What Goes Up: The Genesis and Context of Health Reform in Sweden

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Throughout the twentieth century, Sweden earned a reputation for a generous, comprehensive welfare system predicated upon collective responsibility. As a consequence, the history of publicly funded health care in Sweden during this time is largely one of growth. Trends in the Swedish political economy since the 1980s, however, have indicated a movement toward market-based reforms. This paper analyzes the context of these reforms and argues that the underlying neoliberal ideology valorizing the market is evident not only in macro-level policies pertaining to the public health finance and administration, but also in the specific programs that public health deploys to manage chronic disease—most notably in the advocacy of the human capital approach to health education.

And there's no market forces involved with health care.
-- G.W. Bush, "The Last Debate."[1]

INTRODUCTION

The scope of the public sector in health care has historically reflected a marked difference between Nordic countries such as Sweden on the one hand, and the United States on the other. An OECD measure that tracks the proportion of total health expenditures managed through public agencies reveals that Sweden, among other European Union countries, has tended to average well above 80 percent, while the figure for the United States is only 43 percent.[2] This is reinforced by a Swedish social policy orientation that has tended to view health care as a right for all, as a social good whose cost is to be absorbed across all taxpayers. Toward this end, most health providers have been either publicly financed or non-profit, and are "expected to be motivated primarily by mission, e.g. the welfare of the community."[3] With such characteristics, the Swedish model especially has tended to be viewed in sharp contrast with a much more privatized and streamlined American system. As Saltman notes:

> Almost oppositely, health care in the United States has become, in the past 10 years, predominantly a market commodity. On the production side, providers increasingly conduct themselves as a bottom-line business, in which profit – not mission – is the main motivating incentive. Consistent with this understanding of health care, access to services in hospital and physicians' offices has become defined by ability to pay, either via adequate indemnity or capitated insurance or out-of-pocket.[4]

Efforts at reform in a number of industrialized democracies have introduced more market elements and have begun to move them closer to the American model, as Saltman argues. In the past, however, policy shifts in the European cases have been largely explored from the context of the role of political parties, interest groups, and even performative ruptures in existing policy frameworks—a perspective often associated with the work of Heclo.[5] What emerges from this analysis is not so much a problematization of these kinds of explanations—the role of parties or institutions in explaining *why* policy changes happen—as it is a demonstration of *how* a shift has occurred that problematizes the overall spectrum characterization polarizing the American and Nordic approaches to health management.[6]

In evolving this argument, I do not argue that we are witnessing an ultimate end-point convergence in health care systems; each retains unique characteristics, each has manipulated different techniques of public health governance. Furthermore, Sweden has not eschewed long-standing principles of universal coverage and the guaranteed right to health care. However, as this argument demonstrates, there has been a sustained movement on the part of Sweden to adopt market mechanisms associated with American-style health care, and to apply those to the provision and practice of public health. Such a movement problematizes the utility of this "spectrum" model of cross-national comparison that posits the United States and Sweden in diametric opposition; moreover, in contrast with the aforementioned literature that examines party differentiation in explaining policy reform, this paper demonstrates that neoliberal reforms have been advocated and pursued irrespective of party lines—and indeed by the Social Democratic party, one with a longstanding historical commitment to public welfare.

For the purpose of analytical focus, this paper explores in detail how Sweden's changes in the organization and administration of public health (and in the healthcare system overall) have been part of larger reform initiatives designed to introduce efficiency, streamline bureaucracy, and promote responsiveness to the needs of the consumer. Specific macro policy approaches, such as organizational reform and competition measures, have been deployed to varying degrees in different ways across the Swedish case.

Yet it is the fact that such approaches demonstrate a distinctly neoliberal rationality, or one predicated upon market values and mechanisms, and devolution to local and individual control, that is telling. The same is true for micro-approaches of public health—those specific programs deployed in the population to manage and reduce the challenges posed especially by chronic disease and disease risk. In Sweden, for example, health promotion campaigns have continued to emphasize both a focus on individual, behavioral risk factors, and concomitantly, an emphasis on human capital promotion to encourage individuals to better manage and enhance their lives. It is, again, the pervasiveness of market logic in these macro policy and programmatic elements of public health that problematize the classic "spectrum-model," where Sweden serves as the bastion of welfarism in structural opposition to a streamlined and largely privatized American model.

A core argument developed here—that emerging macro- and micro-level approaches toward health government in Sweden demonstrate key elements of neoliberal rationality—should not be construed as an argument that it and the United States ultimately are equally neoliberal. Sweden's public health commitment to addressing structural determinants of disease, for example, is perhaps unequaled in contemporary public health policy; nor in its provision of health coverage and service delivery is it as "hypermarketized" as the United States. Rather, the central argument is that given the trajectory of policy reform initiatives and public health practices, the historically strange bedfellows of the industrialized world—the United States and Sweden—are really not strange anymore, after all. This argument is developed and substantiated through a four-part analysis of the Swedish case: contextual discussion of neoliberal macro policy reforms; an analysis of these reforms as they pertain to *general* techniques of health governance, most especially the system of health care administration; the application of these techniques to *public health* specifically, and a brief discussion of Swedish health education, one of the micro-level, programmatic techniques of health governance that also demonstrates neoliberal rationality.

FROM JUSTICE TO EFFICIENCY: THE CONTEXT OF SWEDISH MACRO POLICY REFORM

Throughout much of the twentieth century, Sweden earned a reputation for a generous and comprehensive welfare system predicated upon collective responsibility—especially regarding the care of more vulnerable members of society—children, the elderly, and the poor. As a consequence, the history of the Swedish welfare state during this time frame is largely one of growth. For example, the expansion of public sector spending as a percentage of GNP grew from 31 percent in 1960 to 65 percent by 1986.[7] The rate of this growth far outpaced other OECD countries, which also averaged 30 percent of GNP in public sector spending in 1960, to approximately 40 percent in the 1980s, and at the same time was coupled by expansion in public sector employment and strong patterns of investment.[8] Thus, until the closing decades of the twentieth century,

> the only change known to Swedish public administration was that of expansion. It was a consequence of strong economic growth and the widespread belief that social problems could only be solved by collective measures such as legislation, creation of public institutions and organizations, and national labor-market agreements.[9]

Fueled by consistent economic growth and the values embraced by welfare liberalism, social problems demanded a collectivist response. It is in this context that what has come to be termed the "Swedish model" of health care, and of welfare more generally, evolved. Core elements of the model include tax-generated public provision of basic health services to all, including insurance, primary care, and specialist consults; a special emphasis on the most disadvantaged members of society (in terms of prioritization for services); a

corporatist mode of decision-making; and for those working in the health sector, policies emphasizing wage solidarity and strong participation by labor unions.[10]

However, several trends in the Swedish political economy of the 1970s and 1980s came to undermine the halcyon arrangements that had grown up in previous decades. By the mid 1970s, the public sector found itself expanding rapidly—from 45 percent of GDP in 1973 to 60 percent in 1978—even as taxes were raised to finance the spending, and the record economic growth of the 1960s had slowed down. Thus, the welfare state increasingly found itself under scrutiny for operating "slowly and inefficiently compared to private companies."[11] Despite continued economic growth during the 1980s, a large and complex system of public administration led to a record deficit equal to 16 percent of GNP by 1993.[12]

Moreover, specific trends in the political economy of health care further complicated the scenario leading up to reform. Burkitt and Whyman structure an explanation of these trends in economic terms of demand and supply. On the demand side, an aging population increasingly utilized medical and other welfare services, and a changing composition of demand preferences required the flexibility offered by a "menu" of services—inconsistent with uniform and programmed distribution of welfare under the Swedish system. In terms of supply-related trends leading up to reform, a system of rationing based on queue meant long-waiting lists for medical procedures and other services; furthermore, the public sector, while a significant source of employment (33 percent in 1980), experienced understaffing and other resource shortages in the face of increased utilization of health care services.[13] As a result, health care costs increased by 145 percent between 1980 and 1990.[14]

At the time that demand for services increased and economic conditions began to stagnate, Alain Enthoven visited Sweden in 1988 to evaluate its health system's performance and organization. In identifying ways for the Swedish system to improve its "incentives for efficiency and equity," he indicated that the most promising solutions could be adapted from private business. As he laments:

> How can Swedes pretend to be managing their health care system efficiently without the basic management systems that any successful industrial company in a competitive industry routinely has?[15]

In response to pressures both within and without the health sector, in 1991 the Social Democrats, long committed to a deep-rooted welfare state, lost power to a more conservative coalition government. The new government aimed to institute reforms to address the broad economic issues and specific trends in the health sector that compromised its performance. Despite inherent party differences, there was a great deal of convergence on the overall direction that the reforms should take. The Parliamentary Committee on Health and Welfare was formed and charged with the task of managing reform proposals on medical and health care.

Among the parties, the vast majority supported market-oriented reform; the only question was the extent to which it should occur. The right wing New

Democrats and the Conservatives were the most vocal for implementing privatization policies, though these were not supported by the other parties; however, the Christian Democrats, the Center Party, and the Liberals were all ready to support some market-oriented reform, particularly in the arena of purchaser-provider splits and other competition inducing measures.[16] For the new coalition government, "public administration reform became a tool in fighting the fiscal crisis...Neoliberal ideas about competition, marketization, and privatization in the public sector had some impact on all the major parties, but the neoliberal ideology became the trademark of the new government."[17]

This neoliberal impulse manifested in the specific reforms made to the health sector in subsequent years. Under the auspices of a welfare state "modernization program," termed the Stockholm Revolution, this reform program evolved between 1992 and 1995, and constituted a new way of organizing and financing health care, to achieve "more and better health for less money."[18] Important elements of the system included an expansion of patient choice to select their care provider—even a private provider; competition between hospitals and primary care clinics for patients; and finally, a separation of purchaser and provider functions in health care.[19] Hjertqvist further describes features of the Revolution, which include:

> Privatization, opening up opportunities for private ownership of hospitals and other health facilities; the establishment of diagnosis related groups (DRGs), which ascribe a cost to every health or medical procedure, payable only upon verification that the service is actually completed—designed to encourage efficiency and eliminate waste; competitive contracts for providers, open to private suppliers, as well; guaranteed access for consumers, with a limit of three months as a waiting period for treatment; expansion of consumer information campaigns, to encourage awareness and monitoring of patient conditions, and to facilitate healthy behaviors; provision of legal and other forms of support to public medical and health employees to facilitate new businesses, which are then eligible to bid on competitive contracts.[20]

Themes of consumer responsiveness (and responsibility), the separation of purchasers and providers (as in the United Kingdom), and increased competition were thus hallmarks of the reform initiative. The effects of the Stockholm Revolution were evaluated in a 1994 study that charted productivity and cost savings prior to the implementation of the Revolution in 1992, and found that after the change, productivity in the acute care sector increased by 5 percent, patient turnover increased by 18 percent (moving more people through the system), with an overall cost savings of 25 percent.[21] In this way, the goals of introducing a greater degree of cost efficiency, productivity, and consumer responsiveness in the form of facilitated access were well on the way to being realized.

The major limitation with this early review, however, is that it only reflected two years of post-reform performance, and did not consider *differential*

impacts across the system. Other evaluations reveal a more checkerboard pattern of success. Indeed, the *impact* of macro policy reforms suggests that the results were quite mixed. Rather than increasing efficiency across the board, a number of counties within Sweden actually witnessed an *increase* in the cost of health care.[22] According to Twaddle, this was especially the case in the arena of primary health care, though he also notes the broader consequences of neoliberal reform:

> There was a downward diffusion of expensive medical technology from regional to county to local hospitals. New private clinics opened to provide high technology care to those who could afford it, often elites from Third World countries. The medical care system was infused with new energy. At the same time, the quality of health care for the aged deteriorated sharply. Physicians shifted locations into populations that tended to be adequately served and away from areas of need. Regional differences increased. The costs of primary care exploded.[23]

Despite their eventual mixed record of success, the broad support that these reforms received in the early years of the Stockholm Revolution ensured that such reforms diffused throughout the health care system—not only primary care and insurance mechanisms, but public health as well.

MACRO-APPROACHES OF HEALTH REFORM: THE LARGER SYSTEM

As in other industrialized countries undergoing health care reform, one of the key initiatives in Sweden was that of organizational restructuring. In the context of the health sector, the entities historically responsible for the administration of medical and health services are the county councils. Formed in 1862, "the county councils are responsible for financing, planning and providing/purchasing medical care for their inhabitants. This responsibility also includes care that others carry out, for example, private care."[24] Unlike systems such as in the United States, where public health activities and medical practice are mostly carried out under separate auspices and institutional arrangements, the county councils also are responsible for promoting population health, as in disseminating information about prevention and engaging in health education activities.[25] There are approximately 20 county councils, ranging from responsibility for 60,000 (Gotland) to 1.8 million people (Stockholm). To finance health care, the county councils have the authority to charge a proportional income tax specifically for health care–in 2000, an average of 10 percent. This tax revenue covers 80 percent of health care system costs, with the balance funded by patients (3 percent) and the state (17 percent).[26]

Under reform initiatives instituted by the conservative coalition government, and upheld and continued after the Social Democrats regained power in 1994, the councils have been subject to administrative streamlining. From the inception of the Stockholm Revolution in 1992, and through 1999, the number of personnel in the county councils decreased by 21 percent, even as the

hours worked—especially by health care staff such as doctors and full-time nurses, remained fairly constant.[27] Moreover, the county councils devolved certain traditional responsibilities to local health organizations in order to further streamline their operational focus; for example, under the reform initiatives, long-term care was shifted away from the administrative responsibilities of the county councils to local care coordinators. In addition to giving greater focus to the councils' administrative responsibilities, there was a cost efficiency justification for this change, as well. Even as health care costs continued to rise, the new coalition government mandated that counties could not raise taxes between 1991 and 1994 to secure additional funds for the system. The devolution of this responsibility allowed the counties to fend off additional costs; local councils now assume responsibility for payment once acute care is complete, but given their own budget constraints, this has had the effect of shuttling patients through the hospital system as quickly as possible, to move them into nursing homes or to receive long-term care in their own homes.[28]

A second, and perhaps even more key, organizational reform was to shift the role of the county councils from providers of health care, to purchasers that made contracts available for competitive bidding. Under the old system, the councils dispersed funds to hospitals and other care facilities in the form of global budgets—a fixed sum to be dispersed for all services. Under the new arrangement, health care services have been devolved from a global budget and competitively bid upon by providers. Approximately 1,000 medical procedures were analyzed using the abovementioned Diagnosis Related Groups, which assign a cost to each, based on a point system (two points for one procedure, three for another, etc). Providers are then compensated by the councils based on what the points dictate, which encourages "less efficient hospitals to increase efficiency in order to get revenue that matches their costs."[29]

While the purchaser-provider split was implemented at the level of the county councils, the Ministry of Health shared in the vision of applying market principles to the health system, especially in the context of promoting competition. Former Minister of Health Bo Könberg, who headed the Ministry at the time that the reforms were being debated and implemented, has concluded:

> ...much has to do with getting more value for the money within the county council system, or a system with more competition...That's the debate we have with the Social Democrats. We are trying to get more competition between the public clinics, also in some cases between public hospitals and private hospitals.[30]

The push to implement competition in the provision of health care was complemented by other specific reforms. Beginning in 1992, the Stockholm regional government began providing entrepreneurial training to those working in the public sector system to develop business models for bidding on service provider contracts. And as of 1998, all health care services not related to emergency medicine were put up for competitive bidding. The result has been that by 2003, the monolithic system of publicly provided health care had been

adjusted to accommodate more than 200 private providers, dispersed throughout the country.[31]

In addition to employing competitive contracts as a technique of health government, the councils have also more assertively shifted their operational focus to the patient. Beginning in 1992, the county councils began implementing the "Patient Choice and Care Guarantee"; under this reform, patients were guaranteed treatment within three months of receiving a diagnosis, and the right to seek treatment at another facility if their chosen provider could not provide care within that time frame. This measure was augmented when the Federation of County Councils in 1997 drafted an initiative that called for the councils to further "strengthen the patients' position by increasing accessibility and emphasizing freedom of choice."[32] Specific measures in this regard call for granting the individual the right to speak to a medical worker on the day of contact; see a general practitioner within eight days, and see a specialist, if necessary, within either one month (if ambiguous diagnosis), or three (if diagnosis is clear).[33]

Given Sweden's increased emphasis on other neoliberal changes in the health system, it is not surprising to see the valorization of the consumer as a major element of the reform initiative. Indeed, Hjertqvist views the shift toward a customer-oriented focus as the thread that binds all other reforms together:

> Once the foundation has been laid, the system can be reshaped to make the consumer a partner. Supporting infrastructure enhancements...is not only rational from an economic point of view, but also empowers the individual consumer with knowledge, encourages the development of patient groups, and builds credibility in the system. Consumer power has been increasingly recognised as an instigator of change, a tool for implementing necessary reforms, and an efficient indicator of low performing institutions. Assessments made by the consumers should become the standard evaluation, rather than those with no bearing on either performance or outcome.[34]

BRINGING REFORM INTO EFFECT: PRESSURE WITHIN THE SYSTEM

These changes to streamline bureaucracy, promote competition, and become customer-focused emerged out of critiques that the administrative system of the county councils was bloated, inefficient, and unresponsive to consumer needs. And while the reforms initiated under the Stockholm Revolution were generated at the macro policy level, they were accepted, and in some cases embraced, by those within the health sector. Johannes Vang, a World Health Organization doctor and co-author of the Federation of County Councils' 1992 *Crossroads Report*, chastised the pre-reform Swedish health sector for not operating more in accord with market principles, especially in the arenas of consumer responsiveness and monopoly organization.[35] He concluded that a focus on bureaucratic organization and administrative capacity:

> underlined the faults of the administrative system because the patient became less and less important as centralization became also more and more expressed, as hospitals became bigger and bigger...
>
> At the same time as the patient/customer lost importance, it always appeared a total monopoly. In our situation here, we had a total monopoly. It was the *landstinget*, the county councils. They financed it. They produced it. They controlled some of it. The product was very bad. And they could even improve demand, if they wanted to, simply by increasing taxes.[36]

Vang was not alone in his conclusions, either. Anders Milton, Secretary General of the Physician's Union (*Läkarföbundet*), remarked on the 1990s reforms:

> You see a lot of layers of bureaucracy and you create a lot of confusion within the command structure of health care that is not efficient...We proposed a system...that gives the patients a much stronger position than they used to have, meaning the patients make the choice. They carry the money with them, meaning that their choice has a budgetary implication. Also, on the provision side, there should be free competition...within quality boundaries. I mean once you pass the society's need when it comes to quality, then it should be a free market.[37]

And Inger Ohlsson, President of the Nurse's Union (*Vårdförbundet*), concluded in a 1993 interview that the long-standing health care system based on social solidarity and equality of access was giving way to a leaner, meaner, more market-oriented approach to the health.

> The ideological grounds for the system are threatened. People want a greater say, greater choice. Public health care has neglected public demand for a greater say and choice. There is economic pressure on the health care system to do more for less cost...Equality is a value that has become unfashionable.[38]

While Ohlsson remained skeptical of the direction of the reforms, the Nurse's Union itself ultimately contributed to articulating this vision by creating a committee to research new ways to introduce entrepreneurship into nursing practice, and by supporting private practice alternatives.[39]

As one can see, the application of neoliberal macro policies to the health system was facilitated not only by politicians at the national level, but also by actors in all health care sectors. Twaddle thus concludes that while the presence of a conservative coalition government set the tone of policy, "it was also clear that the proposals for change were coming from the Ministry of Health, the Federation of County Councils, and the Physicians' Union."[40]

NEOLIBERAL MACRO POLICY REFORMS IN THE CONTEXT OF PUBLIC HEALTH

With the reform of government policies espousing a more market ideology in the 1990s, it is not surprising that the organization and practices of Swedish public health would come to demonstrate at least some of them. What is surprising, however, is that a national, comprehensive public health system did not have to change in response to the new imperatives: it was developed in conjunction with them, mitigated to a certain extent by the long-standing tradition of collectivism that proved impossible to thoroughly abandon.

This is not to assert that public health did not exist prior to the late 1980s and early 1990s; rather, it was organized not as an arena of national policy, but in accordance with the directives of the county councils. In this regard, Sweden had long been criticized for having "no comprehensive public health policy."[41] Even in a system that has emphasized collective responsibility for many years, the notion of collectivity under the auspices of a central public health organization was not, until recently, a defining feature of the system. Thus, "it has been recognized that politics is a health determinant in different sectors of society, but there has not been any effort to coordinate different governmental offices in order to promote public health."[42]

This aspect may partly be due to the relatively recent emergence of a national strategy on public health in Sweden. The first attempts to coordinate such a strategy began in 1987, with the creation of a task force involving both administrative officials as well as public health scientists. Their aim was to develop an overarching national health strategy, one that could be integrated into the existing system of social welfare. From this task force emerged a recommendation to create a National Institute of Public Health (NIPH), organized in 1992. Its focus was "to direct health promotion and disease prevention activities at a national level and to cooperate with other national authorities and NGOs in health matters."[43] At the time that the NIPH was organized, however, Sweden was already implementing market reforms to emphasize streamlined bureaucracy, competition, and consumer responsiveness. Agren has pointed to the tangible effects that these neoliberal changes had on the direction of activities and research pursued by the NIPH. Where it had been chartered with an agenda that focused on socioeconomic and other structural determinants of health

> the institute did not take on its intended strategic role in the Swedish public health work. Instead its activities focused on programmes directed towards health problems such as alcohol, illicit drugs, HIV/AIDS, injuries, allergic disorders and tobacco use. There was a quite strong emphasis on information directly to the public.[44]

This focus on behavioral risk factors underscores the fact that the health system was reorienting toward the consumer not only in terms of marketing service delivery, but also in terms of engaging individuals as consumers of *information* so that they might better equip themselves to monitor risk factors

and engage in self-care. By focusing on behavioral risk factors in its research and promotion activities, the NIPH contributed to the construction of the individual as both the site of disease risk and the solution for its mitigation.

As the national public health system evolved over the course of the 1990s, it was caught amidst continuing public sector cutbacks and welfare reform. After the Social Democrats regained control of the government in 1994, a move was made to develop broader consensus about the role and function of the national public health system. In 1997, a new committee was formed to articulate not only the content of specific public health objectives, but also organizational responsibilities for achieving them. It was a multilateral effort as indicated by the diversity of interests and perspectives represented on the committee: representatives from all major political parties, labor and other interest groups, as well as experts in the fields of public health and medicine more generally.[45] A number of public health goals were identified, encompassing structural dimensions—supportive social environments, high levels of employment and safe working environments—as well as behavioral factors such as healthy diet, adequate physical activity, and avoidance of drugs, alcohol, and tobacco. By emphasizing both structural and behavioral public health issues, Sweden's approach to public health in this instance mirrors the overall health system that evolved in the 1990s: one that retained a general commitment to the social unit, even as neoliberal principles—in this case, attention to behavioralism and individual risk factors—became intertwined with that commitment.

In early 2001, a bill brought before the *Riksdag* (Swedish Parliament) proposed that the National Institute of Public Health be reorganized and re-tasked effective July 2001. The new mission charged the NIPH with coordinating activities between the public, private, and nonprofit sectors to achieve major public health goals; evaluating programs pertaining to them; acting as a clearinghouse of information for public health research; and assuming responsibility of supervising tobacco and alcohol health initiatives from the National Board of Health and Welfare and the National Alcohol Board. [46]

In the process of this reorientation, the Swedish government commissioned an international panel evaluation of public health research in the country to guide the reorientation process. And again, while Sweden's public health system does not demonstrate the hyper-liberal tendencies of the United States, the panel's 2004 report reflects the shift from population approaches to public health towards those that emphasize clinical treatment of individual persons. In this regard, the panel concluded that the direction of publicly funded research was improperly skewed *away* from population health, as it has been pushed aside in favor of research fitting the biomedical paradigm:

> Considering the outstanding Swedish contribution to international research knowledge in public health as well as national contributions to policy-making, the panel finds it difficult from an international perspective to understand why the Swedish society has allocated so much more priority to basic biomedical and clinical research. For future policy-making in Sweden, the panel recommends that the Swedish society challenge this previous

> prioritization of research funding – and change the balance towards much more PHR [public health research].[47]

While Sweden retains a national public health system organized and coordinated by the NIPH, the practice and dissemination of much public health work occurs at the local levels. Here, too, recent developments demonstrate the application of market principles—in this case, decentralization and greater autonomy for local organizations to manage health activities and to disperse budgets, provided that they develop and implement "comprehensive health action plans." These plans enumerate a series of public health measures consonant with the national public health goals, provide or identify funding for their implementation, and demonstrate activities for evaluation and follow-up. Since 1995, the number of municipalities implementing comprehensive health action plans has more than doubled, from 20 percent to 53 percent.[48]

With the implementation of these health action plans, and in concert with the overall theme of reform, the county councils have further devolved responsibility for public health activities to local public health councils. In the wake of reform measures emphasizing decentralization, the local public health councils have increasingly gained more autonomy in deciding which public health initiatives to pursue. Prior to the late 1990s, public health councils retained mostly an advisory role vis-à-vis the county councils, with little decision-making authority.[49] Complementing this greater degree of autonomy is the trend toward local health councils' managing and dispersing their own budgets, and deciding how particular initiatives will be funded. As of 2003, 57 percent of local public health councils controlled their own budgets, a figure that more than doubled since 1995.[50]

In addition to demonstrating a trend toward decentralization and local control in the public health arena, the distribution of activities pursued by the local councils have focused primarily on behavioral elements of the nation's public health goals. A 2004 NIPH study revealed the majority of initiatives outlined in the comprehensive action programs were directed toward the national health objective pertaining to tobacco, alcohol, and other drug use.[51] The dissemination of public health activities that target educating and modifying individual behavior, taken in concert with trends toward decentralization and local autonomy of public health councils, as well as an orientation of health research toward biomedicine as opposed to population health, all reveal the particular manifestations of neoliberal rationality in contemporary Swedish public health.

Though these changes may not appear dramatic, one might expect that with the overall health system demonstrating features of market reform, that the values and strategies associated with that reform would manifest in the structure and practices of public health. This manifestation carries over necessarily to the micro-level programs of Swedish public health; in this arena, we witness the same emphasis on the primacy of individual risk factors and an orientation toward human capital development that are a hallmark of neoliberal approaches to population health.

HEALTH EDUCATION IN THE SWEDISH CONTEXT: A PROGRAMMATIC ELEMENT OF NEOLIBERAL GOVERNMENT

Neoliberal rationality in the government of health is not limited to the macro-policies that have evolved in Sweden over the last decade and a half. Specific public health programs have also reflected neoliberal techniques of health governance, especially in the area of promoting human capital in the context of health education. Sweden's longest running public health prevention program for cardiovascular disease (CVD), the Malmö Preventative Project, began in 1974 as a way to identify at-risk adults for intervention and prevention measures to reduce the burden of CVD. Since its inception, over 30,000 men and women have participated in the screening program.[52]

A key component of the program is a comprehensive risk factor screening, including a physical, laboratory tests, and a self-administered questionnaire. The questionnaire illustrates which risk factors are emphasized in terms of data collection, prevention, and intervention practices; given that Sweden's public health goals include several directed toward social and economic determinants of health and illness, one would expect to find questions that address these aspects. Yet, the questionnaire reflects more the application of the biomedical model to public health, with questions that deal primarily with genetic predispositions and behavioral practices: family history of cardiovascular disease, hypertension, and diabetes; patterns of smoking and alcohol consumption; physical activity levels (including work and leisure); dietary patterns and history of weight gain; and the presence of symptoms of CVD.[53]

This focus on individual level risk factors in public health program is not limited to the Malmö Preventative Project. In Northern Sweden, the Norsjö prevention program emerged as a result of statistical trends in the 1980s showing that CVD morbidity and mortality was significantly higher in the rural north, while the region also had comparatively fewer public health resources to address the problem. Västerbotten County, for example, demonstrated one of the highest rates of ischaemic heart disease in the country (634 per 100,000); the Norsjö municipality within the county had the highest mortality rates, prompting the county government to launch the Norsjö initiative in 1985.[54]

The initiative was targeted at identifying high-risk individuals between the ages of 30 and 60 on the basis of three risk factors: plasma lipids, blood pressure, and smoking. These individuals participated in an annual survey pertaining to these risk factors, received a clinical evaluation, and were counseled on the basis of their test results; those at higher levels of risk received additional lifestyle counseling about ways to decrease their risk for CVD. A review of the program has identified that its population strategy "concentrated on messages about lifestyle factors (i.e. eating habits, smoking, physical activity, social networking, and emotional support)."[55] Even when pursued as a population health initiative, the analytical lens and techniques of practice of the Norsjö project were firmly rooted in atomistic individualism and the behavioralist imperative such an approach generates:

> The Norsjö model of community intervention planned to address and counsel each and every individual at certain ages, at the same time conveying messages about lifestyle changes, eating habits, alcohol consumption, physical activity, and psychosocial conditions to the general public of the local community.
>
> The overall goal of the individually oriented primary care approach was wider than simply screening individuals for high CVD risk. The main idea was to reach everyone individually and to create an arena for communication between individuals and health professionals regarding health problems.[56]

That a public health education program such as Norsjö consciously adopts a primary care model illustrates how the population approach, so long an entrenched feature of public health, is being eclipsed by an orientation toward a biomedical response. Moreover, it demonstrates how public health approaches to non-communicable disease are predicated upon the notion that individual behaviors are both problem and solution, if the at-risk person can only be educated to change. The notion that individual bodies are sites of investment—to maximize health, longevity, and productiveness—only brings into sharp focus how the neoliberal imperative to convert life and its processes into capital has embedded itself in the programs of modern public health.

CONCLUSION

In terms of governance, macro-level policy reforms in Sweden have introduced elements of neoliberalism to the overall health system, as well as to the specific arena of public health. Sweden remains, on the whole, not so nearly hyper-marketized as the United States; yet the traditional spectrum model differentiating American and Nordic-style health systems appears to be undergoing a transition. Increased evidence of neoliberal rationality in the macro-approaches of public health are present in the Swedish case—organizational reform to streamline bureaucracy, the privileging of competition and internal markets, movements toward decentralization and in some cases privatization, and a reorientation toward consumer responsiveness.

It is also noteworthy that the neoliberal reforms undertaken this case were in part carried out under the administration of a historically *welfarist* party. In Sweden, the move to competitively source all non-emergency health services, as well as the 1997 initiative to strengthen the position of the health care consumer, were implemented under the Social Democrats. Thus, it is possible to witness in this case how the trajectory of health reform reveals a divorce between party politics and the subtle politics of neoliberal rationality.

Moreover, as demonstrated in the analysis, a variety of neoliberal techniques of reform are present in the Swedish case, though not all have been equally emphasized. That is to be expected; Sweden is certainly not re-creating from whole cloth the American model, and its historical and cultural legacy continues to shape the way reforms are pursued and implemented. But when

macro policies are assessed in conjunction with the micro-practices of public health—such as health education campaigns predicated upon targeting individual risk factors and enhancing human capital—it becomes difficult to accept that economics has any disciplinary monopoly on market rationality. Indeed, it is exactly this rationality that is becoming the inheritance of contemporary public health.

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[1] *The International Herald Tribune* (October 14, 2004), http://www.iht.com/articles/2004/10/13/frontpage/web.debate3text.php?page=8.
[2] R.B. Saltman, "The Context for Health Reform in the United Kingdom, Sweden, Germany, and the United States," *Health Policy* 41, no. Supplement (1997): S11.
[3] *Ibid*.: S13.
[4] Ibid. Saltman's assertion about access contingent upon ability to pay is borne out by increasing instances of "patient dumping," or the transfer of uninsured emergency room patients to a public clinic before treatment – even in the face of legislation prohibiting this practice. For a detailed discussion of patient-dumping, see A. Kellerman and B.B. Hackman, "Emergency Department 'Patient Dumping': An Analysis of Inter-Hospital Transfers to the Regional Medical Center at Memphis, Tennessee," *American Journal of Public Health* 78 (1988).
[5] Hugh Heclo, *Modern Social Politics in Britain and Sweden: From Relief to Income Maintenance* Yale Studies in Political Science (New Haven, CT: Yale University Press, 1974). An examination of these and other issues is also addressed by Arnold Heidenheimer, Hugh Heclo, and Carolyn Teich Adams, *Comparative Public Policy: The Politics of Social Choice in Europe and America*, 3rd ed. (New York: Bedford/St. Martins, 1990) ; Their comparative approach engages and explores policy differences in both a European and American context, with particular attention to the dynamics conditioning health policy. For an additional general treatment of comparative social welfare policy that also addresses underlying theoretical explanations, see Harold L. Wilensky, *Comparative Social Policy: Theories, Methods, Findings*, Research Series, University of California, Berkeley International and Area Studies (Berkeley: University of California, 1985).
[6] In order to provide a depth account of the evolution of Sweden's public health approach to NCDs and health care overall, the comparison of these changes with that of the United States is deferred in this particular analysis, though it is assessed in a separate paper. However, in addition to the secondary literature alluded to earlier, ample primary government documents exist charting the neoliberal nature of American health care, as well as the intensification of neoliberal reforms in U.S. public health since the 1990s. For examples, see: *Government Performance and Results Act*, 1st (January 5), 1. National Partnership for Reinventing Government, "Balancing Measures: Best Practices in Performance Management," http://www.orau.gov/pbm/links/npr1.html National Performance Review, "From Red Tape to Results: Creating a Government That Works Better and Costs Less," (Washington, DC: National Performance Review, 1993).; General Accounting Office - United States, "Reinventing Government: Status of Npr Recommendations at 10 Federal Agencies," (General Accounting Office, 2000), 1. Department of Health and Human Services Assistant Secretary for Administration and Management (Ed Sontag), Memo, November 8 November 8 2001. National Institutes of Health Deputy Director for Management (Tim Wheeles), July 9 2003. Council of Public Representatives, "Report to the Director of the National Institutes

of Health on the Organizational Structure and Management of the Nih," (Washington: Council of Public Representatives, 2002), 4.
[7] Brian Burkitt and Philip Whyman, "Public Sector Reform in Sweden: Competition or Participation," *The Political Quarterly* (1994): 276.
[8] *Ibid*.
[9] Peter Ehn et al., "Swedish Bureaucracy in an Era of Change," *Governance: An International Journal of Policy, Administration, and Institutions* 16, no. 3 (2003): 432.
[10] For a more detailed discussion on general aspects of the Swedish model, see Alexander Hicks and Lane Kenworthy, "Cooperation and Political Economic Performance in Affluent Democratic Capitalism," *American Journal of Sociology* 103 (1998). For specific analyses of the application of the Swedish model to the health sector, see: Diane Duffy, "The Effect of Sweden's Corporatist Structure on Health Policy and Outcomes," *Scandinavian Studies* 61 (1989).; and Ellen Immergut, "Procedures for Conciliation: The Institutional Basis for Swedish National Health Insurance," *Scandinavian Studies* 61 (1989).
[11] Ehn et al., "Swedish Bureaucracy in an Era of Change," 432. Others have pointed to the efficiency critique of the Swedish model: see A. Bergmark, M. Thorslund, and E. Lindberg, "Beyond Benevolence - Solidarity and Welfare State Transition in Sweden," *International Journal of Social Welfare* 9 (2000): 241.; and A. Lindbeck, *Welfare State Disincentives with Endogenous Habits and Norms* (Stockholm: Industrial Institute for Economic and Social Research, 1995).
[12] Ehn et al., "Swedish Bureaucracy in an Era of Change," 430.
[13] Burkitt and Whyman, "Public Sector Reform in Sweden: Competition or Participation," 276-78.
[14] Ministry of Health and Social Affairs - Sweden, *Health Care for the Future - Three Models* (Stockholm: Ministry of Health and Social Affairs, 1993).
[15] Enthoven quoted in Stefan Håkansson and Sara Nordling, "The Health System of Sweden," in *Health Care and Reform in Industrialized Countries*, ed. Marshall Raffel (University Park, PA: Pennsylvania State University Press, 1997), 210.
[16] Andrew C. Twaddle, *Health Care Reform in Sweden, 1980-1994* (Westport, CN: Auburn House, 1999).
[17] Ehn et al., "Swedish Bureaucracy in an Era of Change," 434.
[18] Håkansson and Nordling, "The Health System of Sweden," 213.
[19] *Ibid*., 214.
[20] Johan Hjertqvist, "Meeting the Challenges to European Healthcare: Lessons Learned from the 'Stockholm Revolution'," *Pharmacoeconomics* 20, no. 3 (2002): 50.
[21] E. Jonsson, *Has the Stockholm Model Generated More Care for the Money?* (Stockholm: Stockholm University, 1994).
[22] Alan Jacobs, "Seeing Difference: Market Health Reform in Europe," *Journal of Health Politics, Policy and Law* 23, no. 1 (1998), 13. On this point, see also F. Diderichsen, "Market Reforms in Health Care and Sustainability of the Welfare State: Lessons from Sweden," *Health Policy* 32 (1995), 141-154.
[23] Andrew C. Twaddle, *Health Care Reform in Sweden, 1980-1994* (Westport, CN: Auburn House, 1999), 223-224.
[24] Gudrun Lindberg and Måns Rosén, eds., *National Atlas of Sweden* (Stockholm: National Atlas of Sweden, 2000), 83-84.
[25] *Ibid*.
[26] *Ibid*., 85.
[27] *Ibid*., 92.
[28] Ministry of Health and Social Affairs - Sweden, *Annual Report on Local Councils and Their Responsibility for Elderly Long-Term Care* (Stockholm: Ministry of Health and Social Affairs, 1995).
[29] Ragnar Lofgren, "The Swedish Health Care System: Recent Reforms, Problems, and Opportunities," in *Public Policy Sources* (Vancouver: The Fraser Institute, 2002), 4. Gerdtham, et al (1997) conclude that under the new system that casts county councils as purchasers, the councils have realized an average of 13 percent cost savings over using global budgets - U.G. Gerdtham, C. Rehnberg, and M. Tambour, "The Impact of Internal Markets on Health Care

Efficiency: Evidence from Health Care Reforms in Sweden," in *Working Paper Series in Economics and Finance* (Center for Health Economics, Stockholm School of Economics, 1997).
[30] Quoted in Twaddle, *Health Care Reform in Sweden, 1980-1994*, 119-20.
[31] Montreal Economic Institute, "Turning to the Private Sector in Health Care: The Swedish Example," Montreal: Montreal Economic Institute, 2003.
[32] Lindberg and Rosén, eds., *National Atlas of Sweden*, 93.
[33] *Ibid*.
[34] Hjertqvist, "Meeting the Challenges to European Healthcare: Lessons Learned from the 'Stockholm Revolution'," 52.
[35] The *Crossroads Report* had, as its goal, a discussion of various options for reform of health care organization and financing.
[36] Quoted in Twaddle, *Health Care Reform in Sweden, 1980-1994*, 115.
[37] *Ibid*., 124-25.
[38] *Ibid*., 100.
[39] Montreal Economic Institute, "Turning to the Private Sector in Health Care: The Swedish Example," 2.
[40] Andrew C. Twaddle, *Restructuring Medical Care: Swedish Opinion Leaders on the Medical Care Crisis (If There Is One)* (Linköping: Tema H, Universitet i Linköping, 1994), 10-11.
[41] Gunnar Agren, "The New Swedish National Health Policy," *Scandinavian Journal of Public Health* 29 (2001): 246.
[42] *Ibid*.
[43] *Ibid*.
[44] *Ibid*.
[45] *Ibid*.
[46] Ministry of Health and Social Affairs - Sweden, "Towards Public Health on Equal Terms," in *Fact Sheet* (Stockholm: Ministry of Health and Social Affairs, 2001), 3.
[47] Kamper-Jørgensen et al., "International Panel Evaluation of Swedish Public Health Research," (Stockholm: Swedish Council for Working Life and Social Research and the Swedish National Institute of Public Health, 2004), 5. Among the specific issues identified by the panel were the need to increase research productivity in terms of the publication of scientific articles, the need to shift research foci away from descriptive studies and studies pertaining to disease determinants and toward studies pertaining to health promotion and health services, and a need to focus more on innovation in public health research
[48] National Institute of Public Health - Sweden, "The Organization of Public Health in the Municipalities in 2003," http://www.fhi.se/templates/Page____1612.aspx
[49] *Ibid*.
[50] *Ibid*.
[51] *Ibid*. While these comprised the majority, initiatives pertaining to healthy childhood and a safe environment were also cited as numerous. Exact figures were not provided.
[52] G. Berglund et al., "Long-Term Outcome of the Malmo Preventative Project: Mortality and Cardiovascular Morbidity," *Journal of Internal Medicine* 247 (2000): 21.
[53] *Ibid*.
[54] L. Weinehall et al., "Different Outcomes for Different Interventions with Different Focus! - a Cross-Country Comparison of Community Intervenions in Rural Swedish and Us Populations," *Scandinavian Journal of Public Health* 29, no. Supplement 56 (2001). For additional details on the Norsjö project, see: I. Brännström et al., "Local Health Planning and Intervention - the Case of a Swedish Municipality," *Scandinavian Journal of Primary Health Care* Supplement no. 1 (1988).; and L. Weinehall et al., "Shifting the Distribution of Risk: Results of a Community Intervention in a Swedish Vascular Risk Profile," *Journal of Epidemiology of Community Health* 53 (1999).
[55] Weinehall et al., "Different Outcomes for Different Interventions with Different Focus! - a Cross-Country Comparison of Community Intervenions in Rural Swedish and Us Populations," 47.
[56] L. Weinehall et al., "Prevention of Cardiovascular Disease in Sweden: The Norsjo Community Intervention Programme--Motives,

Methods and Intervention Components," *Scandinavian Journal of Public Health* 29, no. Supplement 56 (2001): 15.