent American approach which is actively reducing public commitment and stimulating rampant private-market competition. It should also be possible to test the assertions (heard often in the United States and now in Sweden) that competition in health services will increase efficiency and improve quality of care. This should be considerably easier to study and measure in the more homogeneous environment of Swedish health care delivery.

The way in which the Swedish Social Democratic government responds to the growth of its indigenous private health care market will be a crucial example of whether a health care system can maintain equity in the face of increasing economic constraint and the need to reduce public-sector spending.

Appendix Note A

A report, just released by the Nordic Health Care Research Group, compares the extent of private practice in four Nordic countries based on figures from 1982. For 1982 Sweden had the lowest proportion of private care of the four countries. Many of the figures cited in this article are for more recent years. It will be important to see how the percentages quoted in the Nordic study will change by 1990.

APPENDIX NOTE A, TABLE 1
Comparison of Private vs. Public Practice in Four Nordic Countries

	Denmark		Finland		Norway		Sweden	
	Private	Public	Private	Public	Private	Public	Private	Public
Financing	10.4%	89.6%	20.6%	79.4%	13.4%	86.7%	9.2%	98.8%
Ownerships	28.9	71.1	27.6	72.4	33.1	66.9	10.2	89.8
Management responsibility	28.9	71.1	27.0	73.0	22.7	77.3	8.9	91.1

Source: Rohde and Hjort.

Appendix Note B

The figures 18.8 percent to 27.1 percent are obtained in the following manner:

1. 18.8 percent (3,765 physicians affiliated with the Social Insurance fund and getting reimbursement constitute 18.8 percent of 20,000 physicians in Sweden in 1984);
2. 25.4 percent (3,917 physicians holding part-time risk insurance, and 1,161 physicians holding full-time risk insurance constitute 5,078 or 25.4 percent of 20,000 physicians);

3. 25.4 percent minus 18.8 percent equals 6.6 percent (the differences between physicians collecting from the Social Insurance fund and those holding some form of private practice risk insurance);
4. 18.8 percent plus 6.6 percent equals 25.4 percent (the percentage of physicians in a position to offer private care);
5. 27.1 percent (5,509 physicians actually affiliated with Social Insurance in 1984 and potentially able to collect reimbursement).

APPENDIX TABLE 1
Doctors Offering Private Medical Care and Affiliated with the Social Insurance Plan: 1975–1984*

Time period	Doctors whose affiliation: has lasted for the whole time period	has been started during time period	has been discontinued during time period	has both been started and discontinued during time period	Affiliated doctors at the end of time period	Net change during time period
1975	1,676	164	76	59	1,840	
1976	1,768	115	70	46	1,883	+ 43
1977	1,792	242	85	42	2,034	+ 157
1978	1,957	271	77	32	2,228	+ 194
1979	2,125	239	103	38	2,364	+ 136
1980	2,263	260	101	32	2,523	+ 159
1981	2,378	497	145	32	2,875	+ 352
1982	2,750	1,307	125	38	4,057	+ 1,182
1983	3,805	993	252	51	4,798	+ 741
1984**	4,759	453	39	7	5,212	+ 414

Source: Statistisk Rapport 1985, 5, table C.
* Reflects the growing interest among Swedish doctors in positioning themselves for private practice. They obtained affiliation with the Social Insurance fund directly until the Dagmar reform changed the rules. Dagmar requires going directly through the counties and changes the possibilities. Dagmar will be evaluated late in 1986. While these figures do not indicate those *actually* practicing, they do indicate growing interest in offering private care, through the Social Insurance fund. What is unknown are those offering care entirely on a fee-for-service basis.
** Preliminary data, January to March.

APPENDIX TABLE 2
The Number of Affiliated and Active Doctors, 1975–1984*

Year	Number affiliated during the year	Of those: Active	Not active	Of those with at least 2,000 visits per year (1,000 visits per six months)
1975	1,975	1,882	93	807
1976	1,999	1,838	161	746
1977	2,161	1,921	240	718
1978	2,337	2,039	298	670
1979	2,501	2,121	380	637
1980	2,652	2,206	446	625
1981	3,049	2,451	598	592
1982	4,220	3,105	1,115	590
1983	5,101	3,710	1,391	611
1983**	4,683	3,346	1,337	666
1984**	5,509	3,765	1,744	662

Source: Statistisk Rapport 1985, 6, table D.
* Provides a more detailed picture of the activities of affiliated doctors. It shows which are actually active and how many visits are actually involved. While activity subsides between 1975 and 1984, it has started to climb again; more doctors are showing smaller numbers of visits and increasing numbers are positioning themselves to offer private care in the future.
** Data covers period of January to March.

APPENDIX TABLE 3
Affiliated Spare-Time Doctors and Visits, 1981–1984*

	Affiliated at the end of the time period	Active	Number of visits	Percentage of all visits
1981	651**	421	233,300	8%
1982	1,863	1,214	346,849	11
1983	2,790	1,925	601,925	19
1984***	3,254	1,987	352,210	20

Source: Statitisk Rapport 1985, 7, table E.
* Breaks out those affiliated doctors who are "spare-time" (working full-time for the counties and moonlighting). These almost quadrupled between 1982 and 1984.
** Data covers August.
*** Data covers period of January to June.

APPENDIX TABLE 4
Affiliated Doctors: Sex and Age, 1983*

Doctors' age	Affiliated doctors: Number of men	Change from 1982 in absolute numbers	Number of women	Change from 1982 in absolute numbers	Subtotal	Percentage of subtotal	Number of difference	Percentage of difference since 1982
29 and under	89	+ 3	16	+ 6	105	2.1%	+ 9	−0.2%
30–39	1,510	+377	265	+ 69	1,775	34.8	+446	+3.3
40–49	1,132	+260	222	+ 50	1,354	26.5	+310	+1.8
50–59	671	+ 75	125	+ 6	796	15.6	+ 81	−1.3
60–69	485	+ 16	100	+ 12	585	11.5	+ 28	−1.7
70–79	358	+ 3	30	− 6	388	7.6	− 3	−1.7
80+	88	+ 5	10	+ 5	98	1.9	+ 10	−0.2
TOTAL	4,333**	+739	768***	+142	5,101	100	+881	

Source: Statistisk Rapport 1985, 20, table 4.
* Demonstrates that the biggest increase in affiliated doctors is among younger doctors, those 30–39 years of age, followed by those 40–49 years.
** 84.9 percent of all physicians; number has decreased 0.3 percent since 1982.
*** 15.1 percent of all physicians; number has increased 0.3 percent since 1982.

APPENDIX TABLE 5
Active Spare-time Doctors and Visits by County, 1983*

Social Insurance office by county	Active spare-time practitioners		Visits	
	Number	Percentage	Number	Percentage
Stockholms	583	29.4%	189,850	31.5%
Uppsala	103	5.2	22,995	3.8
Sōdermanlands	52	2.6	22,064	3.7
Ōstergotlands	86	4.3	18,027	3.0
Jōnkōpings	55	2.8	12,644	2.1
Kronobergs	23	1.2	7,845	1.3
Kalmar	17	0.9	6,588	1.1
Gotlands	9	0.5	792	0.1
Blekinge	20	1.0	2,075	0.3
Kristianstads	67	3.4	19,805	3.3
Malmōhus	198	10.0	50,216	8.3
Hallands	48	2.4	8,883	1.5
Bohuslāns	50	2.5	17,480	2.9
Alvsborgs	66	3.3	28,586	4.7
Skaraborgs	25	1.3	7,262	1.2
Varmlands	19	1.0	6,381	1.1
Orebro	43	2.2	25,093	4.2
Vāstmanlands	35	1.8	6,124	1.0
Kopparbergs	44	2.2	8,138	1.4
Gāvleborgs	29	1.5	8,494	1.4
Vāsternorrlands	13	0.7	2,428	0.4
Jāmtlands	8	0.4	799	0.1
Vāsterbottens	39	2.0	9,308	1.5
Norrbottens	25	1.3	4,650	0.8
Mälmo	135	6.8	45,144	7.5
Gothenburg	189	9.5	70,265	11.7
TOTAL	1,981	100	601,926	100

Source: Statistisk Rapport 1985, 22, table 6.
* Indicates which counties have the largest proportion of active spare-time doctors. These are, not unexpectedly, the three largest cities of Sweden: Stockholm, Mälmo, and Gothenburg.

APPENDIX TABLE 6
Active Doctors and Visits by Specialty, 1982–1983

Specialty	Active doctors*				Visits			
	Number in 1982	Percentage	Number in 1983	Percentage	Number in 1982	Percentage	Number in 1983	Percentage
No Specialty	438	14.1%	681	16.2%	128,321	4.2%	159,757	4.9%
General Medicine	474	15.3	518	14.0	616,604	20.3	608,251	18.8
Anesthesiology	39	1.3	60	1.6	13,567	0.4	20,684	0.5
Pediatricians	115	3.7	148	4.0	109,321	3.6	110,386	3.4
Skin Diseases	78	2.5	87	2.3	133,268	4.4	138,900	4.3
Internal Diseases	576	18.6	683	17.9	609,364	20.1	630,697	19.5
Surgery	477	15.4	602	16.2	441,016	14.6	513,930	15.9
Gynecology	267	8.6	310	8.4	324,589	10.7	341,916	10.6
Psychiatric	295	9.5	340	9.2	189,775	6.3	211,827	6.5
Eye Diseases	118	3.8	122	3.3	153,648	5.1	172,831	5.3
Ear-Nose-Throat Diseases	197	6.3	220	5.9	300,804	9.9	316,721	9.8
Tumor Diseases**	—	—	7	0.2	—	—	2,234	0.1
Specialty Outside List	31	1.0	32	0.9	10,595	0.3	9,008	0.3
TOTAL	3,105	100	3,710	100	3,060,872	100	3,237,152	100

Source: Statistisk Rapport 1985, 23, table 7.
* Provides a picture of the most active specialists among the affiliated doctors offering private care. These include internists, surgeons, and general medicine.
** Added July 1, 1983

APPENDIX TABLE 7
The Extent of Private Practice, 1975–1984*

	Visits and phone consultations 1975–1984					
	Visits (incl. home visits)		Phone consultations		Total of consultations	
	Thousands	Percentage change from previous year	Thousands	Percentage change from previous year	Thousands	Percentage change from previous year
1975	3,609		914		4,523	
1976	3,302	−8.5%	888	−2.8%	4,190	−7.4%
1977	3,183	−3.6	865	−2.6	4,048	−3.4
1978	3,109	−2.3	858	−0.8	3,967	−2.0
1979	3,000	−3.5	831	−3.1	3,831	−3.4
1980	2,904	−3.2	808	−2.8	3,712	−3.1
1981	2,881	−0.8	757	−6.3	3,638	−2.0
1982	3,031	+5.2	730	−3.6	3,761	+3.4
1983	3,237	+6.8	757	+3.7	3,994	+6.2
1984**	3,326	+2.7	725	−4.2	4,051	+1.4

Source: Statistisk Rapport 1985, 4, table A.
* Affiliated with the Social Insurance. Provides an overview of the decline and growth of private medical care as measured by visits and phone consultations. It reflects a slowing rate of decline and their increase again, beginning in 1982.
** Prognosis based on statistics for January to November 1984.

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