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MLI

True North In Canadian Public Policy

Straight Talk

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Straight Talk: With Sven Otto Littorin

PART 1 OF 2

In the latest instalment of *Straight Talk*, MLI spoke with Sven Otto Littorin, who, as Sweden's Minister for Employment, oversaw a number of major policy reforms. He explains the Swedish approach to health care, which could hold lessons for reforming Canadian medicare. In a forthcoming instalment Littorin discusses the reform of Sweden's social services. The interview has been condensed and edited for clarity.

Sven Otto Littorin was Sweden's Minister for Employment from 2006–2010, in charge of major policy reforms, including an overhaul of the unemployment insurance system and a complete renovation of the Public Employment Service. During the Swedish Presidency of the European Union in the fall of 2009, Mr. Littorin was President of the European Council of Ministers, in its EPSCO formation (Ministers for Employment, Social Policy, Health, and Consumer Affairs). As such, he oversaw the European Union response to labour market effects caused by the financial crisis of 2008–09. In the previous election term, 2002–06, Mr. Littorin was the Secretary General of the Moderate Party. He is currently an independent adviser on change management, policy reform, and related issues.

MLI: Let's start by talking a little bit about the Swedish character, particularly the Swedish political character; what is it that people want from government?

Littorin: I think it's probably a bit difficult when you're in the culture to describe it accurately, but I think there are a couple of patterns that stand out to me at least. One is that it's very egalitarian. It probably has a long historical background from the Vikings and onwards. You are supposed to be among others in a group rather than being the big guy, and that goes across the line actually. The second is that we are also a Lutheran country, which means that there is a strong work ethic, almost to the brink of ridiculousness. You know, you work otherwise you're not pulling your weight. The third characteristic would be an engineering tradition, which makes things quite methodical or logical, if you like, also approaching the brink of ridiculousness because every government agency in Sweden looks the same and has the same set of governance around it and so on.

MLI: And how does this then manifest itself in the attitude that people have toward government services – health care, employment services, and so on?

Littorin: I think that it's a sort of a no-nonsense approach. It means that most people really don't care who is providing these services as long as they are provided and as long as they are general in their nature and accessible and reasonably priced. They just want it to work. . . . There's still room for lots of political fighting though, I mean, don't get me wrong. There are lots of political fights.

MLI: Tell us what you think the dominant features are of the health care system that make it satisfactory to the people that you've just described.

Littorin: I think what happened is it started out as one of the welfare reforms that came in the early 20th century and it grew into becoming almost a socialist planned economy structure where the public sector was both financing, producing, organizing, and doing the whole kit, but it was quite obvious even in the late 1980s and early 1990s that this had to shift because it wasn't delivering what people were expecting it to deliver. The answer has been, over time, to introduce within this publicly funded system, a larger portion of private suppliers of these services. Again, it doesn't really matter to people whether the doctor you have in front of you is privately employed or publicly employed as long as you get the care that you are paying for through taxes, right? So, that has made a dramatic shift, I think, in terms of the ways that doctors and nurses can decide. If they don't like the system they are in, if they don't like their bosses, they can actually drop out of the public system, start their own private care facility, and still be a part of the publicly funded system.

At the same time, I as an individual have the right to choose my own doctor and my own care facility, which has led to a situation where, in the primary care sector today, about one-third is privately operated, but publicly funded. I think quality-wise and delivery-wise it has been good not only for those who have these private operators, but also for the rest of the system because competition is a way of improving services across the line and within this publicly funded system it's got very few down sides.

MLI: You talked about the political fights that come with these kinds of reforms. Swedes accept this notion that there is a publicly funded system, but they don't care whether providers are public or private operators?

Littorin: I think the biggest fight, as always, is about the total amount of funds available for health care with changing demographics where people stay alive longer and become older. Of course this is a challenge. How do we keep the system functioning? So there are lots of discussions about that. There are also discussions, of course, about quality and governance issues. Do we get what we pay for? How do we make sure this system is viable over time? There have been some examples of private providers within the system who are owned by venture capital companies and they have taken some profits out

of the country. This upsets a lot of people, arguing that tax dollars end up in the pockets of a few who are enriching themselves on people's need for good health care. There has been a debate on long-term responsibility among owners. But overall having private operators has not been a big issue.

MLI: And it's not an issue, say, with the social democrats?

Littorin: No, I'm fairly sure that if there was a change in government, it would not be a part of their agenda to change that because it's widely accepted and they know that they can't turn it back. Telling these doctors that you now have to become publicly employed or tell patients that you now have to go to a public hospital, it's a fight they can't win. It's a useless fight, you know it works so why change it?

MLI: Canadians will want to know a little bit about what kinds of services are provided because as you know, the range is rather limited in Canada. If you go to see a doctor, anything the doctor does for you is pretty much insured. If you go to a hospital any service the hospital decides you should get is insured. Anything else, if you go to a non-hospital facility or if you see anybody who is not a doctor, like a nurse practitioner, it's not insured. Drugs are not insured, dentistry is not insured.

Littorin: I think that we have wider and deeper coverage, which means that basically most things are covered by the insurance. We do have user fees in the system, but they are capped and they are not all that high. There's a special dental insurance system in place, but it works more the same way. Drugs are treated slightly differently. Every prescription drug is subsidized in one way or another as a percentage of the actual cost, but there is also a cap on the actual amount so you don't have to become ruined just because you are sick.

MLI: And you started to talk a little bit about user fees. We're very interested not only in how user fees work, but what the mentality is behind the user fee. In Canada some people say "don't bother with user fees, you don't raise any money".

Littorin: Well, that's true. User fees aren't there for the money primarily even though it is 15 percent or so of revenue that's needed to cover costs. I would say the real value of user fees is two-fold. One is that it gives a signal to every single person that there is actually a cost involved here. I mean, it's not free, there is no such thing as a free lunch; there is a cost involved. And the second is to manage demand in the system. When things are free we tend to overuse them and there is a risk, of course, that if there's no cost involved whatsoever there is no barrier to going down to the GP's office every single day if you like. It almost becomes like a social thing. To have a small user fee prevents that overuse or misuse. I would say it's a fairness issue because if you get rid of the overuse or misuse then we can use the funds that we have to help those who really need it.

MLI: When you raise the idea of user fees in Canada, the response of the people who defend the system is that you might discourage someone from using the system, and if you think you need to see a doctor there shouldn't be any barrier to seeing them. Do Swedes have that?

Littorin: That's not happening in real life because what happens, of course, is if you are sick you go to a doctor. If it's a one-time fee of $15 or something like that it doesn't prevent you from going to a doctor. It's also the case that if you are without means you're exempt from paying this fee. So it really is just a way of keeping this repeat customer, if I may call it that, out of the system to be able to focus the resources on those who really need it.

MLI: So, the consensus in Sweden is that the existence of user fees does not damage the health of Swedes?

Littorin: I'd say that. When it was raised, this user fee, it was raised some 15 or 20 years ago, there was a discussion about this, but it tapered off and it's all gone now. That is not the thing that people are

worrying about or talking about. It's more about assuring long-term quality as people get older. I think that's where the debate is right now.

MLI: So, the debate is moving on to issues of population aging, intergenerational equity?

Littorin: I think it becomes a very individual thing because there are lots of people, like myself, who are in a situation where we have quite old parents who are in need of care or will be in need of care. We worry about ourselves because I mean let's face it, 20, 30, 40 years from now I'll be there and then we have children who are quite young at the same time. So, we're sort of in the middle of this generational shift, if you like, and we see the system has to work as we get older. So, there's a big discussion about that, and it sort of also taps into the question of pension age, retirement age, the whole question of how we get people to work more for longer. So, it becomes a rather difficult political question because which politician in their right mind would like to go to the voters and say, listen you have to work more for longer, otherwise you won't be able to go to hospital or your children won't have any schools. That's not a very positive message, but it's still true.

MLI: Now, let's talk for a minute about quality in the health care system because you said that Swedes are quite practical, they don't fuss about whether it's public- or private-sector providers, but they do care about quality. How does the system respond in a way that Swedes are satisfied that they're getting quality services?

Littorin: I think that if you ask the average Swede they would probably say, "I'm fairly satisfied with the quality of service I get, but I'm worried that I'm not going to get it tomorrow". That's where the debate is right now. You have competition within the system. As a doctor if you're dissatisfied with your boss or the publicly-run system, you can leave and set up shop with your fellow doctors and a couple of nurses and then you're up and running. The only barrier for that to happen is that you have to be quality-assured by the county council. From the user end, you, as an individual, have the right to choose which doctor you want to go to. That is quite powerful within the publicly-funded system. It is quite powerful in order to make sure that you raise quality within the system. It also has to do with information, of course; so you can compare doctors for instance. It's not only the way the doctor looks or how kind he is, but it's also about how well he treats his patients of course.

MLI: And there's information available about that, sort of patient ratings of doctors?

Littorin: Yes, patient ratings, but moreso I think, things like the number of malpractice problems a doctor has had, and so forth. There is a quality element to that. It is available, but it's not good enough, I'd say. It had room for improvement in order to be pedagogic for the end-user.

MLI: And if you were in need of a surgical procedure, would you be able to check how long the queue is in this hospital versus the other hospitals?

Littorin: Yes, there is a four-step guarantee. It's 0-7-90-90. Zero is the length of time that you are supposed to wait to get to a primary care facility. It doesn't mean a doctor, that's the seven-day guarantee to meet a GP, but probably what you would do is pick up your phone, call your local office, and you'll speak to a nurse. The nurse will be your first contact. She will give you advice on what to do and she will book you with a GP if that's necessary, and you'll meet a doctor within seven days. It normally takes much less than seven days. Then, there's the 90 plus 90 guarantee for specialized care. So, within 90 days you will get an examination and establish contact with your secondary care facilitator, and within an additional 90 the care you are supposed to get commences.

This actually works quite well. There are cases where the time has not been met, but according to the rules what it means is that if you have to wait more than 90 days and your local county or local region can't give you that, they have to pay to ship you somewhere else to get that care. That's quite a powerful tool because no county would like to pay another county for your patients.

MLI: We've talked about both public and private providers within the public system; in other words you can see a private doctor and have the public system pay. Can you be outside the public system all together?

Littorin: Yes, you can. There is a growing number of people who do take out private health care policies and it's increasing in specialized services. People who are specialists in their area, for instance, have employers who are so keen on having them healthy and fit that they are prepared to pay a premium to get private health care insurance, and then there are hospitals that would take care of you within that policy. So, that is possible, absolutely, although I do believe that this will become more and more politically sensitive if it becomes too big because people argue, "well we've paid taxes to get this service so now do I have to pay twice?" That's one argument, and the other argument would be, okay so you've done this but are you buying yourself to the head of the line?

MLI: In Canada, the argument is that if you allow private sector medicine, if you allow doctors to opt out of the public system, the system has lost those doctors. There's less medical capacity then for the people in the public system. So, in effect, if you allow private medicine you're robbing the public system.

Littorin: Well, I'm not so sure about that. I mean, you have the same amount of patients going around. It's not that people become more sick just because you have a couple of private doctors. It just has to do with the way that you finance these operations. So, to me it's not a big problem that you have people who have opted out of the public system. They still pay taxes so we still get the revenue from them, so it's a bigger problem for them than the rest of us.

MLI: The cost of providing health care in the public sector in Canada is rising faster than population growth, rising faster than economic growth, it's rising faster than revenues. It's rising faster than everything. And, in effect, it's starting to crowd out other kinds of public spending. Are you having a similar experience?

Littorin: It's a problem all over, I guess. It's a combination of factors and it's hard to distinguish which is which because if you have an aging population, it's quite natural that it would probably rise quicker than any other cost that you would compare it to, but that can't be the entire question because there's also a problem of measuring productivity in the publicly-operated system. How do you do that? In national accounts productivity growth is always at zero for the public sector. Is that really true? I'm not so sure about that. It shouldn't be, we should have productivity growth also in the public sector, of course. So, there's lots of discussions going on and how do you measure output in the health care sector?

I think it's absolutely certain that we need to make sure that we have quality increase over time and cost decrease over time and the only way we can do that is by increasing productivity, that's the only way.

MLI: Would it be your view that the competition that's possible within the Swedish system is a way of improving the productivity of the system?

Littorin: Absolutely, and the funny part is that Swedes are not revolutionary. We do not like revolutions. We like a small steady pace of improvements, sort of in the equality-driven engineering tradition of Lutheran, hard-working Swedes, right? And the evidence is that it works because we've had that sort of state monopoly system going for a long time and it wasn't efficient enough. So, we introduced these small steps to improve the system and as I said earlier, now we have about one-third of our primary care facilities operated by private operators. Will it be 40 percent or 50 percent a couple of years from now? I don't know. To be honest, I really don't care that much because it doesn't matter if it's 30 or 20 or 40, but just the fact that the opportunity is there and that it can shift over time without limitations makes me believe that there is something there that has to do with quality and productivity. It does the job and that's the important thing.

The same thing happened to our school system. We introduced school vouchers 20 years ago – it's not a huge change in terms of numbers. There's about 13 percent of kids in primary grades and 26 percent in high school who go to private schools funded by the public sector, but the impact on quality has been dramatic throughout the system. It made public schools think about what they deliver in terms of both quality of the environment that the kids are in, but also in pedagogic terms being able to test what works and what doesn't and that is the key element I think. The ability to try and fail sometimes and to have lots of influences coming into the system; I think that's really the key.

MLI: One of the greatest obstacles to this kind of experimentation within the public system in Canada is you have a public sector monopoly which then had another layer of monopoly on top of it which is public sector unions. Sweden is very highly unionized. Presumably workers in the health care system are unionized. How have you got them to buy into these incremental reforms?

Littorin: I think it was just because they were incremental, but they were highly opposed by trade unions when they started, absolutely. Then, along the line, even the unions saw that it wasn't all that bad. It was actually probably quite good and especially among the doctors and nurses that were able to opt out of the system and start their own facilities, the perception is, of course, that the system is great because they have the opportunity to get another employer, which they didn't have before. They had one employer and now they can be their own boss if they like or have someone else as a boss. That has improved their quality of work quite a bit and that is an opinion that flows back into the trade unions. You know, we're not a nation of conflict, so even though we've been pushing these things, we've tried to do it step by step, piecemeal, you know, not a revolution. It's a way of improving quality over time and focusing on the right thing, not a sort of game around it, if you like.

MLI: MLI published a paper in 2013 by a woman who used to be the finance minister for a social democratic government in one of our provinces, and she accepts the argument that people should pay something towards their health care, but she doesn't want to impose a user fee at the point of service. She says that might discourage people from using the doctor. So what she wants to do is, at the end of the year, add something to your tax bill representing the number of times that you went to the doctor. But that doesn't give you what we want with a fee at the point of service, because we're trying to moderate demand.

Littorin: That sounds like a compromise which doesn't do the trick. To me, it sounds like the worst of two worlds because you have the fee but you don't get the result that the fee was intended to deliver. It would just annoy people I would say. I think that if you pay $15 when you go to a doctor you know that there's a cost involved because it is a service that is delivered to you that you've paid for. So, you pay a small amount of money to get access. I live in the UK now and point of service is completely free. Well, if I go to the doctor's office I see people there who are basically spending their social life in the office of their GP – it's ridiculous. The cost crowds out resources that could be used for people who actually do need some help, so in that respect, I think, doing it that awkward way of taxing it somewhere along the line later on, it misses the point.

MLI: Do you have physician shortages?

Littorin: We do and that's actually a big problem especially in rural areas, in the north for instance, and this is actually a big political debate right now. What happens is that we basically have to get temps in and motivate them by spending a lot of money for them. That, of course, is something because income disparity in Sweden is a big no-no, you know, for all kinds of reasons that I've told you before. So, paying these doctors huge amounts of money to go up and live in the north to treat people who are rarely there is a big politically sensitive issue, absolutely, but that's the only way we can do it. Now, we are obviously hoping for doctors from other parts of the world to come to us to help out, which happens

through the European Union. We do have doctors coming from other parts of the world; the problem is language, of course.

[For example], with Polish doctors, even though they are so close, it does pose a problem language-wise and also because there are licences and they are not licensed to practise, so they have to take all of their courses and do all of the things they have to do to be licensed to practise. So, that is definitely an issue and the only way they try to solve it right now is through financial incentives – pay these guys more to go up there, and that's so-so. To be perfectly frank you'd have to pay me quite a lot to go up there and live there as well because it doesn't only have to do with the kind of work you do, it has to do with where your friends are and your family are and the weather and the mosquitos in the summer and the darkness in the winter and all of that.

MLI: It seems possible to have a system that has advantages that Canada doesn't have – broader coverage, pharmaceuticals, dentistry, and so on – with improved productivity, greater experimentation, and better use of resources within the system. So, let's talk a little bit about those coverage issues. Talk about gaining access to them.

Littorin: Let me start off with drugs, for instance. Prescription drugs are covered similar to user fees in the accessibility of health care facilities. It means that prescription drugs are covered by a percentage of their actual cost up to a ceiling. The ceiling is quite low, so you do pay up to about I'd say $200 or so, and then you're maxed out. That's it. Which means that people who are dependent on drugs for treatment, for instance, don't get ruined. It means also that people like myself who rarely reach $200 per year in prescription drugs do actually pay. There's also a little quirk to the system and that is you have to get your card stamped, and I have to admit that I don't normally do that because I forget my card, which means that I probably pay more than $200, but I can afford it. So, I'm fine and that actually helps the system in a way, but those who know that they are limited in resources will definitely get their card stamped. So, that acts as an equalizer in the system. That's a quirk, you know, but it does make some sense in a way and it does help people.

When it comes to dentistry, same thing applies. There's coverage that is a percentage of the cost involved. It's basically incremental in several steps, but there's a max ceiling. People in Sweden would argue that that is really expensive and it is. I mean, you can pay a lot of money for dentistry in Sweden, but you still have a maximum amount at least and that's always something.

MLI: And in Canada basically the only people who matter in terms of providers are the physician, and the system will not reimburse if you have the nurse practitioner you talked about in your 0-7-90-90 formula.

Littorin: Oh, that's interesting because I find that the nurses are often the best in the first step. They weed out people who basically need an Aspirin and a glass of juice or something from the people who really do need to see the doctor and they're very experienced and very, very good. They can sort of tell why you're calling and sometimes they can tell more than a doctor to be honest because they can feel if it might be something that is of a more psychological nature or if there's something behind the scenes that they need to test. So they are quite good and they are part of the system. They are covered, absolutely. It doesn't matter who you see really at the doctor's office, if it's a nurse or a doctor. So, yeah, that's good.

MLI: **One of the great debates in health care, of course, is the distribution of costs over the life of a patient, and we know that as patients reach the very end of their life we increasingly throw all kinds of medical resources at them; it doesn't necessarily extend their life particularly. On the other hand, these are human beings, they're sick, and we want to look after them. So, where's the debate about that in Sweden?**

Littorin: I think that the last 100 days of a person's life are when the majority of the health care costs occur normally and I think there is huge debate about the dignity of the individual, especially towards the end of life. I think any measure trying to curtail that, trying to sort of minimize that would be extremely stupid for all kinds of reasons. I mean, just myself, would I like to have quality dignified care towards the end of my life – yes I would and I think I've paid for it, to be honest. So, the question or the debate is rather on how to improve the dignity. It's not only about the quality of care and the quality of the health care system, the accessibility to drugs and so forth, it has to do with dignity in the system. Are you treated well, do you feel that you get the serenity that you would like to have in your last weeks of life, those kinds of issues.

I'll tell you, I've had a couple of extremely positive encounters with the Swedish health care system. One was when my mother passed away and she passed away at the private hospital in Stockholm covered within the system, one of the seven private hospitals. The care that she was given and the dignity of the care that she was given was absolutely outstanding I'd say. It was a wonderful experience even though it was so tragic. The second would be when my children were born. I think the system allows for a lot of personal interaction that is very humane, if you like. That is exactly what I think people are looking for.

RECOMMENDATIONS:

1) Implementing modest user fees for those who can afford them would give people an understanding of the price of care and discourage frivolous use.
2) Introduce greater competition from private operators to improve choices for care and employment options for health professionals.
3) Broaden coverage to include pharmaceuticals and different kinds of health care professionals to provide the appropriate level of care.

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Very much enjoyed your presentation this morning. It was first-rate and an excellent way of presenting the options which Canada faces during this period of "choice"... Best regards and keep up the good work.

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