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Short article

Is patient choice democratizing Swedish primary care?

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ABSTRACT

Choice and competition reforms in healthcare often involve the idea of empowering patients through the mechanism of 'exit'. Using Swedish healthcare as an example, this article illustrates that this kind of efforts to empower patients may not only affect patients' chances of influencing healthcare but also those of citizens, who may lose 'voice' as a result. Thus, it is an example of the conflict between representative democracy and the customers' control over welfare services; a conflict that may be overcome by providing new forms of collective decision-making. This was not the case when introducing a patient choice reform in Swedish primary care in 2010.

1. Introduction

Choice policies inspired by New Public Management (NPM) are currently being implemented in European healthcare, not least in the UK and in Scandinavia [1]. For instance, in 2010, the primary care legislation in Sweden was changed [2]. The new provisions were similar to those of the UK's controversial Health and Social Care Bill. Among the key measures were ways of promoting *choice* and *competition* in publicly financed healthcare [3]. Using Sweden as an example – where governance of healthcare is decentralized to democratically elected county councils/regions – this article illustrates how choice policies may infringe upon local democracy unless other forms of collective decision-making are provided.

Creating choice and competition in public services is strongly associated with the shifting balance between politics and markets [4]. Besides efforts to improve healthcare system performance, the reasons for increasing choice often involve the idea of *empowering patients.* This was certainly needed in Sweden, since patients have complained for many years about their lack of power and the insufficient attention being given to their preferences [5]. One important aspect of the reform of primary care in Sweden was the idea of empowering patients by giving them purchasing power, i.e., making them *customers* of primary care services [3,6,7]. In the article I argue that, in healthcare systems that are democratically governed by elected representatives, these kinds of efforts to empower patients not only affect *patients*' chances of influencing healthcare but also those of *citizens*. The reform in Swedish primary care can be seen as an example of the conflict between representative democracy and the customers' control over welfare services.

The core of the argument is that citizens and patients are not identical groups. Citizens are taxpayers and voters, and may have different opinions to the narrower group of patients. On matters as costly treatments for the very ill, the same person may think differently, depending on whether he/she adopts a patient's perspective – representing a specific interest – or the perspective of the citizen – representing a general/public interest. To explain how choice and competition may affect patients' and citizens' opportunities to participate in and influence public

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services, Hirschman's mechanisms of 'exit' and 'voice' [8] are used. In brief, the term 'exit' ('choice' is often used synonymously) implies the possibility of withdrawing from the relationship, while 'voice' entails possibilities to influence decisions. According to Greener [9], choice agendas position public service users (such as patients) as consumers driving improvements by choosing good providers over bad, while voice agendas advocate citizen participation either through *political process* or through the *direct involvement* in the running of the services. In this article a distinction is made between participation through political process that is carried out in the context of *representative democracy* and participation through forms of *direct democracy*, which may include *user democracy*.

Furthermore, 'exit' and 'voice' can have a collective as well as an individual dimension; see e.g. [5], and may target specific interest (i.e., patients) or general interest (i.e., citizens). Examples of these dimensions will be given in the analysis, where I argue that the primary care reform in Sweden implies that the capacity for patients to make individual exits is strengthened while the collective voice of citizens is reduced as the decision-making scope for the elected representatives is restrained and no other measures have been taken to enhance the collective voice of citizens or patients. The underlying question in this article is: is the primary care reform democratizing healthcare as was suggested by the Swedish government [10]?

2. Core changes – economic empowerment

The new law from 2010 provides patients the right to choose between public and private providers of primary care. A money-follows-the-patient-principle was introduced alongside an any-qualified-provider-principle (AQP). AQP means that all providers that meet the requirements are allowed into the public healthcare system to compete for public reimbursements; public as well private providers and employee-owned companies as well as multinational ones. The money-follows-the-patient-principle means that patient's choices allocate resources. The basic idea behind the Swedish choice reform was that providers will be more sensitive to patients' needs and wishes, and compete for patients by increasing quality and access, when patients can take their money to another provider if they are dissatisfied [3,6,7]. Choice of provider in Swedish primary care is thus an expression of individual exit for patients. Patients are assumed to 'exit' providers with low quality and enter ones with high quality.

This new way of providing primary care in Sweden is an example of a customer-driven model for service delivery rather than a citizen-driven model. In the citizen-driven model, according to Pierre [4], the source of individual entitlements is legal or communitarian rights, responsibilities are civic or political, and state-individual communication is verbal (voice). In the customer-driven model the source of individual entitlements is purchasing power; there are no special customer responsibilities, and state-individual communication is non-verbal (exit) (see also [11]). Furthermore, Pierre argues that citizenship may be labeled '*political empowerment*' while the customer-driven model focuses on '*economic empowerment*'. Basically, economic empowerment implies that resources are transferred to the individual – in this case patients receive most of cost from the state as out of pocket payments are limited – to be used to purchase services according to individual preferences, i.e., to maximize individual gain (e.g., high quality, fast access, or optimal satisfaction). Individual patients are not expected to take account of public preferences. Patient-led allocation – now the leading principle in Swedish primary care – is thus a reflection of the sum of the will of individual patients, i.e., it takes account of the *interests of the individual*. Thus, based on Pierre's model, Swedish patients have been economically empowered. Have they also been politically empowered?

3. Local self-government and democratic control

It is necessary to give a brief account of the Swedish system to contextualize the primary care reforms' impact. In Sweden self-governing regional governments, or *county councils*, are responsible for the financing and provision of healthcare; see e.g. [12]. The county councils are democratically elected every four years and county-council politicians are thus the representatives, i.e., the voice of the *citizens* when it comes to public healthcare organization and delivery. This principle is in fact laid down in the first paragraph in the Swedish constitution, which says that "Swedish democracy is to be realized through *representative* and *parliamentary* polity and by *local self-government*" [13]. Decision-making in the elected assembly and in the committees in county councils is an expression of local self-government and thus an important feature of the Swedish polity, and utmost an expression of the founding principle of 'government by the people' [14]. By moving decision-making power from the central state to the county councils in the beginning of the 1980s, citizen participation and political accountability was thought to increase.

Although the organizational structure differs between county councils, they all have a committee of democratically elected politicians commissioning healthcare in order to cover the population's needs. This task is carried out without clinical representation. As mentioned earlier, politicians in these committees represent the *citizens* and are supposed to take account of the *interests of the community*. Before the reform in 2010, these elected committees decided how to allocate resources in primary care and were thus able to directly support providers in areas with, for instance, extensive need for healthcare. The elected representatives could also control the number and location of providers. As patients' choices of provider after the reform in 2010 allocate primary care resources, the political representatives now have less decision-making power in this respect. For example, politicians in these committees, as well as in the county-council assembly, can no longer control what kind of primary care centers setting up or in what part of the county council [15]. What the politicians can do is readjusting the reimbursement system, which is equal for all qualified providers, so that reimbursement levels are higher for, for example, patients living in rural areas or patients with extensive care needs. Over time, this can lead to the establishment of a new primary care provider in a specific area. Seen from a representative democracy