# *Medical Ethics and New Public Management in Sweden*

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**Abstract:** In order to shorten queues to healthcare, the Swedish government has introduced a yearly "queue billion" that is paid out to the county councils in proportion to how successful they are in reducing queues. However, only the queues for first visits are covered. Evidence has accumulated that queues for return visits have become longer. This affects the chronically and severely ill. Swedish physicians, and the Swedish Medical Association, have strongly criticized the queue billion and have claimed that it conflicts with medical ethics. Instead they demand that their professional judgments on priority setting and medical urgency be respected. This discussion provides an interesting illustration of some of the limitations of new public management and also more generally of the complicated relationships between medical ethics and public policy.

**Keywords:** new public management; priority setting; healthcare queues; Sweden; Swedish Medical Association; Doctors' Appeal

"New public management" is a term introduced by Christopher Hood to denote various market-like management methods that have increasingly been introduced into the public sector.[1] Among the major characteristics of new public management are reliance on private sector contractors and management by objectives, often with economic incentives attached to the achievement of these objectives. In Sweden, both these methods have been used extensively in healthcare, welfare, and education, in particular since 2006, during which period the country has been ruled by a four-party, right-wing government. One of the measures taken in healthcare, the so-called queue billion, has increasingly given rise to discussions in ethical terms that provide an interesting illustration of the difficult relationship between managerial accounting and the professional ethics of physicians and other healthcare personnel.

## The Queue Billion

In 2005 the Swedish parliament adopted a national healthcare guarantee, according to which a patient in need of healthcare is entitled to a consultation with a primary care physician within 7 days, after that to a consultation with a specialist physician within 90 days and then to treatment beginning within 90 days. Thus, treatment should start within at most 187 days from the first contact with primary care. Beginning in 2009, a sum of one billion Swedish crowns (about €115 million) per year has been distributed among the county councils (who are responsible for healthcare) according to how they satisfy the healthcare guarantee. Judging by the available statistics, the queue billion has contributed to reducing the queues to which it applies.[2]

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But obviously, it does not apply to all contacts with healthcare. In particular, it does not cover return visits. Because total healthcare resources are limited, it would not be surprising to find that the speeding up of first visits can cause delays for other patients, such as those in need of return visits (displacement effects). In 2012 the National Board of Health and Welfare presented a study of the queue billion. Due to lack of waiting-time statistics for return visits, it was not possible to obtain a general picture of the prevalence of displacement effects. However, clear evidence of their existence was found in interview studies. Three out of four specialist physicians who were interviewed in 2011 believed that displacement effects occurred within their own county. In particular, return visits for severely and chronically ill patients were given lower priority than first visits for patients with less serious diseases. In another interview study, 8 out of 10 orthopedic surgeons maintained that the wrong patient groups were prioritized due to the healthcare guarantee.[3]

In an analysis of its own previous inspection cases, the National Board found several cases in which the healthcare guarantee had contributed to a medically unacceptable treatment delay. In one case a diabetic had waited too long for an eye exam, because the clinic had been enjoined to prioritize new patients in order to fulfill the guarantee. In its verdict on that case, the National Board had concluded that "the priority given to tasks related to fulfilling the healthcare guarantee has endangered patient safety due to neglect in the care of chronic diseases."[4] A follow-up of other cases from the same clinic indicated that this was not an isolated case. Thirteen patients had been kept waiting so long for a return visit that the delay may have caused visual impairment. The general lack of resources and also the priority given to first visits were plausible causes of these unfortunate outcomes. (In a newspaper interview, an ophthalmologist at this clinic said: "I am looking at sties instead of severely ill diabetics and glaucoma patients. The county administration listens to what we say, but they have no choice since we depend on the money, so now we have to do like this."[5])

In 2012 the Swedish Medical Association conducted an interview study in order to "complement the data used in the analysis of the National Board of Health and Welfare with a professional perspective."[6] Interviews were performed with 20 physicians, both general practitioners and specialists. The interviewees were physicians who volunteered because they considered themselves to have information to contribute. In general, they were positive in regard to the healthcare guarantee and to measures addressing the long queues for healthcare. However, they also had strong views on the types of measures that were now implemented.

Abundant evidence of displacement effects was presented in the report. Operations with low medical priority, such as tonsillectomies and inguinal hernia surgery, were prioritized due to their contribution to the guarantee, whereas patients with more severe diseases had to wait. Cataract surgery was given higher priority than return visits for patients with glaucoma, because the former but not the latter contributed to the guarantee. This, of course, could lead to increased risks for the glaucoma patients. One of the interviewed physicians had a diabetic patient whose eye exam had been delayed six months and whose eyesight had deteriorated severely during that time. In one clinic, phimosis operations had higher priority than prostate cancer operations. "There is no medical risk involved, but how can we take the prostate cancer patients' suffering and anxiety into account?" said the physician.[7]

A certain tension between primary and specialist clinics could be seen in the material. Specialist physicians tended to criticize primary care physicians for referring patients that they could have treated themselves. Primary care physicians, on the other hand, complained that specialist clinics sent back more referrals than they used to do, presumably in order to reduce the number of patients in their own queue. They also increasingly sent back patients to primary care for follow-up visits instead of seeing these patients themselves.

The interviewed physicians were in agreement that the displacement effects were not caused by the healthcare guarantee itself but by the queue billion, that is, the economic incentives that had been added to it. Due to these incentives, parts of the priority-setting tasks of physicians had been taken over by administrators, economists, and others. Sometimes this made it difficult for doctors to take full medical responsibility for their patients.

In Stockholm County, the largest county in Sweden, the County Audit Office made a study of the frequencies of first and return visits in the years 2008–2011. They found that in this period, the number of return visits increased at a lower pace than that of first visits (4.7 and 12.1 percent, respectively). Furthermore, the number of return visits per patient decreased by 6.5 percent. This effect was larger for patients with a specific group of chronic diseases (asthma, arthritis, diabetes, epilepsy, and chronic obstructive pulmonary disease) than for patients in general. For these chronic patients, first visits increased by 15.0 percent and return visits by 8.1 percent, and the number of return visits per patient decreased by 11.2 percent. The Audit Office concluded that first visits had been given increased priority as compared to return visits, which they saw as an indication of a displacement effect.[8]

**Public Debates**

Since the queue billion was first introduced, it has increasingly been subject to critical reports in the media. Under headings such as "The Queue Billion Risks Lives," several of the cases mentioned above have been made known to the public.[9] Newspaper commentators have blamed the queue billion for serious complications among patients in the queues it does not cover. "The optic nerve dwindled during the too long wait in a non-prioritized return visit queue."[10] A much-discussed article series in February 2013 by a respected journalist, Maciej Zaremba, in the country's largest morning paper contributed much fuel to the debate.[11]

Several physicians have taken active part in this debate. In 2011, three chief physicians at the Karolinska hospital in Stockholm published a newspaper article in which they used diabetic foot ulceration as an example. With the combined efforts of several specialists and a high degree of availability to the patient, amputation can be avoided. However, return visits and the mobilization of several specialties are not rewarded by the queue billion. According to these authors, economic incentives have to be changed in order to "create a situation where the medical outcome for the individual is at focus. Only then does the citizen have a real healthcare guarantee."[12]

In 2012, Christer Petersson, a primary care physician in southern Sweden, reported on a failed attempt in his own county to qualify for a share of the billion. The hospital management realized that the hospital's child and adolescent psychiatric clinic did not have resources of its own to reduce its queue enough to compete

for some of the reward. Therefore they contracted with a private medical company to reduce the queue for first visits. This was successful, but there were no resources for the treatment that was supposed to follow after the first visit. Due to the resulting queues for the first treatment session, the county received no share in the billion. Instead they spent 5 million Swedish crowns in a remarkably inefficient way. Petersson generalizes his criticism of new public management as follows:

> The hang-up on measurable goals and quick results often becomes self-defeating: A sound ambition to make care safer and more efficient threatens to deprive it of its personal, empathetic core. Quality becomes (pseudo) quantities. Concepts like meaning, family, and social context risk losing their value. And the control apparatus for ensuring goal achievement becomes more and more extensive as the time for personal encounters becomes more and more restricted. How many good therapeutic encounters could not have come out of 5 million crowns?[13]

In June 2013, the organization of patients with gastroenterological diseases joined forces with representatives of gastroenterology. In a joint newspaper article, they pointed out that, in particular, young patients with inflammatory bowel disease and other severe gastrointestinal conditions are in need of sustained and sometimes rather intensive support from specialist healthcare. "Therefore it is alarming that return visits can now be assigned lower priority or even cancelled as a consequence of the queue billion's focus on the speedy reception of new patients."[14]

**The Swedish Medical Association**

The Swedish Medical Association, which organizes most physicians in Sweden, has expressed increasingly negative views on the queue billion. In July 2011, their chair, Marie Wedin, said at a seminar:

> The healthcare guarantee has been good. It puts focus on availability and on how processes can be slimmed. But at the same time we see displacement effects in combination with lack of resources. The consequences become medically unethical. Physicians have to take the responsibility while the politicians profess their innocence. In practice the effects are that first visits are valued higher than return visits, contrary both to medical priorities and to the priorities that have been politically decided.[15]

The association proposed a reformed healthcare guarantee that would be more individualized and based on a medical assessment of the urgency of treatment. However, they were skeptical of combining even an improved version with economic incentives. In 2012, Wedin expressed hopes that their criticism of the queue billion would be taken seriously by the government. "We hope," she said, "that the decision-makers now realize that a committee must be appointed to improve the current healthcare guarantee."[16] In an interview in 2013, she repeated her criticism but was less hopeful that politicians would act:

> There is nothing wrong with the ambitions, but the reforms have created a culture where short waiting times are more important than healthcare according to needs. It is ethically and medically serious if patients with

> the largest needs do not have the first place. It is the elderly sick, patients with multiple and chronic diseases who are negatively affected. The groups that are displaced are large, certainly hundreds of thousands of patients. But there is no political willingness to do anything or even to admit the problems. The government is too proud of its queue billion and does not want to tarnish the image even by appointing a commission.[17]

In June 2013, the chairs of the Swedish Medical Association, the Swedish Teachers' Union, and the Swedish Police Union published a joint newspaper article in which they criticized the effects of new public management on their three professions in more general terms. They recognized that its purpose was increased efficiency, but this, they said, had not been achieved.

> The solution became NPM, new public management, that was based on economic theory with lofty ideas on market models and competition. But the attempts to organize municipalities, counties, and police districts as companies have not resulted in better education, healthcare or police work. To the contrary these organizations are now characterized by a larger administrative superstructure than previously. Their operations are ruled by statistics. Of course it is a good thing to measure wisely, to evaluate and develop. But problems arise when the measurements are not based from the beginning on the participation of the profession. Administrators and economists have kidnapped the evaluation process. Reliance on professional responsibility has been replaced by a control system that risks leaving professional ethics aside and threatens the basic human qualities of the work to be done.
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> Our message is that now the politicians must rely on the professions, rely on our good judgment. Rely on the teachers, the doctors and the police. We are responsible for human activities that society cannot do without. Treating them as simple industrial units has had devastating consequences for quality and for the professional pride of our members.[18]

### The Doctors' Appeal

On June 19, 2013, 108 physicians published an appeal for better healthcare in *Läkartidningen*, the journal of the Swedish Medical Association:

> We are worried about you who need healthcare in Sweden today!
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> We are doctors who work daily with patients and now we want to tell you about our daily work. The picture that politicians paint of today's healthcare does not correspond to our reality. In Swedish healthcare so-called improvement work goes on every day but we see how healthcare loses in quality due to a system that was wrongly constructed to begin with.
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> Swedish doctors spend least time in Europe on their patients. This depends in part on a healthcare system that is based on economy and production instead of the patient's needs. In order to report our productivity we have been assigned an enormous administrative burden that takes time from our patients.
>
> A system that puts focus on production often runs into conflict with the patient's best interests. The patient is not a product like any product on a market. In today's system the patient is supposed to behave according

> to a predetermined pattern. In reality, the patient is complex and therefore does not fit into today's system. Production-centered healthcare puts our professional ethics at risk. According to medical ethics the principles of need and human value should always have priority. Today's system is ruled by the principle of cost-efficiency. We see its consequences.
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> Where politicians rejoice over an increased number of healthcare visits we see the quality deteriorate. Where politicians relish shortened queues to healthcare we see how chronically ill patients are displaced by patients with minor ailments. Where politicians require shorter completion times in emergency departments we see how patient safety is threatened. Where politicians see efficiency improvements, we see lack of hospital beds, and we must spend a large part of our working hours trying to find beds for our patients, or send home sick patients due to lack of beds. Where politicians see shortened hospital stays as efficiency gains we are worried by an increased number of readmissions and complications.
>
> Like the politicians we want a cost-effective healthcare. But we believe that today's system is counterproductive and contributes to larger costs and worse results. We are seriously worried over today's healthcare. Until now we have done our utmost within the given conditions, but now it is time to change these conditions.
>
> *We want a healthcare governed by the patient's needs.*
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> *We want a healthcare where we can act according to our professional competence.*
>
> *We want to do what we are educated for; to be good doctors who take care of our patients in a knowledgeable, ethical, and empathetic way.*
>
> *Allow us to do that!*"[19]

The doctors' appeal has been unusually successful, with thousands of signatories added on the Web site within a few days. By June 30, 7,911 persons had signed it. However, the response from politicians on the government side has been negative. The minister responsible for healthcare accused the appeal of severely misrepresenting the status of Swedish healthcare,[20] and one of his aids described it as "complete nonsense."[21] The chair of the Parliamentary Committee on Social Insurance suspected that a large number of the signatories are members of opposition parties, presumably seeing this as a reason not to pay much attention to the contents of the appeal.[22]

## Conclusion

Medical ethics and healthcare politics are usually kept apart. Traditionally we apply the principles of medical ethics to the professional activities of physicians, nurses, and other healthcare personnel, but—perhaps graciously—we refrain from applying them to political activities that concern healthcare. More than any other issue, prioritization makes this distinction difficult to uphold. If it would be unethical of a physician to give priority to sties over glaucoma, is it not then also unethical of a politician to oblige, induce, or encourage the physician to do so? The ongoing and currently intensifying discussion among Swedish physicians about the queue billion and other expressions of new public management provides a thought-provoking illustration of how medical ethics connects with the fundamental moral issues in our societies.

## Notes


1. Hood C. A public management for all seasons? *Public Administration* 1991;69:3–19.
2. Socialstyrelsen. *Vårdgaranti och kömiljard—uppföljning 2009–2011*. Stockholm: Socialstyrelsen; 2012.
3. Winblad U, Andersson C. *Kåren och köerna: En ESO-rapport om den medicinska professionens roll i styrningen av svensk hälso- och sjukvård*. Rapport 2010:9. Stockholm: Expertgruppen för studier i offentlig ekonomi; 2010.
4. Socialstyrelsen. Vårdgaranti och kömiljard–uppföljning 2009–2011. Stockholm: Socialstyrelsen; 2012, at 86.
5. Aschan AF. De sjukaste får vänta på vård. *Dagens Nyheter* 2012 June 12; available at http://www.dn.se/nyheter/sverige/de-sjukaste-far-vanta-pa-vard/ (last accessed 16 Mar 2014).
6. Sveriges läkarförbund. *Medicin med detsamma? Förslag till en rättvisare vårdgaranti*. Stockholm: Sveriges läkarförbund; 2012, at 32.
7. See note 6, Sveriges läkarförbund 2012, at 39.
8. Lövtrup M. Fler tecken på att kömiljarden lett till undanträngning. *Läkartidningen* 2013(1–2):110; available at http://www.lakartidningen.se/07engine.php?articleId=19094. (last accessed 16 Mar 2014)
9. Franke P. Kömiljarden riskerar liv. *Värmlands Folkblad* 2012 Nov 1; available at http://www.vf.se/asikter/ledare/komiljarden-riskerar-liv (last accessed 16 Mar 2014).
10. Kjöller H. Kömiljarden: Alla system har sina avigsidor. *Dagens Nyheter* 2012 June 29; available at http://www.dn.se/ledare/signerat/komiljarden-alla-system-har-sina-avigsidor/ (last accessed 16 Mar 2014).
11. Zaremba M. Hur mycket bonus ger ett benbrott? *Dagens Nyheter* 2013 Feb 20; available at http://www.dn.se/kultur-noje/kulturdebatt/hur-mycket-bonus-ger-ett-benbrott/ (last accessed 16 Mar 2014).
12. Åkerlund B, Gerok-Andersson K, Saro C. God tillgänglighet är inte lika med god sjukvård. *Dagens Nyheter* 2011 Aug 17; available at http://www.dn.se/debatt/god-tillganglighet-ar-inte-lika-med-god-sjukvard/ (last accessed 16 Mar 2014).
13. Petersson C. Kömiljarden kväver vårdkvaliteten. *Läkartidningen* 2012;109(19):937; available at http://www.lakartidningen.se/07engine.php?articleId=18218 (last accessed 16 Mar 2014).
14. Rehnby B, Graf W, Jäghult S. Kömiljarden har gjort vården politikerstyrd. *Svenska Dagbladet* 2013 June 17; available at http://www.svd.se/opinion/brannpunkt/komiljarden-har-gjort-varden-politikerstyrd_8272638.svd (last accessed 16 Mar 2014).
15. Thornblad H. Gehör för medicinsk vårdgaranti. *Sjukhusläkaren* 2011 July 6; available at http://www.sjukhuslakaren.se/2011/07/06/gehor-for-medicinsk-vardgaranti/ (last accessed 16 Mar 2014).
16. Lövtrup M. Undanträngning ett utbrett och reellt problem: Läkarförbundet vill ha alternativ vårdgaranti. *Läkartidningen* 2012;109(29–31):1330–1; available at http://www.lakartidningen.se/Functions/OldArticle.aspx?articleId=18428 (last accessed 16 Mar 2014).
17. Mellgren F. Garantins luckor nära döda honom. *Svenska Dagbladet* 2013 June 17; available at http://www.svd.se/nyheter/inrikes/vardgarantins-luckor-nara-doda-honom_8270620.svd (last accessed 16 Mar 2014).
18. Jansson B, Nitz L, Wedin M. Våra yrken har kidnappats av ekonomernas modeller. *Dagens Nyheter* 2013 June 24; available at http://www.dn.se/debatt/vara-yrken-har-kidnappats-av-ekonomernas-modeller/ (last accessed 16 Mar 2014).
19. Makdessi M, Halmin M. Läkaruppropet. *Läkartidningen* 2013;110:CD3I; also available at http://upprop.nu/VVGV (last accessed 16 Mar 2014).
20. Lindau B. Läkarupprop mot brister i svensk sjukvård. http://sverigesradio.se/sida/artikel.aspx?programid=83&artikel=5571536 (last accessed 16 Mar 2014).
21. Sundkvist F. Sveriges läkare har fått nog av dålig politik. *Metro* 2013 June 20; available at http://touch.metro.se/nyheter/sveriges-lakare-har-fatt-nog-av-dalig-politik/EVHmft!EuNEx3KUwlNEI/ (last accessed 16 Mar 2014).
22. Axén G. Glömde de att ut partibeteckning? Downloaded July 1, 2013 from www.gunnaraxen.se, now removed, but a copy is available from the author.