Priority setting in health policy in Sweden and a comparison with Norway

Johan Calltorp *

Health Sciences Faculty, University of Linköping, Regnavaegen 24, S-13150 Saltsjö-Duvnäs, Sweden

Abstract

The development of priority setting policies has been an important part of the national agenda for health services in Sweden and Norway during the past 10 years. Both countries have health systems with a pronounced public character and a declared emphasis on equity and solidarity. Both countries have also had National Priority Commissions that have developed general documents providing advice, but not very detailed guidelines, on how to set priorities. Resource constraints and the rapid restructuring of the health care system were important characteristics forming the background for the National Priority Commission in Sweden (1995). In Norway, the starting point for the first-ever Priority Commission in the world (1987) was how to set limits for health care in a society with rapidly increasing wealth. The second Norwegian Commission (1997) critically reviewed the effects of the general principles for priority setting that have been put forward, and demonstrated the importance to link them to steering tools within health care services. © 1999 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

This paper will review priority setting policies during the past 10 years in Sweden, with brief comparisons with Norway. First, the features of both health systems and the general health policy measures that have been undertaken in recent years are introduced. This is followed by a description of the specific National Priority Commissions that were established in Norway and Sweden. Third, actual priority
setting activities are discussed; and finally, the impact of the specific approaches taken by the National Priority Commissions in the two countries are evaluated. Due to the author’s nationality, the paper focuses mainly on Sweden.

2. The health systems

There are many features common to the health systems of Nordic countries. Even though historical and cultural developments within individual countries have led to differences, these are mainly marginal [1]. The Nordic systems have an overwhelmingly public character with regard to both the financing and the delivery of services. Private elements traditionally have been quite firmly integrated into the public management of the systems; for example, doctors practising ‘privately’ do so mostly through public funding and are closely monitored by the national government and/or local health authorities. However, following more constrained public funding during the 1990s, there is a clear trend showing that the private share of the systems is growing, especially through user charges. Private health insurance is still relatively insignificant in the Nordic countries.

Both the Swedish and Norwegian health systems are based on local authorities (called County Councils in Sweden and Fylke in Norway). These are in charge of organising most parts of the health service system for the population within their own geographical area. The decentralised structure of the health care systems give rise to two other important features. First, the majority of health services (≈75–80%) are financed through local taxes and, second, the politicians who are responsible for running health services are appointed through local elections, thus making them accountable to local voters and patients. Over the years, a power balance between central government and the local health authorities has been developed in Sweden. However, this is now changing with the occurrence of a marked decentralisation and the conferral of stronger powers to county councils, and particularly to the newly formed regions (formed by the merger of County Councils). On the other hand, in Norway, there is a move towards centralisation with greater central government intervention in health policy.

Another traditional feature of both health systems is the regional-level planning for highly specialised care. Of course, this is not unique among European countries, but the Nordic model was developed early in the 1960s and now has become an important part of the rational planning approach, with an emphasis on trying not to duplicate high-cost resources, and observing and judging variations in medical practice. In Sweden and Norway, there are special co-operation bodies established for this purpose and these are made up of the County Councils/Fylke within a given region. Integral to these publicly dominated and accountable systems is the fact that a population-based, public health perspective to planning and organising health services is essential. Inter-sectoral co-operation is well developed, even though it is not always clearly delineated in practice through the establishment of a special body responsible for co-ordination activities. The generally high level of health in Sweden and Norway as well as the relatively small gaps between social
groups (in comparison with many other countries) can be attributed to the large number of inter-sectoral co-operative mechanisms that exist and which operate more or less by tradition. The principle of equity is a pronounced feature of health systems in Nordic countries and this principle has been one of the main driving forces behind discussions of priority setting. As in all countries, the general issue behind priority setting discussions is how to balance the pressures and demands that demography, new biomedical technology and increased public expectations create within health systems, while these systems simultaneously attempt to meet cost constraints. In the Nordic setting, it would be fair to say that concerns over the equity principle and a wish to safeguard it have been an important driving force for the rationing debate and the specific priority setting activities that have been undertaken.

The Nordic health systems, as already mentioned, are mainly publicly financed through local taxes and matching central government contributions. Patient contributions such as user charges are low, but are generally increasing as part of ongoing cost-shifting strategies. Fig. 1 shows the health expenditure trend in Scandinavian health care systems, measured as a percentage of Gross Domestic Product (GDP). Comparing Denmark, Norway and Finland with Sweden, and plotting the development of funding since 1970, we can see that Sweden started out with the most resource-rich system and a corresponding infrastructure (with more personnel, and generally more spacious and well equipped buildings). The Swedish health system attained its greatest size as a proportion of the national economy in 1982 (9.7% of Gross Domestic Product). After this period, Sweden was forced to reduce its public spending, and health care has taken a relatively greater share of this decrease than many other sectors. By the early 1990s, the level of resources allocated to the health sector had gone back to that of 1970, i.e. just over 7% of GDP according to OECD data. However, the massive cost containment that is implied by these figures is somewhat overemphasised as the data is not fully comparable over the period 1970–1993.

Fig. 1. Health care expenditure in the Nordic countries as a percentage of Gross Domestic Product.
Reforms in Sweden have transferred some health-related activities that were previously performed within the County Council sector to the municipalities, and their costs are no longer counted as health care expenditure in statistics. This is true for non-medical, long-term geriatric care, where responsibility was shifted from County Councils to municipalities in 1992. Similarly, responsibility for the mentally disabled and some other handicapped groups has been transferred. In total, an estimated 1–1.5% of GDP has been shifted in this way from the County Council health care sector, mainly to the social services sector whose competency lies with the municipalities [2]. If we use standardised definitions and calculating methods for the years 1982–1996, the estimated level of cost containment measures employed within the health care sector shows a decrease from 9.7% of GDP in 1986 to just under 9% in 1996, i.e. ≈1% decrease in GDP. Of course, this decrease in resource allocation has been a trigger for many policy developments within the health care sector and for the priority setting debate, as the demands on the system have also increased considerably during the same period.

Fig. 1 also shows that in Norway, the level of resource allocation to health care has actually increased. This is due to higher economic development and the absence of an immediate need to shrink the public sector, as was the case in Sweden. Norway has enjoyed a very strong economy during the past two decades, which provided the means through which health expenditure could increase. On the other hand, current problems related to the country’s balance of payments are creating economic pressures within Norway.

Thus, the development of health care resource allocation in the four Scandinavian countries featured in Fig. 1 has not been the same over time, resulting not only in different internal pressures for structural change and reform, but also different backgrounds for the priority setting debate and subsequent policy action. Schematically, we can describe cost containment in Sweden as comprising three phases: the first phase occurred between 1982 and 1990, where there was very little visible action (e.g. general cost saving campaigns and wage freezes); phase 2, from 1990 to 1994, saw the introduction of new measures and principles for managing the system along the lines of the ‘purchaser–provider’ split; and phase 3, from 1994 onwards, was quite a rapid phase of hospital mergers and restructuring that has dominated the County Council sector. There have also been structural reforms, including the mergers of several County Councils into big regions of between 1 and 1.5 million inhabitants (the two newly formed regions of Skane in the south and Västra Götaland in the West). This development has created a new situation regarding the pattern of centre–periphery power relations within the Swedish system; the move has been clearly towards greater local power, which presumably will have an effect on the opportunities for implementing national criteria and guidelines on priority setting in the future.

The priority setting discussions in Sweden and Norway can be linked to the overall economic outlook and pressures within both countries. In Sweden, a focused debate began in 1988, when resource constraints had been in place for ≈5 years and the outlook was towards increased economic pressure [3]. However, a National Priority Setting Commission chaired by Jerzy Einhorn, a Professor of
Oncology, former Member of Parliament and a very well known person in Swedish public life, was not established until 1992. This move was partly stimulated by the Norwegian work that had been undertaken in this area.

Norway launched the first National Priority Commission in the world (known as Lönning I), which operated between 1985 and 1987. A second commission (Lönning II), which tabled its report 10 years later, in 1997, followed this.

3. The Swedish Parliamentary Commission on Priority Setting

After several waves of public and media discussions during 1988–1991, the Swedish Parliament took the initiative and organised a public hearing focused on the issue of choices in health care. This resulted in a request to the Government to set up a Parliamentary Commission, which in Sweden is a traditional way of formally investigating an important social issue. After deliberations by Government officials, during which time there was a general election and a change in Government from a social democratic to a liberal coalition, the Priority Setting Commission was appointed in the Spring of 1992. Also, in line with tradition, the Commission was composed of seven members of Parliament, representing the main political parties, and nine expert advisers from areas such as clinical medicine, health economics, health services management, law and ethics. The political representatives formed the real backbone of the Commission, as they alone possessed voting powers; the experts’ role was to help with the collection and analysis of information. In practice, however, the Commission worked as one group including both political and expert members in joint meetings during its entire 3-year working period. The Commission finalised its work in March 1995 and published a report entitled ‘Priorities in Health Care—Ethics, Economy, Implementation’ [4]. The report is available in English, as is ‘No Easy Choices’, the Commission’s discussion document presented in November 1993 [5].

According to its terms of reference, the Commission was active to stimulate public debate on the issues it dealt with. The Government seemed to take the standpoint that increased public awareness and a greater understanding of the complex issues regarding health care needs, demands, resources and allocation would be beneficial and could form part of the solution. This view also seemed to be shared by the two governing coalitions involved; the final report of the Commission was presented to a Social Democratic Government that took office in the autumn of 1994. The final report was written with the full consensus of Commission members and no major political tensions emerged during its preparation. Critics have claimed that this ‘consensus result’ (a long-standing tradition in Swedish public life) was produced by side-stepping the most controversial issues or not giving enough concrete examples of priority setting. For its part, the Commission argued that achieving political consensus in a public document addressing such a sensitive issue as health care choices and rationing is very valuable, even though details were sometimes sacrificed and the most contentious issues may have been left aside in the interests of unity.
The Commission worked in a traditional way, hearing evidence from its expert members, from other national experts called to give evidence, assessing relevant literature, and conducting hearings with patients’ organisations and other groups representing different aspects of the entire health care system. Some new data regarding the general public’s attitudes towards priorities in health care, as well as attitudes among physicians, nurses and political and administrative decision-makers, was collected through surveys.

The Commission’s interim report received wide attention when it was published in November 1993 and was discussed at regional public meetings throughout the country during the spring of 1994. Moreover, the document was circulated officially to several hundreds of health authorities and other associations, both locally and nationally, for their feedback. Thus, the consultation process and discussion was broad based and, in this sense, one of the aims of the exercise was fulfilled: to increase public awareness of the issues.

The Commission’s final report contains background, analytical and descriptive parts covering more than one-half of the entire volume, and then very general proposals for handling the issues. The background chapters describe the nature of the problem—answers to questions such as: why choices and what kind of choices? It also describes and presents, for a wider audience, relevant methods and techniques, such as health economics, technology assessment, quality development and different evaluation methods. Recent developments in health care financing and organisation (like the purchaser–provider split) are analysed in the context of the necessity, and possibility, of making explicit choices in health care. A special chapter is devoted to an overview of the international models for priority setting that had emerged at the time of the report (Oregon, New Zealand, The Netherlands and Norway). These are discussed and evaluated in relation to their relevance for the specific circumstances of the Swedish health care system.

The key components of the Commission’s proposals are: (i) a so-called ‘ethical platform’; and (ii) some practical advice in the form of two lists, one for political/administrative priority setting and another for clinical priority setting. The ethical platform consists of three principles that should guide decision-making players in all the different types of problematic decisions, which may present themselves. These principles, quoted directly from the Commission’s report, are set out in the following (in rank order).

### 3.1. Swedish Priorities Commission — ethical platform principles

1. The principle of human dignity. All humans beings have equal dignity and the same rights, regardless of their personal characteristics and their functions in the community.

2. The principle of need and solidarity. Resources should be committed to those fields where needs are greatest. Solidarity also means paying attention to the needs of those groups that are unaware of their human dignity, those who have less chance than others of making their voice heard or exercising their rights.
3. The cost-efficiency principle. When choosing between different fields of activity or different measures, one should aim for a reasonable relation between cost and effect, measured in terms of improved health and improved quality of life. The cost-efficiency principle should only be applied in comparisons of methods for treating the same disease. Where different diseases are involved, fair comparisons of the effects is impossible.

In discussing the principles and their application, the Commission’s comments on some of the issues commonly include concrete examples such as the following.

- Advanced age must not in itself be a basis for prioritisation; definite age limits must not be applied to medical decision-making. On the other hand, notes the Commission, impaired physiological reserves are normally included in medical assessment and clinical decision-making.

- Caring for premature, underweight newborns must not be based on standard limits (this was discussed intensely both internationally and within Sweden itself after publication of the ‘Oregon List’ in the early 1990s). If medical assessment shows that interventions are appropriate, they should be undertaken; if not, they should be discontinued.

- Self-inflicted injuries must not lead to negative discrimination. The Commission accepts, however, that life style can be a factor in the medical decision-making process. The clearest example is patients with peripheral arterial stenosis who continue to smoke. The Commission regards a physician’s request to a patient to stop smoking before an operation to be an ethical and justifiable one.

With regard to concrete advice to the health care community, the Commission did move at least one step towards a prioritisation list. It actually presented two lists defining in broad, general terms different diagnostic and treatment conditions. The lists are similar in construction and content: one concerns the political and administrative area of decision-making, and the other the clinical area (Tables 1 and 2).

The idea was that the lists should be used as a general guide by decision-makers, and be used in major discussions and deliberations in clinical, management and

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**Table 1**

Swedish Priority Commission: political/administrative prioritisation

<table>
<thead>
<tr>
<th>Priority group</th>
<th>Content of care</th>
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<tbody>
<tr>
<td>I</td>
<td>Care of life-threatening acute diseases and diseases which, if left untreated, will lead to permanent disability or premature death</td>
</tr>
<tr>
<td></td>
<td>Treatment of severe chronic diseases</td>
</tr>
<tr>
<td></td>
<td>Palliative terminal care</td>
</tr>
<tr>
<td></td>
<td>Care of people with reduced autonomy</td>
</tr>
<tr>
<td>II</td>
<td>Prevention having a documented benefit</td>
</tr>
<tr>
<td>III</td>
<td>Habilitation/rehabilitation as defined in the Health and Medical Services Act</td>
</tr>
<tr>
<td>IV</td>
<td>Care of less severe acute and chronic diseases</td>
</tr>
<tr>
<td>V</td>
<td>Borderline cases</td>
</tr>
<tr>
<td></td>
<td>Care for reasons other than disease or injury</td>
</tr>
</tbody>
</table>
Table 2
Swedish Priority Commission: priority groups in clinical activity

<table>
<thead>
<tr>
<th>Priority group</th>
<th>Content of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>Care of life-threatening acute diseases and diseases which, if left untreated, will lead to permanent disability or premature death</td>
</tr>
<tr>
<td>IB</td>
<td>Care of severe chronic diseases</td>
</tr>
<tr>
<td></td>
<td>Palliative terminal care</td>
</tr>
<tr>
<td></td>
<td>Care of people with reduced autonomy</td>
</tr>
<tr>
<td>II</td>
<td>Individualised prevention in contacts with medical services</td>
</tr>
<tr>
<td></td>
<td>Habilitation/rehabilitation as defined in the Health and Medical Services Act</td>
</tr>
<tr>
<td>III</td>
<td>Care of less severe acute and chronic diseases</td>
</tr>
<tr>
<td>IV</td>
<td>Borderline cases</td>
</tr>
<tr>
<td>V</td>
<td>Care for reasons other than disease or injury</td>
</tr>
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</table>

Political circles. The Commission passed its own judgement that group IB on the clinical list (Table 2) receives insufficient resources in comparison with groups II and III. In annexes to its report, the Commission discusses concrete examples in somewhat more detail, and tries to place them within the grouping scheme.

After the traditional wide-ranging hearing where all segments of society were asked to comment on the proposals, a decision was taken by Parliament in April 1997. Generally, the comments were positive and critical remarks were mainly related to the relative lack of concrete advice on how to undertake priority setting. There were also expressions of disappointment that the Commission’s final report did not add much more than was already contained in the interim report of 1993 that had already been widely circulated. Parliament took the decision to adopt the general principles in the report, especially the ‘ethical platform’, as the basis for concrete priority setting decisions made by all actors in the health system. In keeping with the long-standing arrangement that detailed decisions on health care matters are taken at the local level, it was only logical that the parliamentary decision was stated in very general terms. The health system is governed by ‘framework’ laws and general principles provided at the national level, and only in a very few instances do detailed directives exist. The different county councils’ freedom to develop the pattern of health services within their jurisdictions is quite advanced. Notwithstanding this, the national health legislation also states that all citizens should be provided with the health services needed to live a healthy life, so no restrictions on the range of services delivered are recognised by national health laws. The future dilemmas that will arise when attempting to balance both these aspects of health services provision is obvious, since strong cost-containment measures introduced by the national government have forced the County Councils to restrict their volume of services considerably.
4. The new National Commission for priority setting

In order to maintain a national monitoring mechanism for priority setting, Parliament also decided to set up a new national body for priorities in health care, the National Priority Commission [6]. With a 3-year mandate, the Commission began its work in mid-1998 and has the following main functions:

- to disseminate information on Parliament’s decision regarding priority setting;
- to develop methods to promote implementation of the decision;
- to monitor and evaluate the effects of the decision; and
- to compare the Swedish situation with international experience and monitor practical developments in priority setting.

The composition of this new Commission is basically the same as the original one, and includes members of Parliament, experts in the field and representatives of patients’ and health professionals’ organisations. It has begun its work with activities encompassing all aspects of its terms of reference, with special emphasis on information dissemination. For example, 1 million copies of a special ‘supplement’ on priorities was distributed via several health-related journals in March 1999 [7]. The Commission holds meetings with local groups which are responsible for priority setting and ethical matters within County Councils or municipalities, and several research projects to monitor implementation have been initiated.

5. Local developments in priority setting within Swedish County Councils

As with most other areas of health services in Sweden, the development of priority setting now occurs within the County Councils. Several County Councils have developed their own local models for priority setting. In some County Councils, the focus is on ethical committees, while in others, more independently based priority committees have the task of developing priority setting methods or increasing general discussion of the issues involved. Local implementation of priority setting schemes varies greatly, although the common theme is the development of further principal guidelines such as those contained in the national Priority Setting Commission Report, rather than establishing detailed or firm criteria on what to include or exclude from the range of health care services that are delivered.

Some of the more distinctive local models are described briefly in the following:

5.1. Dalarna County Council

Dalarna county council has developed its own priority list, which describes seven levels of priorities (in rank order). The priority levels have been set by comparing workloads (i.e. the occurrence of different diagnoses and the resulting demand for resources) at the various departments (clinics) within the County Council’s main hospital. The list was developed by a working party consisting of representatives from different hospital departments and the primary care units, co-ordinated by the hospital director. The first version of the list was put forward as early as 1990 [8].
The adoption of the ‘list’ has been incremental. Currently, all hospital departments have described their workloads and their waiting lists in the format and methodology that was agreed upon in the original priority levels exercise. This instrument is now used mainly to compare resources, outputs and patient workloads between departments. The list is also used in discussions and negotiations between primary care and specialised hospital care units. Dalarna County Council was among the first in Sweden to adopt the purchaser–provider split model for managing health services. In negotiations between the different parts of the system, purchasers and providers now use the priorities list as a practical instrument. Further to this early work on priorities, the County Council recently produced information and study material for the general public, patients’ organisations and others. The aim is to increase the general understanding of the issues among the public. Therefore, by developing its own model for priority setting before the National Commission put forward its national one, this county council has progressed quite a long way towards having the general idea of setting priorities embedded in many aspects of its activities, especially in clinical work. Experiences in Dalarna, and in many other county councils, illustrate that it is only through practical implementation which has been occurring over a long period of time that changes will occur.

5.2. Gävleborg County Council

Gävleborg County Council [9] began a locally based priority setting project in 1993, which originally was inspired by the priority list developed in Oregon, USA. Work was begun within the Central Ethics Committee of the County Council, with representatives from the medical profession, nurses, and managers. The Committee started off from the practical idea of having a detailed list of priorities, like the Oregon example. A quickly produced early draft, which actually listed concrete diagnoses and conditions where limits could be exercised, was leaked to newspapers, prompting a great deal of public discussion and strong reactions. Negative criticism focused mainly on the proposal to impose a definite limit on intensive care for small, premature newborns weighing less than 500 g. The Committee, surprisingly enough, survived this early confrontation with the strong public emotion that this issue provokes and has continued its work. The Committee has produced a more general list of five priority levels, in rank order, based on definitions of both disease conditions and types of care intervention. A large number of concrete examples are linked to each priority group, although these are not listed explicitly in order, as with the Oregon list. This list is used within the planning processes of the County Council and its hospital clinics. The Gävleborg Priority List is an interesting example of how ideas on priority setting from one part of the world have been transported and modified to suit a different national context. The list also illustrates how the precise priority setting methods are strongly linked to the traditions, characteristics and cultural features of the existing health system.
5.3. Östergötland County Council

This is a third County Council that has developed locally formed and quite extensive activities in the area of priority setting. The county council of Östergötland hosts Sweden’s newest medical faculty in the city of Linköping, and the university has a strong profile of interdisciplinary work. Research institutions have been actively involved in the development of a priority setting strategy. Since initiating priority setting activities in 1995, the County Council has developed its work around ‘medical care programmes’ [10]. Working Groups were organised around diagnoses such as stroke, psychiatric disorders, heart diseases, dementia, cancer and respiratory disorders. The focus is ‘horizontal’, covering the whole County Council area, and encompasses both inpatient and outpatient services for the respective disease category. Data is collected on epidemiology, costs, treatment protocols and programme outcome (in terms of quality of life, life year increase and prevention activities). Information is collected for programmes related to each disease and used as a very practical ‘working tool’ in discussions between professionals, managers and politicians. While the programmes could be described as an advanced planning tool, they are specifically aimed at collecting and linking concrete data concerning epidemiology, costs and outcomes for each diagnostic category. This information is then disseminated to medical professionals working in particular specialist units across the county council to facilitate communication between them. The data is also used in discussions with primary care and specialist care units. An important part of the exercise is the involvement of politicians and patient representatives to gauge the value judgements relevant to the issues concerned.

Another example of the work performed in the County Council of Östergötland is a project on specific priority setting within the area of heart disease. As with other cases, professionals (both cardiologists and thoracic surgeons) interact with both politicians and managers. A detailed description of the conditions treated, treatment options, costs and outcomes is provided and discussed by doctors within the entire medical care region. Much of the focus is on how to define treatment options and carry out actual limits to care.

5.4. Other examples

Within some medical specialities, quite distinct priority setting decisions are evident in other county councils. For example, with regard to in-vitro fertilisation (IVF), a treatment defined as ‘borderline’ by many priority commissions, two County Council (Västerbotten) has taken the decision not to finance it, but to leave it to the private sector. In most County Councils, decisions are taken regarding limits to the number of treatment sequences provided. IVF is the most intensely discussed priority setting issue among the public. It should be noted that in both Sweden and Norway, IVF availability was explicitly discussed in Parliamentary sessions following publication of the Priority Commissions’ reports. In both countries, IVF was raised one place in the rank order of priority levels. Thus, IVF has
demonstrated many of the major difficult issues regarding prioritising; for example, the borderline between ‘health’ and ‘illness’ as well as the issues of ‘rights’ and ‘equity’. One proposal put forward by the College of Gynaecologists and Obstetricians suggests that society does accept the consequence of IVF being, in reality, a ‘borderline’ area and access should be increased by raising user charges for this treatment to half of the real cost. So far, however, this has not been implemented.

The provision of psychotherapy is limited in many County Councils, partly because much psychotherapy treatment is provided by the private sector (and is strictly regulated) and by psychologists themselves, who generally are more financially constrained than physicians in terms of access to public funding to provide treatment. Another new therapy that has proven very useful for patients but is subject to limits on provision, mainly through long waiting lists, is the use of advanced hearing aids. This is mainly due to their high cost.

Access to pharmaceutical care may be restricted mainly through user charges (see later). Each County Council has a pharmaceutical committee, which defines a formulary to be used for inpatient and outpatient purposes. There are still no financial penalties for prescribing a medicine not included in the formulary, but this issue is under intense discussion and different methods for controlling pharmaceutical costs (which are rising much more rapidly than any other health care component) are expected to emerge in the next few years, especially as the County Councils take over financial responsibility for this sector from government (see later). The idea of ‘generic prescribing’ implemented for an experimental period in the County Council of Skåne has been criticised heavily by physicians. Patients’ associations have also been active in this area. Moreover, there has long since been a policy that certain pharmaceuticals are provided free for patients; for example, drugs for diabetics. When the government tried to change this 4 years ago and impose the same level of co-payments as for other medicines, the Diabetics’ Association undertook a successful lobbying campaign.

Using budgets as an important mechanism for cost containment also leads to a de facto priority setting. Generally, non-acute areas with chronically ill patients feel the impact of this strategy. In the acute hospital sector, the pressure often exercised through the media secures extra money, while ‘non-fashionable areas’ (like mental health and geriatric care), long waiting lists and less-than-optimum functional services are tolerated to a greater extent. However, this is also an international phenomenon.

6. Specific measures influencing priorities

As is evident from the presented information, the Swedish national priority recommendations are very general. Somewhat more detailed directives for action have been developed in certain County Councils. In some areas, national decisions influence this field, even if they are not directly linked to prioritisation. The following areas and activities are the most important:
6.1. User charges

User charges for health services have been increased quite extensively in recent years. User charges are used as an attempt to direct patients between the different levels of the health service system, which lacks a strong tradition of gate-keeping in primary care. The County Councils are free to decide on the level of co-payment and these now vary from 50 SEK per visit for a primary care consultation to 250 SEK for a visit to an acute emergency care department.

However, there is a maximum ceiling for co-payments where patients pay no more than 1300 SEK per year in total. Parallel to these co-payment increases and the financial restrictions affecting many social groups, there have been lively discussions on whether some patient groups suffering from some diseases are restricted to accessing health services. Arguments have been put forward that some low-status, socio-economic groups (for example, pensioners) live within economic margins where this high cost ceiling of annual patient fees is a barrier [11]. However, health care is always provided regardless of patients' ability to pay. In practice, County Councils extend credit and bill patients after their consultations. County Councils have reported that patient debt arising from this practice is increasing and has given rise to the issue of what legal mechanisms are available to County Councils to claim back their money. Of course, there are many dimensions to this issue: real economic dimensions as well as psychological ones. However, no clear evidence seems to have been presented as yet concerning financial barriers to services. There is an absence of good studies, making this an important area for further work.

6.2. User charges for pharmaceuticals

For pharmaceuticals, there is a similar type of cost-sharing as there is for health care; a maximum annual patient payment of 1300 SEK applies to drugs at present. The system operates so that a patient’s initial prescriptions are paid for almost completely by himself/herself and then reduced costs are introduced quite rapidly as a patient approaches the maximum annual payment level. A new scheme is being presented for parliamentary ratification. This scheme raises the annual individual payment for medicines to 1800 SEK per patient and works along the same principles already outlined. The same issues surrounding the level of user charges in health care are also being debated with regard to pharmaceuticals. This sector has been analysed more extensively and one recent Uppsala County Council study of 2000 consumers of prescription drugs (undertaken in the mid-1990s) showed that sensitivity to increases in user-charges varied greatly between different socio-economic groups. The young, those with poor health status, low education and low income were most likely to decrease their consumption of prescription drugs when user charges increased [12].

The financing scheme for pharmaceuticals until now has been handled by the national government but is now being transferred to the County Councils. There are strong concerns over cost control in this sector as Swedish pharmaceutical costs
have been rising at a rate that is among the fastest in Europe, accounting for approximately 12% of the total health care budget in 1999. The hope is that the County Councils, when they receive full responsibility for financing both health care and pharmaceuticals, will develop better mechanisms to control costs. New methods have not been implemented as yet, although it is expected that the main route will be through increasing physicians’ awareness of costs and stimulating cost-conscious clinical behaviour. An interesting question for the future will be how strong the efforts to control physicians’ behaviour will be. Proposals have been put forward regarding limiting prescription rights to ‘generic prescription’ or to a defined list of pharmaceuticals that different medical specialists can prescribe. These options are currently being discussed and one can predict that this will be an important and controversial area in the future. Swedish physicians enjoy a high level of clinical freedom and, presumably, there will be a future battle over the exercise of this freedom.

6.3. Patients’ rights

Currently, the issue of patients’ rights form an important policy field in Sweden, as in many other countries. National proposals to strengthen the position of patients have been put forward during the past year [13] but no decisions have been taken so far. The other Nordic countries have moved faster in this area, with both Norway and Denmark having introduced relevant legislation. [14]. An important part of policy initiatives regarding patients’ rights in Sweden has been the introduction of a ‘maximum waiting-time guarantee’ in 1992. The initiative is a joint agreement between the Swedish Government and the Federation of County Councils, following recommendations by the latter in line with local suggestions by individual County Councils. The guarantee covered 12 of the most common surgical procedures, and patients were guaranteed a waiting period of no longer than 3 months from a physician’s decision to treat or operate. Cataract surgery was one of the 12 procedures for which a maximum waiting time guarantee was introduced. An assessment of the guarantee showed that ophthalmic surgery units vary in their adoption of the guarantee, leading to different levels of achieving targeted waiting times. There were two groups of less successful units: one where the units had a low operation rate, and the other where the units chose not to follow the priority setting recommendations listed in the guarantee. [15] A careful evaluation has shown a positive overall effect on reducing waiting lists during the first 2 years of the scheme, which was achieved mainly through increased production efficiency and better management of waiting lists. However, after a few years, waiting lists again began to increase (mainly due to ongoing resource constraints) and discussions intensified over the negative effects on diagnoses not covered by the guarantee. Therefore, several County Councils now have moved to a ‘general care guarantee’ covering all treatments, but expanding the time guarantee to 6 months instead of the original 3 months.

General discussions about access to information, e.g. regarding the performance of individual hospitals and clinics, is progressing strongly in line with international
patterns. There is a movement within the different medical specialties to collect quality data and, currently, one specialty (internal medicine) has published some selected quality data comparing 42 different hospital clinics across the country. For the first time, these clinics have been compared openly and their names have been published.

6.4. Technology assessment and an emerging regionalised structure for clinical evaluation

For over 10 years, technology assessment has been an area that is developing rapidly in Sweden. The National Council on Technology Assessment (SBU) has been active since 1988 [16] and has now reached maturity, having achieved an established and respected position. It has produced a great number of advisory documents that have been disseminated widely within the health care community. The main issue relates to implementation of technology assessment information. Nonetheless, it is quite obvious that merely producing and disseminating reports does not lead to changes in practice. The SBU has been pursuing different strategies. One such strategy is actively to develop a system of ‘ambassadors’ for technology assessment who travel around County Councils more or less like ‘pharmaceutical consultants’ holding meetings and interacting with doctors. This strategy is quite new, and its usefulness and results are not fully evaluated as yet.

Interest in the area of evaluation (i.e. technology assessment as a national and international ‘meta-activity’, and quality assurance as a clinically relevant practical activity) has been growing steadily in Sweden. Within the ‘quality movement’ overseas, a large number of different activities are being undertaken [17] but, attempts to change and develop medical practice are not systematically linked to technology assessment and the data generated by the latter process. An important step forward may now be taken during the next few years as a result of the decentralisation of the health care service’s delivery system and the creation of new regions formed by merging County Councils. Different types of university and applied research in the fields of health economics, medical sociology, social medicine, management and political science now are actively encouraged by the new regions. The National Research and Development Institute within the health service, SPRI, will be closed down from the year 2000 and will be replaced by a regional structure, with local health services’ research and development groups at the six university hospitals [18]. These groups will serve the needs of their respective regions but also will have a wider national mandate, e.g. providing a national profile for health services research. The first task of this kind will be given to Linköping University, to develop a national centre for research and development on priority setting methods, building partly on the work of the medical care programmes undertaken within this County Council (see earlier). It is expected that these groups, working in between research and practical implementation, will pioneer new types of instruments and develop general tools for the priority setting process.
7. Public involvement

In summary, so far, the Swedish health services system can be described as a system that has experienced strong economic pressures over a number of years. During the past few years, the emphasis has been on structural reforms and the reallocation of resources. The National Commission on Priorities produced guidelines of a general sort, emphasising an ethical platform and a principal list of priority groups. Implementation and development of more practical tools are left to the local level of the system, the site of the system’s main focus and dynamics. There are signs of emerging differences between the County Councils with regard to decisions taken on selected medical areas. The development of research-based tools for prioritising within a new structure of health services research groups in the new regions is expected to be important for implementing priority setting decisions in the near future.

It is worth noting the growing diversity in the priority setting strategies pursued by different County Councils. This parallels a general growth in the differences within Swedish health services provided by County Councils. The previously very homogeneous country is breaking up in several ways. However, the idea and supporting legislation for an equitable health care system is very much alive. One can foresee increased tensions in the years ahead between the wish to minimise variations from the central authorities and the need to handle resource dilemmas, the structure of health services and delivery patterns in different ways according to local circumstances, traditions and resources. Public discussion of priority setting has been intense during the 1990s, both in the media and in County Council political debates. There has been a high level of awareness and discussion of this issue among the medical profession. Moreover, during the past few years, there has been a tendency towards tough cost-containment, and a focus on the relative lack of resources rather than the issue of setting limits per se. In several of the local priority setting projects described, there have been attempts to involve the public actively in discussions concerning values. Patients’ organisations, which play a very strong and active part in the Swedish health care system, have been especially active in expressing the patients’ voice with regard to these issues. These organisations also have a strong role in the present National Priority Commission whose task is to follow up the guidelines ratified by Parliament in 1997.

8. The Priority Commissions in Norway

Norway was the first country in the world to undertake work on the priority setting issue though a National Priority Commission. As early as 1985, a National Parliamentary Commission was set up with the task to analyse and propose guidelines for national and local health policy priorities. The commission was composed of health care experts as well as members of the public; but unlike Sweden, no politicians were included. The commission was chaired by the former rector of the University of Oslo, a Professor of Theology, Inge Lönning, and the
report that was published in 1987 is commonly referred to as ‘Lönning I’ [19]. The question often arises as to why Norway was such an early leader in addressing the priority setting issue. The explanation advanced most often focuses on Norway’s greatly changed economic situation after the discovery of the rich oil fields in the North Sea in the 1970s and the economic boom that followed in the 1980s. It is argued that the resulting income from the oil boom produced national wealth that could not be used domestically for fear of the inflationary effects it would have induced. Thus, this situation created a climate of forward-looking public policy building. Another feature cited is the relatively rich, national health policy environment in Norway, with its early established health services research group in the 1970s, and the relatively strong general standing of the humanities and social science research. All these factors fostered a climate that led to pioneering work performed by the Lönning I Commission.

The Lönning I report contained a thorough and detailed description of priority setting issues in health care, how it has emerged and how it was expected to develop. It drew on the health policy literature that was available at the time. A literature search performed by the Commission also demonstrated what was evident at the time; namely, that specific frameworks or ‘tools’ for priority setting in health care had not been developed anywhere in the world. Typically, the discussion and analysis was developed by individual researchers or within disciplines like health economics. The pioneering book ‘Who Shall Live?’ published in 1973, by Victor Fuchs, is perhaps the best example of this kind [20].

The Lönning I commission also discussed priority setting issues from the perspective of how resources should be increased within a context of system growth, but it decidedly took the view that resources should be balanced throughout the entire health care system. The Scandinavian health services model, with its profound emphasis on fairness and equal rights, was both the starting point and the objective of the Commission’s work. One interesting aspect of the Commission’s work is its emphasis on the medical and social effects of different health interventions as the principal basis for setting priorities. This reflects the early days of the technology assessment movement. Another major basis for creating a priority list containing five levels was the seriousness of the diseases cited. The list is a general description of four levels (in order of importance) by which health service interventions could be prioritised. Level 1 includes those treatments which are ‘life-saving’ and essential, level 2 refers to ‘treatments in less severe situations where withholding them would be harmful’, level 3 covers ‘treatments for chronic disorders with a proven benefit’, while level 4 refers to ‘treatments with unclear benefits that can be marginally effective’. A fifth (no-priority level) concerns services that are neither needed nor have a proven value, and thus could be excluded from public financing altogether.

If Norway was the first country to perform this exercise with a National Commission for Health Priority setting, it is also the only country which has undertaken the exercise twice. In 1996, a new Commission was set up with a similar composition to the first. Again, Inge Lönning was named Chairman. The Commission’s terms of reference were to evaluate the implementation of the first Commis-
sion’s recommendations and to consider techniques for formulating priorities. After less than a year’s work, the Commission put forward its recommendations in May 1997 [21], commonly called the ‘Lönning II’ Report. This time, the Commission did find a specific literature on priority setting models proposed in different parts of the world, and its report summarises and discusses this material in relation to the early Norwegian formulations of the five priority groups. An important part of the report is a critical analysis of what occurred in the Norwegian health care system following Lönning I. Did the publication of the Commission’s five priority groups as general recommendations produce any effect in practice? The Commission concluded that the main answer was no. The major conclusion of the report is that much more emphasis should be placed on managing and implementing mechanisms. The report’s general discussion focuses on the issue of power mechanisms, vested interests and tools for steering health care services. The Commission also showed that in several cases, those parts of health care services that were judged to be under-funded in relation to other areas (psychiatry in particular) had fallen further behind in terms of resource allocation. Another important discussion by the new Commission concerned the dividing line between ordinary, established health care practices and investigative research activities; for example, medical methods being tested clinically. This led to the formulation of a new set of guidelines, described in the following and in Fig. 2.

1. Basic health services. These are defined on the basis of detailed criteria regarding disease seriousness, treatment outcomes and cost efficiency. This category should be fully covered by the public system.
2. Additional health services. This category includes less serious conditions and less definite treatment outcomes. These services should be covered as far as possible.

3. Low priority, or ‘borderline’ services. In this category, services should be provided if resources are left over after priorities I and II are covered. Examples include services such as IVF and cosmetic surgery. The Commission proposes that in this category, patient co-payments should be introduced, could vary and actually be used as a regulatory mechanism, thus providing a mix of public and private funding for each treatment, the ratio being decided by health service providers.

4. No priority and outside public financing. This category includes investigative research activities and treatment methods under evaluation for potential introduction into regular clinical activity. This category should be kept outside the priority system and funded separately.

With regard to the important issue of implementation, the Commission has suggested that speciality-focused expert groups be set up at the national level to describe in detail how individual diagnoses and treatment methods should be handled within each specialism. National guidelines or treatment protocols should be developed in this way. The Commission also proposed that a permanent National Priority Committee be established to oversee the scheme.

The proposals of the Lönning II Commission were widely circulated and discussed in health policy circles in Norway. This process is continuing and the Government is expected to present a policy package to Parliament at the end of 1999. The general policy line seems to have picked up the idea from the Lönning II Report that priority setting should be seen as a function of many different ‘tools’ in the health policy arena. Special emphasis will be placed on linkages to the national structure and implementation strategies for technology assessment, where Norway hosts a strong Nordic hub of the Cochrane Collaboration. Equally important is the link to quality assurance and techniques in this area, which are vehicles for actual change in clinical settings. Thus, the Government’s policy line seems to be a strategy that attempts to avoid painstaking discussions on what would be included and excluded from a ‘basic health care package’. The idea of a basic package has been rejected (as in Sweden). Instead, there is a reliance on physicians and professionals defining services that are sound and provide value from a medical/professional standpoint. The National Board of Health (Helsetillsynen) is expected to provide general guidelines. There is a borderline area of disputed services (as exemplified in Fig. 2) similar to those in Sweden. Thus, cosmetic surgery, to a large extent, is performed in the private sector and is funded through direct payments from patients. The provision of in-vitro fertilisation is handled differently across the country. Following the Lönning II Commission Report, major discussions took place regarding waiting times and how to handle waiting lists (which are of a similar magnitude to those in Sweden), from the perspective of the priority setting framework previously endorsed. The main policy is that the national government pays a large part of health insurance contributions to County Councils through a scheme aimed at stimulating productivity (‘action based financ-
ing’) within a number of the most common procedures where waiting lists frequently occur. Diagnostic related groups (DRGs) are used as the basis of financing, and the government contributes 50% of the cost of DRGs up to a maximum predefined volume.

The Government also imposes user charges for visits to polyclinics and primary care settings of 120 NoKr per visit, with an annual maximum payment of 1300 NoKr. For inpatient services, no co-payments are levied. For pharmaceuticals, there is a national system that defines important medicines for the treatment of selected conditions, such as serious chronic diseases, where reduced co-payments apply. Conditions and substances are specified on a national formulary. With regard to dental care, there are no public subsidies for adults, but dental care for children up to 18 years is free of charge.

9. Sweden and Norway — some comparative aspects of priority setting

Although Sweden and Norway are quite similar to each other with regard to many aspects of their governing styles and tradition, as well as in the structure of their health care systems, there are several, interesting differences in their handling of priority setting. Norway established a National Commission on Priority Setting very early on. It is worth noting that in Norway, the discussion on priority setting was triggered, paradoxically, by a situation where limits on health care had to be defined even though the country’s general level of resources was rising. In Sweden, the National Priorities Commission commenced its work 6 years later than in Norway, when Sweden had undergone significant cost-containment measures in its health budget for 10 years, i.e. since 1982. Thus, the Commission’s work in Sweden was more driven by funding restraints and clearer expressions of what problems were affecting health care services. The second Norwegian Priority Setting Commission worked much more within a background of balancing resources and emerging deficiencies in health services, paradoxically in areas in which the first Commission had recommended that resources be strengthened. This helped to put the focus on implementation methods and to link the priority setting principles to steering tools within health care services.

Both countries established parliamentary commissions to work with defined terms of reference and which tabled their reports in the legislature. The Commissions’ composition differed, however, reflecting national traditions. In Sweden, parliamentary commissions are commonly composed of politicians, preferably members of parliament, who exercise voting powers, while experts are linked to the commission and perform an advisory and analytical role. While this formula is sometimes used in Norway, there is also a tradition of forming expert commissions and this was chosen in the case of the two Lönning Commissions. The composition of the commissions shaped the formulations (and perhaps their clarity) in addressing the most controversial issues in the area. The mixed Commission in Sweden had to reach a common ground across all political parties and between politicians and experts. It is possible that this led to compromises and an avoidance of some
politically sensitive areas. This can be seen from the fact that even though it published its report 8 years after the first Lönnning commission, the Swedish commission does not go into detail with regard to implementation methods and controversies. In one respect, the Swedish commission report does address this issue, in that two priority lists are outlined: one for the political and management levels of decision-making, and one for the clinical level.

On the other hand, with regard to practical implementation and the dissemination of ideas and principles on priority setting within the health care system, Sweden may be ahead of Norway. Because Sweden already possessed a more pronounced cost-containment programme in health services in the late 1980s, the country was more receptive to the contents of the first Lönnning Commission Report. When the Swedish commission was set up in 1992, it was given a special mandate to produce an interim discussion document and disseminate it to the general public, as well as to the health-service personnel for feedback. Thus, the general ideas (the ethical platform and the priority lists) became widely known in Sweden in the early 1990s. When the final document was published in 1995, there was some disappointment because nothing new seemed to emerge. Subsequent developments in Sweden have resulted in several local-level variations in priority lists and, despite the absence of uniformity in development, there has been widespread activity.

Currently, in Norway, health policy is more centralised—in contrast to Sweden. The Lönnning II Commission Report is a document that theoretically is at the forefront of the priority setting agenda with some politically quite controversial proposals. After 2 years, the Government has not yet presented a formal priority setting strategy, based on the commission’s proposals to Parliament.

From an international standpoint, Norway set up the very first National Priority Commission. At first, the commission’s findings did not play a significant role within Norway itself, becoming instead very widely disseminated and influential in discussions in Sweden. The Norwegian priority setting report also had an impact on some of the ideas that pervaded the Swedish Priority Setting Commission. During the 1990s, both countries have been open to a great deal of influence from other priority setting ‘models’, such as the Oregon model, the Dunning Report in the Netherlands and the New Zealand experience. There has been a rapid international spread of ideas on rationing through scientific meetings, study visits and analyses of research literature. The ideas generated from these activities have influenced thinking and been important in illustrating how priority setting can be undertaken within different health care systems. International experiences have been important in putting the issues on the agenda and providing illustrations. However, as in other parts of the world, in Sweden and Norway, the concrete solutions and proposals for priority setting have been very closely linked to the characteristics of each country’s health care models and value systems.
References


