CONSUMER-FRIENDLY CARE

HOW NEW IDEAS ON FUNDING CAN PROVIDE NEW HEALTHCARE SERVICES

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Preface

Welfare states only undergo reform if the changes are truly necessary, ie economically. It follows therefore that the economic crisis can create a dire need for reform. This was witnessed during the 90´s and the pension reform in Sweden at that time, and it could be said that this followed on from the reforms of the 80's in both the United States and the United Kingdom. Perhaps the same thing will come to pass with the reform of social services funding?

However the road to that point is bordered by debate and discussion. Before a decisive crisis is upon us, since the staus quo will rapidly become unaffordable, we must have a conversation about the important values of different reforms, and which strategies and solutions will be most able to encourage those changes. This will provide decision makers with a starting point when the need for reform arises.

If there is to be a healthy and productive discussion about values, strategies and solutions, we need perspectives other than just the "musts" and an analysis of the long-term advantages of different possible solutions, as this strengthens the foundation for decisions – a "should perspective."

We already know a good deal about the "must perspective," i.e. the purely economic reasons regarding the funding of healthcare in the future, from sources including Långtidsutredningen 2008 (the 2008 Long-term Survey), Per Borg's ESO-rapport 2009 (the 2009 ESO Report) and the report from the Borg-kommissionen (2010), a mutual cooperation between Arena Idé and Timbro. Their conclusions are important and merit constant repetition, not least because the political parties have chosen to ignore them.

In this report the "should perspective" has a chance to be heard. More private funding of healthcare yields opportunities to develop new and improved services that may be available to everyone, in the form of more effective care and therefore better health in the long term.

Using original arguments and examples from other countries, the author points to the beneficial extra contributions in the form of new funds for the welfare services of the future – and to the merits of the fact that these are indeed private funds, i.e. not channeled via taxes and public bureaucracies.

The report is written by Carl Elfgren, who has a background in political work both in the Swedish Government Offices and as a consultant specializing in topics including the development of services.

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Stockholm, April 2011

Eva Cooper

Project Director, Welfare and reform strategy, Timbro

Why write a book about services in health care?

In the autumn of 2004 I was diagnosed with IgA Nephritis. This is a kidney disease which, simply put is an inflammation of the kidneys, and it is chronic, ie it can not be cured. The prognosis looked bleak. The doctors thought that within a few years it would become so bad that I would need to be put on dialysis. This is something that is required when kidney capacity falls below 10 percent of normal.

Today, six years later, I feel good. Thanks to medication, regular check-ups and a somewhat different lifestyle I am almost completely symptom free. Renal capacity is stable at around 35 percent, which is quite sufficient to be able to live a good and relatively stress free life. Nobody knows what the future will bring, but the conditions are there for me to remain symptom free for a long time to come.

This trip has given me hands-on experience of the Swedish health care system. These experiences have been both positive and negative, ranging from high quality care and good human encounters to non-empathic treatment, confusing information and a sense of being in the way of the care production system. These, very personal experiences are the basis of my strong commitment to harnessing the enormous potential of health care transformation from a county bureaucracy to a service industry.

My second approach is to advise companies on questions relating to strategy, customer orientation and service development. For several years I had the privilege to work with professor Richard Normann (1943-2003), author of books such as Service Management, and perhaps the most internationally recognized Swedish management thinker. Richards pioneering thoughts about “servicification”, network economics and the power of the consumer is today considered a reality in many industries.

Meanwhile, health authorities in Sweden, as in many other countries, are still marked by an old industrial mindset that puts consumers on the sidelines. My starting point is that the philosophy that has transformed the market economy must now also be reflected in healthcare. Not just as a means of saving money, but also to increase the quality of the service and to put power firmly in the hands of healthcare consumers. For that to happen, you start to take hold of the politically sensitive issue of how medical services are financed.

The discussion of the future funding of healthcare is dominated by the economic perspective, which focuses on the limitations of public funding of future healthcare needs. A greater element of private funding – for example through insurance – is described primarily as a way to address the strains that the geriatric care sector will undergo in the future.

However there is another perspective that deserves to be highlighted in the debate: innovation and the development of services in the healthcare sector. Would a larger private component in healthcare funding stimulate the development of new and better services? Does medical care have anything to learn from other industries? Are there examples from other countries where the development of services is more advanced?

The purpose of this report is to demonstrate how a greater private component in the funding of Swedish healthcare and eldercare can contribute to, and even be a necessary condition for, the development of new services that contribute to the health and well-being of patients/customers, and to decreased absences from work.

I am grateful that Timbro have given me the opportunity to write this report and thus be able to express a few of my thoughts on the usefulness and modalities for increased service content in healthcare. I hope that it can contribute to a further discussion of these issues.

Even if the opportunities for service development are naturally partly determined by how the funding system is designed, the purpose of this report is not to make such proposals. Rather it is to outline the opportunities that could open up if a greater share of private funding were allowed. Progress in medical technology is also outside the scope of this report.

However the basis of the argument is the fact that the ever faster development of diagnoses, treatment methods and medications provides the individual with hitherto unimagined possibilities for health and quality of life, while at the same time posing the existing production and finance system with challenges related to how to make the resources go far enough, what they should be used for and who should benefit from them.

The report begins with a description of the problem that focuses on the situation in Swedish healthcare, how it may evolve and the challenges that this development poses. Problems and challenges are set out relatively well in various reports and studies published in recent years. This section also contains an analysis of the need for the development of services in Swedish healthcare, today and five to ten years from now.

The report's second section contains a more theoretical approach to service development and some basic principles for innovation and development.

The main idea in this section is that the Swedish healthcare system can develop in the long term into a commercially successful health industry that – in addition to offering citizens world-leading healthcare – can also be Sweden's next export success, of great importance to economic growth and the creation of new jobs.

Market-based solutions have partially or entirely taken over in many important markets for infrastructure and transportation services such as electricity, telecommunications, postal services, the railroads, taxis and the airlines. The modern state has learned to harness, or rather exploit, market forces in these areas. As a result, with a few exceptions the service level and array of services has exploded while costs have fallen. One starting point is that experiences from some of these deregulation scenarios are worth putting to use for the healthcare sector as well.

The third and last part of the report presents several examples of the successful development of new services in the healthcare sector, and how service innovation can create greater value for the user. The Netherlands receives particular attention when it comes to healthcare; since 2006 they have been implementing an extremely exciting transformation of the healthcare funding system. The experience of the Netherlands has received negligible attention in the Swedish debate on the future and funding of medical care, even though it is extremely relevant to Sweden.

The basis for this report is partly studies of relevant literature and published reports in the area, and partly background conversations and interviews with fifteen experts and players in the areas of healthcare and funding in Sweden and the Netherlands.

Background and starting points

The healthcare sector is at the center of political debate. This is understandable, given the sector's size and importance, as both a supplier of social services and an employer.

The healthcare sector employs approximately 665,000 people. According to Statistics Sweden, in 2005 total healthcare costs were SEK 220 billion. Meanwhile costs for municipal eldercare, care of the disabled and care of individuals and families amounted to approximately SEK 150 billion. Thus we're talking about the largest field in the Swedish service sector.

About 85 percent of the 665,000 employees are employed by public healthcare providers. About 7 percent of Swedish doctors work in private healthcare. About 90 percent of total healthcare costs are taxpayer-funded. The exception is patient fees, which only represent a small percentage of funding, and dental care and medications, for which households pay approximately SEK 20 billion annually.

A private healthcare industry has developed in Sweden over the course of the last fifteen years or so, mainly as municipalities and councils have opened up opportunities for private sector operators to offer healthcare services within the public care framework. The greater element of private production has primarily taken place when companies took over activities previously operated by the government, or the county council or municipality allowed private operators to bid on the operation of some activities.

The private healthcare sector has grown considerably since the 1990s, both in turnover and the number of companies. In 2008 there were 12,600 private healthcare firms. The sector is highly fragmented, with a small number of large operators and a large number of small businesses. About 90 percent were so-called micro companies with one to nine employees. According to statistics from the Swedish Association of Local Authorities and Regions (SKL), 29 percent of all visits to the doctor in 2008 were to private healthcare providers.

It should also be pointed out that there is increasing interest in private health insurance, which is certainly an example of an element of private funding in healthcare. According to the Swedish Insurance Federation approximately 359,000 people had this type of insurance in 2007, which means that the number of people insured grew by 250 percent during the 2000s. Over eight out of ten in

this group, 84 percent, were insured through their employers. The leading motive for obtaining private health insurance is greater access to healthcare. By insuring employees, employers can reduce costs for sick leave caused by long wait times for medical care.

The growth of a private care industry in Sweden has been a positive trend for the healthcare sector. The competition makes greater scrutiny of productivity in publicly managed care possible as well. On many fronts new players have been able to elevate both productivity and quality. The great variety of new operators has also advanced organizational innovations and new work methods that have raised productivity, improved resource utilization and not least advanced new leadership. This is extremely positive.

The increased presence of private healthcare providers has likewise increased freedom of choice for the patient/user. This is the case primarily in the geriatric care sector. The LOV (The Act on System of Choice in the Public Sector) has been in force since January 1 2009. Under this law municipalities are allowed to introduce systems of choice in eldercare.

The LOV sets out the regulations for municipalities and county councils wishing to open municipal and county activities to competition by transferring the choice of providers of support, medical and care services to the user or patient. Systems of choice are intended to serve as alternatives to procurement processes, according to the Public Procurement Act, LOU. All care providers that meet the stated requirements may participate in the system of choice. 177 municipalities have applied for the stimulus grants distributed by the National Board of Health and Welfare for introducing or developing existing systems of choice. 29 of these municipalities already have some type of system of choice.

This report proceeds from the hypothesis that customers will have limited ability to affect the design of services within the framework of a system that almost completely taxpayer funded, despite the beneficial changes that have been implemented in recent years through measures including the LOV or the national customer choice system that was introduced in primary health care in 2010.

In fact customers will have even less influence in the longer term, because demographics and medical advances will put even more cost pressure on an already strained system. This will most likely mean even more stringent demands for rationalization and prioritizing, since almost no one is prepared to raise taxes drastically in order to meet increasing needs for care.

The report proceeds from the assumption that Sweden can choose another path for the future funding of healthcare. This path means that the healthcare services consumer receives greater

power, at the expense of political and administrative decision makers.
One of the fundamental prerequisites is that the customer (patient) takes on a new role. Today the customer is usually called a user or patient, terms that express passivity, and in many cases the individual has only marginal influence over his or her care and the resources that he or she is paying taxes for.

The “customer” concept is controversial in the healthcare debate. Naturally there are numerous situations where the customer is in a weak position for obvious reasons, for example when a person is extremely ill. Meanwhile many of the problems in the healthcare sector are because the proxy customers have gained great influence at the expense of the actual customers. Therefore in the report I usually prefer to use the “customer” concept rather than the more passive terms "patient" and "user."

Development needs and challenges

Why is the issue of healthcare funding important?

In many respects Swedish healthcare stands up well in an international comparison, in the sense that it costs relatively little in relation to the medical outcomes produced. In 2004 Swedish healthcare costs represented 9.1 percent of GDP, which is roughly equivalent to the OECD country average. Sweden is in a strong position, both as a producer of advanced medical services and in terms of several health indicators such as average lifespan, infant mortality and the rate of various cancer diagnoses.

At the same time it is clear that Swedish healthcare has problems. The most striking problem may be availability, which primarily takes the form of long wait times.

The county councils' healthcare guarantee means that patients should have contact with medical services on the first day, be able to meet a general practitioner within seven days, be able to see a specialist within 90 days and receive treatment within an additional 90 days. In other words in practice the guarantee means that patients should be able to receive care within six months.

In its report European health consumer index 2009, Health Consumer Powerhouse points to the long wait times as a large and growing problem in Swedish healthcare. The study ranks 33 national healthcare systems in Europe based on 38 indicators in six different key areas: patient rights and information, e-health, wait times, treatment outcomes, the extent of the care commitment and access to medication.

The index ranks Sweden ninth overall – a drop from fifth place in the previous year's report. According to the study the Swedish healthcare system's strengths are a high level of technical quality of care and consistently good health outcomes in the Swedish population. The latter is attributable to factors other than the user-friendliness of the healthcare system, such as demographics, eating habits, lifestyle and living conditions in general.

On the other hand the Swedish system receives blistering criticism when it comes to access and the patient's position. According to the report, various policy measures intended to help county councils cut wait times have not been able to overcome the problem in any significant way.

“The quality endures, but unfortunately so does the wretched Swedish level of access. Neither billions in reward funds for cutting wait times, campaign promises nor choice of care seem to have taken a bite out of wait times. In fact it is easier to see a doctor in Albania than in Sweden,” said Dr. Arne Björnberg, Chief Investigator at Health Consumer Powerhouse.

The Netherlands, which stands out as a model of consumer-friendly healthcare in their analysis, took the top spot in the index for the second year in a row, followed by Denmark and Iceland. The report states that Dutch healthcare reform has put medical care consumers in the driver's seat and given them a strategic role in the medical care system, in a way that is completely different from medical care systems with more central planning such as the Swedish system or the British National Health Service, NHS.
In order to reduce the problem of long wait times, in the autumn of 2008 the Swedish government presented a programme for shortening waiting times, which in simplified terms means that county councils that succeed in cutting wait times receive extra resources from the government from a total pool of SEK one billion. So far the results of the queue billion initiative are that wait periods have been reduced in several county councils, and the number of people forced to wait longer for treatment than the time promised by the national care guarantee has been cut in half. At the same time it is clear that financial incentives work in healthcare as well. However the question is whether the problem of long wait times can be solved purely by allocating more resources to the existing system. In the long term more comprehensive reforms will likely be needed. The results of the European health consumer index appear to confirm this.

Back in 2008 the report stated that countries that had chosen pluralistic funding systems (where a group of different entities, both private and public, are responsible for healthcare funding) systematically ranked higher from a consumer perspective than systems (such as the Nordic systems or the British NHS) that are exclusively government-funded.

Large healthcare systems with funding monopolies seem to have a difficult time truly creating value for customers. The reasons for this are debatable. Two reasons stated in the European health consumer index report, which are definitely relevant to Sweden, are that government-funded systems fail to create the required dynamism and leadership for service production to become customer-oriented; and that loyalty to the various players in the care systems is felt more by the so-called proxy customers, the politicians, than by the users, i.e. the healthcare consumers.

There is a great deal of evidence that this is a fundamental problem in the Swedish healthcare system. As long as production and funding are not separated (regardless of the extent of private vs. public funding), politicians will be in an extremely strong position – at patients' expense. Since political decision makers with power over funding also "own" the production system, they tend to defend the interests of production over those of patients.

One main problem with the current system is that the roles of funding source and healthcare provider are not kept separate. Even if there are private elements in care, and more and more services are contracted out to private players, the county councils are both the primary funders and the producers of care. Therefore the system lacks both dynamism in the interplay between production and financing, and competition for customers' resources that could motivate healthcare providers and other players to develop new services.

Thus the customer has limited influence in the choice of funding source and healthcare provider. To the contrary, in the SNS report Vem styr vården? (Who runs healthcare?) Paula Blomkvist says that the three most important groups in charge of healthcare today are the county council politicians, civil servants in the healthcare bureaucracy and doctors, the so-called profession. It is typical that patients/customers aren't even mentioned except for patients' associations which are often regarded as special interests.

This is also reflected in the debate on patient relations in healthcare. Between 2000 and 2007 the number of cases lodged with the patient board concerning "patient relations, communication, information" rose by 41 percent – from 2,591 to 3,644. According to the National Board of Health and Welfare's 2009 Healthcare Report, this is primarily because care is not patient-focused, being dominated instead by a "function- and enterprise-specific perspective."

It's clear that the customers/patients of today and tomorrow will increasingly demand the same personal service and customer-oriented approach from medical services as from other service providers. At the same time it is clear that healthcare is still governed by the industrial mindset that was also dominant in the business world as the European welfare states were being built up in the twentieth century.

What drives demand for healthcare?

Demand for healthcare services is primarily driven by three factors: demographics, medical advancement and the population's standard of living.

Like the majority of other developed industrial nations, Sweden has an aging population. A very large share of the healthcare system's resources is used to meet the needs of the older segment of the population. The 20 percent over the age of 65 use approximately 40 percent of the total healthcare resources. In the next few years their share of the population will rise by several percentage points, while their share of healthcare costs will rise by twice as much.

Medical advances move at a fast pace. Diagnoses and treatments that seemed unimaginable only one or a few decades ago are now commonplace. The rate of innovation in pharmaceuticals and medical technology is very high, unlike publicly managed and funded healthcare. This means that patients will demand new types of treatment and new drugs in the future, putting additional pressure on costs. New treatment methods such as laparoscopic surgery and angioplasty provide new opportunities, as do new treatments for cancer and cardiovascular diseases which enable more and more people to live longer and longer – sometimes with great needs for medical care as a result.

An additional factor to be considered is an ever higher standard of living due to economic growth. Why shouldn't people want a higher standard of medical care when their standard of living is rising in other areas? People set a high value on health, and it's clear that they will want to consume more and better healthcare as incomes rise.

A higher level of education among the population combined with information technology advances have made patients better informed than ever before. Occasionally the patient is at least as well-informed as the doctor, and can place demands in a way completely unlike the patients of previous generations did. It goes without saying that these factors help drive demand for healthcare services.

Will government-funded healthcare be able to respond to this rapidly rising demand?

No, not if one believes SKL, which in its report Healthcare until 2030 estimates that up to 2030 the healthcare sector will need to increase its resources by approximately 50 percent owing to demographic trends and medical advances. This estimate assumes that the productivity growth of

recent decades will continue and that the standard remains unchanged, which is questionable since the standard of living in general is likely to increase up to 2030.

If SKL's estimates are accurate, this means that in 2030 healthcare and eldercare will need an amount corresponding to 3 percent of GDP in resources beyond available public resources – which means somewhere between SEK 90 and 120 billion per year depending on how economic growth develops up to 2030.

One way is to improve productivity in the healthcare sector even more, i.e. getting more care for the same money. Productivity in the care sector rises for example with new technology and new medications that make shorter periods of care possible or entirely remove the need for hospitalization. By introducing new concepts and methods, private healthcare providers have been able to achieve enormous improvements in productivity in some places.

This report is not intended to investigate the potential for productivity gains in the healthcare system. We can note that there is work to do in this area, but this is hardly sufficient to resolve long-term funding problems.

Another approach might be raising taxes. However the question is whether there will be any government up to 2030 that is prepared to increase the tax burden by the equivalent of 3 percent of GDP in order to finance a largely unchanged standard of healthcare.

If people wish to preserve both an unchanged tax burden and a completely taxpayer-funded healthcare system, the alternative is even stricter rationing. The current debate on setting priorities in healthcare will become much more intense. What should the public commitment consist of? Who should receive care, and for what? How long are the queues that patients will need to accept for medical care?

As long as the prevailing political consensus is to preserve the public funding of healthcare without drastically raising taxes, these issues must be brought out in the open in the healthcare debate.

The number of senior citizens will place increasing pressure on the geriatric care sector. Certainly many of them will be healthier than today's retirees, but it is estimated that total healthcare needs will rise dramatically. In that case will we have eldercare that is more like warehousing and less like care, where personalized care and the little things that make life worthwhile are replaced by something more like poor relief?

We see then that Sweden is at risk of become an ever richer country with ever richer citizens and an ever poorer medical care sector. As incomes rise citizens will demand more advanced healthcare services, but they will be hindered by a planned economic model managed by the county councils, where resources are allocated by queuing. For a relatively small (but growing) minority, it's possible to receive speedier care and more services through insurance or direct payments.

This is paradoxical, since the leading argument for preserving the public monopoly on the financing of healthcare is solidarity and equality. Care according to needs, not according to people’s wallets, is the slogan of those who advocate continuing the public funding monopoly. Another defense is that a supply-driven healthcare system that is effectively rationed keeps costs down, and that greater market determination leads to overconsumption of healthcare services.

If fact there is a great deal of evidence that the government-funded healthcare system leads to underconsumption of care. The political planning process can't predict the healthcare needs of all citizens. They want to keep down the costs for treatments that people might be willing to pay for in a more market-oriented system. According to statistics from the OECD, Sweden has the lowest number of hospital beds per 1,000 inhabitants in the entire Western world. Is this a result of the superior efficiency of Swedish medical care, or could it be because there is unmet demand for medical services?

The development of services

Entrepreneurship is about creating value for customers. A business that lives in a competitive landscape and can do something about its revenues and expenses is forced to be innovative; otherwise it will fail. The benefit is falling prices and continually improved offerings – in a market that is working properly. Innovations that provide better solutions to customers' problems spread in the marketplace.

This is the basis of all product and service development. The picture is clear in many industries, such as computers and IT, telecommunications, and the automotive and grocery industries.

Traditionally the production of goods, and even services to a great extent, was organized as a so-called value chain. Various actors add value to the end product along the links of the chain before the customer consumes it, thereby "destroying" the value. In this model there is a sharp dividing line between producer and consumer, and the consumer is not much more than a passive recipient of value. Since production is often sophisticated and complex, the production process receives all of the attention while relatively little attention is devoted to the customer, the customer's needs and how the product is used for the benefit and delight of customers and their "customers."

It's nearly thirty years since Harvard business professor Michael Porter introduced the concept of the value chain. Since that time technological progress, deregulation and globalization have turned much of the world on its head. Today a growing share of value creation in the economy takes place according to different principles. The line between customer and supplier is no longer clear. New examples are interactive offerings on the Internet such as YouTube and Facebook, but this is not a new phenomenon. Perhaps the most established example is IKEA, which led the transformation of the furniture market by involving customers in production, customers who get to transport the flat packs home from the warehouse and assemble the furniture themselves.

THIS "NEW" ECONOMY IS CHARACTERIZED BY AN EVER GREATER ROLE FOR SERVICES:

- The focus moves from the product to how it is used by the customer.
- You need to understand the customer, but also "the customer's customer."
- The customer is much more clearly involved in the creation of value: "co-production."

We see this trend in the healthcare area as well. Today the relationship between doctor and patient is different than it was in the past. As patients have become better informed and pose more questions, in many cases the doctor's role has gradually evolved from an authority figure to more of an expert of equal stature.

When truly serious conditions and the very old are involved, the patient's role is naturally still passive to a great extent. Meanwhile it is becoming increasingly common for patients themselves to play an important role in the care process. They can make preventative lifestyle changes or keep an illness from getting worse. More and more treatments are also being conducted with patients' active participation: for example a growing number of kidney disease patients perform so-called self-dialysis, meaning that patients themselves operate the dialysis machine, either in the hospital or at home.

In many industries it has been possible to eliminate various stages of the value chain through rationalization. There are countless examples in everyone's everyday life. We pay our bills through online banking. Amazon and other e-commerce companies have rearranged the roles of customers, suppliers and middlemen. Digital services and free newspapers have revolutionized the media landscape.

Many traditional industrial firms such as Ericsson, Scania and Sandvik are increasingly selling services rather than just products. In many cases the trend has gone so far that it hardly makes sense to draw a distinction between service and product companies.

Services differ from products in a number of respects. Services are intangible. They can't be stored, but in many cases they can be digitized or automated (as with Spotify or an ordinary ATM withdrawal).

Unlike products, many services require customers' participation to produce. Some web services such as Facebook and YouTube are completely built upon users' participation. Nor is the concept of "services" entirely uniform: there are many different types of services, more or less knowledge-intensive and more or less labor-intensive.

Healthcare is an extremely service-intensive business. Whether it is care or surgery that is being provided, we must regard the healthcare sector as a service industry. On the other hand the situation in the healthcare sector is different than in the competitive markets described above. While medical

progress has made great strides over the years, the level of innovation is relatively low in the entity that delivers the medical treatment to patients.

Therefore healthcare can learn from customer-oriented, innovative service businesses. There are interesting examples of regulated and not entirely customer-oriented industries that became both customer-oriented and innovative after deregulation.

Two industries of interest for purposes of comparison are mobile telephony and passenger aviation. Around 20 years ago both were completely regulated industries dominated by national monopolies, often in the form of state-owned companies. Many people remember the large clumsy mobile phones of the 1980s. Owning and using a mobile phone was an unattainable luxury for the very few. Many financial yuppies did their deals on an Ericsson Hotline 900 Pocket, a phone that weighed 600 grams, had 30 minutes of talk time and cost SEK 30,000 in the monetary value of the time.

In 1990 there were 10 million mobile phone subscriptions worldwide; today it is estimated that 45 percent of the world's population, or three billion people, are mobile phone users. Technical innovation combined with new business models have made it possible for most people to own a phone with technical performance that is vastly superior to that of the 1980s, for a fraction of the cost.

The market for telephony services has been completely revolutionized in the same way. The pricing of the previous monopolies had no connection with customer value (or with production costs for that matter), but since pricing became unrestricted the market has seen an explosion of new products and services, while the prices of voice and data traffic are constantly falling.

The deregulation of domestic aviation in both North America and Europe has likewise produced an extremely competitive market for passenger flights. The exclusive airline flights for a small number of travellers seen in the past have been replaced by today's discount fares for the mass market, where people can get around within Europe or the US for the equivalent of a few hundred Swedish kronor, an amount that was completely inconceivable fifteen or twenty years ago.

For the old producers, the national airlines, it's been a painful process. Many of them, such as Swissair and Sabena, didn't survive the change and went bankrupt. Others are still in the market but have great profitability problems even after a comprehensive restructuring process.

At the same time the market for discount players has grown. Ryanair not only eliminated airport lounges and "free" alcohol on flights; above all they have a different business model. Many of the

discount airlines that started up over the years have not survived, but the total effect of discount air travel's entry into the market is huge gains for customers.

In many ways the healthcare industry in Sweden and other European countries is reminiscent of both of these industries before deregulation. In purely medical terms the services are high quality and the technical standard is high. However so far the customer is still in a weak position. As we have seen there are great shortcomings in access, which is seen in queue systems and long wait times that would be unthinkable in many countries. Customers, in the sense of patients and their families, have limited influence on how resources should be used – and therefore they are in a weak position that favors the "proxy" customers in county council politics and the healthcare bureaucracy. Instead customers must convince politicians of the value of producing the particular services they are demanding.

The common denominator for the new companies (invaders) that have transformed former monopoly industries is that they succeeded through an in-depth understanding of what creates value for the customer, enabling them to create offerings that differ dramatically from those of competitors. Quite simply they dared to define the industry and the value it creates for customers in a different way than the traditional players. While the traditional players have had an inward-looking focus, the invaders have been able to find new creative solutions that are much more than just "low prices."

The invaders have often met with the same skepticism and opposition from the establishment that many private firms in the healthcare sector encounter today. At the outset the established furniture industry accused IKEA of not making "real furniture." It's not surprising that the established industry tries to defend itself against newcomers, but in the case of healthcare the new players are encountering stronger opposition since the established healthcare providers have such strong relationships with the political decision makers who determine both funding and the rules of the game in the market.

It is reasonable to assume that the new players will be the ones responsible for the greater part of future service innovation in healthcare. Certainly there are many innovative private healthcare companies today, and many have created new concepts and processes that have considerably increased productivity and improved customer orientation. But so long as the funding system remains unchanged and care consumers' demands have no impact on healthcare providers' revenues, the development of new services will be limited.

The process of development in the service sector is radically different from that in traditional industry. Instead of research and development (R&D) departments, development projects and prototypes, the view of innovation here is much more pragmatic. Service innovation is capital-efficient, it takes place in the business, close to the customer and close to customers, often in collaboration with them. When new companies break ground in established industries, it's often because they have identified previously unaddressed customer segments and customer needs. Discount air travel has expanded the market for passenger air travel to entirely new groups, especially among leisure travelers. Through its emphasis on high-quality classical music at low prices, the Naxos record label has reached new audiences far beyond the traditional circle of listeners. There are more examples.

In other words service innovation is driven by understanding of customers' needs and what creates value for customers and their customers. The customer must be treated as just that, a customer who has the right to place demands and expect value. This is a challenge for the healthcare sector, which up to this point has rarely had to think along these lines, but rather where a strongly production-oriented industrial mindset still predominates – a mindset that was left behind a long time ago in many parts of industry.

If the healthcare provider can't alter its revenues by developing new services, but is instead directed toward revenues established through the political process, the range of services will be uniform.

In this case the pressure that several competing funding sources would create is also missing. This is an argument against a system that is fundamentally a planned economic system, such as Swedish government-funded healthcare, being able to achieve any significant development of new services. Quite the opposite, a somewhat cynical observer might say. Why take the trouble to listen to customers and develop new services when there are waiting lines for many of the services that already exist?

The healthcare of the future – a new growth industry?

How would breaking up the funding monopoly and having more sources of healthcare financing change this situation? Of course that depends on how the system is designed, which is a question beyond the scope of this report.

However we can assume that a reformed system for the funding of Swedish healthcare would still contain an element of taxpayer funding, supplemented by some sort of private, probably mandatory insurance solutions.

We can also assume that this system would contain important components that guarantee access to care regardless of income as in the Netherlands. It should likewise mean the equalization of risk for the chronically ill, for example by insurance companies being prohibited from denying insurance policies to the chronically ill, but in return being compensated by the government for the higher risks entailed in having the chronically ill among their policy holders.

Above all an important distinction should be drawn between healthcare provider and funding source, roles that today are largely both held by the county councils. This would mean that the strong link between healthcare providers and the proxy customers in the political system would be weakened.

Healthcare providers would probably have stronger incentives to organize care in a more patient-centered way, since the individual would have more influence over how resources are used. One prerequisite for new types of financing to yield more efficient and more patient-focused care is an increase in the share of private healthcare providers. Today about one-tenth of the healthcare business is privately run, a share that needs to rise sharply if it is going to be possible to realize the potential for efficiency and innovation that more open financing brings. Already the diversity that comes from letting private players compete with public healthcare providers has been shown to drive the development of new processes, methods and management concepts leading to higher productivity and lower costs, while maintaining or improving the quality of care.

New opportunities for the development of services: some examples

With a different healthcare financing mechanism, customers' preferences and demands will have a greater impact on what is offered. This will provide stronger incentives for renewal and development, of both healthcare providers' internal work processes and their service offerings.

Does this mean that we will automatically see an explosion of new services and offerings that rapidly transforms the supply of healthcare?

The evidence suggests that to the contrary it will be a long-term evolution. The transformation of the healthcare sector to a health industry will take time. This is supported by developments in many of the other service industries that have been deregulated in recent decades. It took time for gains from deregulation to show an impact in the form of new services and lower prices for customers. In addition, in the case of healthcare a crucial part of the private funding will take place through insurance. Thus the new services that emerge must be able to meet "insurable" needs, i.e. a line of business for the insurance companies must be part of the picture.

Nonetheless the diversity of funding sources ought to result in customers' power being strengthened. One clear example is the Netherlands, which introduced a new healthcare funding system based on private mandatory health insurance in 2006. In the first year after the reform was implemented, 20 percent of the Dutch changed insurers, which is an exceptionally high proportion. Now the percentage has declined to around 5 percent annually, but it's clear that customers appreciated their new power as consumers, which also resulted in significant downward pressure on premiums.

Healthcare services are often complex by nature. Offering skilled medical services often requires coordinating several different professional specialties. Another restraining factor may be that customers aren't accustomed to requesting services in health care. Especially in a market like the Swedish one, where medical care is still often regarded as a free benefit, consumers aren't used to playing the role of customer. This means that the emergence of new services can be slow in the beginning, and then pick up when customers have gotten used to new behaviors.

Finally of course there is an information problem for healthcare consumers who are usually not experts – even if there are exceptions among well-educated patients with chronic illnesses. Healthcare providers will still have a knowledge advantage, and with more healthcare providers and non-standardized services, things will not be more transparent to healthcare consumers, at least not in the beginning.

What kinds of services might be relevant in practice? In some places there is a caricature where private elements in healthcare funding would create luxury services for the wealthy few, while the majority of customers would have to make do with financially undermined and increasingly lean public care. The experience of the Netherlands says otherwise. Here we will list several areas that should be of interest for the development of services, based on an assessment of where there are important unmet customer needs.

Shorter queues and greater access

With regard to opportunities for service development in the short term, the job is to identify which critical customer needs are not being met today within the framework of government-funded healthcare. Where can unmet customer needs be met?

Without taking a position on the exact design of a future health insurance system, we can state that it will in all likelihood be a mix of private and public funding, with insurance accounting for the bulk of the private portion. It's also reasonable to believe that this insurance would largely be linked to employers. This means that the demand for services will largely be driven by employers' need for healthy, productive employees with a high rate of attendance.

At the same time a system of mandatory health insurance means that a person who becomes unemployed or changes employers does not risk being left without health insurance. To the contrary, it’s quite reasonable to think that attractive health insurance benefits will be an important factor in competing for the workforce of the future.

It’s clear that the most important of these needs is access – the ability for people to receive non-emergency care on a timely basis. There is already a market for private health insurance here. As already mentioned, today approximately 400,000 Swedes have this type of insurance, the majority of them (eight out of ten) through their employer.

Insurance companies can attach to these services others that are directed to employers, for managing the sick leave reporting process, rehabilitation etc., which make things easier for employers and also provide financial incentives for improving employees' health and reducing risks at work. These types of services already exist in the Netherlands, and are offered by companies including the insurance company CZ, which is one of the largest in the country with three million policyholders.

CZ's offerings include integrated corporate services for reporting someone sick, healthcare and rehabilitation, which makes these things easier for employers to deal with and also helps cut costs. Services are likewise offered in the area of preventive care, for example programs that help employees lose weight, while employers can be reimbursed for the costs of employees' treatment for obesity.

The value of insurance that reduces wait times and clearly improves access is easy to measure. Experience shows that it's possible to offer attractive insurance policies in this area. Services that improve the quality of care in various ways are more difficult to design and evaluate, so they will probably be developed more slowly. For employers this may be an important way to reduce costs for sick leave, especially if it is desirable in the future to build incentives into the social security system that make it profitable to get people back into productive work quickly. Here we can see that a reform of healthcare funding could have rapid practical significance. More sources of funding, combined with greater power for healthcare consumers, would mean that currently unmet demand (in the form of wait times) would be met by new services.

Medical tourism – an industry of the future?

The potential to receive medical care abroad has existed for several years. Swedish citizens can find care abroad and be reimbursed afterward by the Swedish Social Insurance Administration. According to the Swedish Social Insurance Administration, in 2008 1,264 people were reimbursed for planned medical care abroad. The largest group, approximately 40 percent, chose to receive medical care in Finland. Many of them are residents of Norbotten province living close to the Finnish border. Other countries to which people travelled for care are Estonia, Poland, Spain and Germany. Over 50 percent of the approved cases were for dental care. Treatment of joint and muscle diseases and eye diseases is also common.

Today there are already companies, such as Fecit in Uppsala, that offer solutions for private citizens to utilize medical care in other EU countries, especially Germany. Like the county councils, Fecit has a "healthcare guarantee" that means that patients will receive treatment within a month of their first contact.

Many countries, especially the US, currently have well-developed offerings for so-called medical travel, or medical tourism, which mean travelling to another country to receive medical care. The purpose is to receive high-quality care at a lower cost than at home. Destinations include places in Asia and Latin America. Similar services are found in the UK, which like Sweden has serious problems with access to public healthcare.

It's reasonable to think that future insurance offerings will increasingly include medical care abroad if the care cannot be offered in Sweden. The insurance companies have an interest in gaining access to healthcare resources for their customers if necessary, even outside Sweden.

One interesting example of the development of services for care in another EU country is **Ten$_4$Health**, a project that aims to develop a web-based service package to facilitate cross-border medical care within the EU. The tool will include things including information in the patient's native language about where and when treatment can be provided, information about insurance status and electronic reimbursement processes. Ten4Health is operated by three insurance companies (including the Dutch company CZ) and eleven hospitals in five member countries: Austria, Belgium, the Czech Republic, Germany and the Netherlands.

A more secure old age

Another area with visible potential for the development of services is eldercare. The number of senior citizens will rise in the future, especially as the large generation born in the 1940s becomes older. The senior citizens of the future will be richer and healthier than any other generation of retirees. They will place demands on the healthcare and service that they receive in their old age, demands that government-funded healthcare will likely have a difficult time living up to.

In the first quarter of 2009 the Association of Private Care Providers' Healthcare Indicator showed significant concern among many people born in the forties, especially women, about care of the elderly. According to the indicator 73 percent of women and 65 percent of men are concerned about geriatric care in the future. Expectations for future geriatric care are also low: nearly half (47 percent) of all of the respondents believe that they will receive worse geriatric care than previous generations.

At the same time there is a strong commitment to freedom of choice: 90 percent of the women and 82 percent of the men state that it's important to be allowed to choose their eldercare. With regard to the quality of care, the top priorities were security and the ability to live with one's spouse or partner. On the other hand "extra" services such as movies, spas, activities and other things received low priority in the survey.

Today the time spent in geriatric care is relatively short; the average time spent living there is no more than about a year. Therefore geriatric care is care-intensive.

Many people will want to keep living at home, perhaps buying household help services as other people do. Others will demand residential living with a higher service level than the senior housing of today (ordinary rental or condominium apartments with communal facilities, such as SEB's BoViva and the JM group's Seniorgården), which is not as care-intensive as geriatric care.

It's possible to imagine several solutions for eldercare; one is linking future pension savings to various types of insurance solutions for housing and service after retirement. One option being discussed is geriatric care insurance, which has existed since 2000 in Japan, a society where care of the elderly is traditionally the job of the family. The objectives of the reform are to make eldercare a right for everyone (which it was not in the past), give customers freedom of choice and stimulate the expansion of eldercare through competition.

Greater knowledge and better evaluation

One of the areas where the development of new services is proceeding most rapidly is tools, often web-based, that make it easier for customers (such as patients and their employers) to find information on various illnesses, treatments and care options. As individuals themselves are taking increasing responsibility for their health, the demand is growing for relevant and understandable information on illnesses and treatments options, as well as lifestyle issues and preventive measures.

Likewise new services are growing in countries including the US and the Netherlands that compile information on the quality and costs of various care options. These services facilitate consumers' choice of providers, and they are driving increasing competition between providers by increasing market transparency.

These services are relatively common in the US. One example is **Optum Health**, which offers clinically reviewed information and tools for customers to work on their health and lifestyles themselves. Like

other similar services such as WebMD.com, Optum Health does not offer medical advice, treatment recommendations or drug prescriptions. It is rather a way for customers to increase their knowledge on their own.

Teladoc provides its customers with advice over the phone, 24 hours a day 365 days a year. Ordinarily the patients receives a call from a doctor, usually with 40 minutes of the first call. Teladoc connects customers with qualified primary care physicians who can make diagnoses, recommend treatment and prescribe medications over the phone. The physician refers the patient to a specialist if needed. Teladocs' physicians primarily treat simple illness that are not urgent in nature, such as respiratory infections, allergies and urinary tract infections.

Best Doctors is an international company with over 10 million members in 30 countries. It has grown into a leading player in the medical information field since its inception in 1989. To put it simply, Best Doctors' business model is to provide second opinions from leading specialists in different countries.

Unlike the web-based services mentioned above, Best Doctors focuses on providing its members with advice on serious illnesses such as lung disease, cancer and kidney disease, or neurological diseases such as Parkinson's. Best Doctors' services are intended to be a guiding and supporting supplement to the opinions of patients' regular physicians.

Best Doctors has access to 50,000 leading specialists in approximately 400 specialties worldwide in its database. Once a member contacts Best Doctors with questions about their illness and how it should be treated, a compilation of their medical information is prepared, which is then sent to the physician who is to provide the opinion. After the doctor has analyzed the material and given his or her opinion, the member (and their doctor) receives an answer to their questions via Best Doctors.

HealthGrades is the leading company in the US in the ranking and grading of hospitals, nursing homes and doctors. Their website, www.healthgrades.com, contains quality rankings and cost data on 5,000 hospitals, 16,000 nursing homes and 650,000 practicing physicians in the US. Their website receives approximately 5 million unique visits a month. Customers can also buy reports on various healthcare providers, with detailed information on qualifications and treatment outcomes. HealthGrades publishes studies in areas such as clinical results, patient safety and women's health. Every year they rank the 50 best hospitals in the US, and also give awards for the best patient relations and customer experience.

Aetna Insurance's DocFind is a similar service, where customers can search for specialists with good medical outcomes and compare quality and costs.

The Dutch insurance firm CZ has a web service that lets customers search for healthcare providers (such as hospitals or doctors) and contains a database of information on wait times and medical quality. CZ also works with Best Doctors so that they can offer their customers second opinions.

This service is an example of how insurance companies' increasing influence in the Netherlands has improved competition among healthcare providers, while also generating new ways to measure and report efficiency and healthcare outcomes. It's clear that the new funding system is gradually generating greater interest in the measurement and evaluation of healthcare outcomes.

One of the purposes of the reform is to increase efficiency, through measures including enabling medical funding sources to find healthcare providers through a competitive procurement process. This in turn has caused the insurance companies – as in the example above – to stipulate higher demands for the reporting of results and costs from healthcare providers. Up to this point the cost aspect has been the most important, since price competition between the funders is intense and policyholders' choice of insurer is primarily determined by price.

Meanwhile quality aspects are having increasing impact. One important player is the Miletus Foundation, which was founded in 2006 and is jointly owned by the major insurance companies – who represent roughly 90 percent of Dutch policyholders. Miletus has developed the CQ Index – a standardized method of measuring customers' perception of quality in medical care – which is primarily used as a tool for insurance companies in the healthcare provider procurement process. The CQ Index is also used by healthcare providers and patient organizations.

As the market matures, and both the insurance companies and their customers become better informed and new behaviors are established, the quality aspects and access to relevant evaluations become increasingly important. Here the expertise of the insurance companies that procure healthcare services plays a critical role, since they have better opportunities than customers do to identify differences in quality and place higher demands on the healthcare providers. Therefore the Dutch funding system, which is pluralistic, creates clear incentives for the emerging outcome and quality metrics to have a greater impact in the marketplace as well.

"Primary care stores"

In the US there is a growing selection of accessible low-priced primary care where customers can quickly get help with the diagnosis and treatment of common ailments. The staff are primarily nurses who are able to make diagnoses and offer treatment through cooperation with nearby hospitals and doctors' offices. These "primary care stores" are often located in shopping centers or large store chains, and they are often open for long hours seven days a week.

Today there are more than 1,175 of these clinics in the US. Over 270 of them opened in 2008. Most of them belong to the large chains Rediclinic, Take Care or MinuteClinic. Of course the value for the customer lies in easy accessibility and time savings. By developing these quality-assured concepts for standardized diagnoses and treatment of relatively common ailments, companies can offer healthcare consumers an alternative to hospital emergency rooms, which entail higher costs in terms of both time and money.

Tailored services

One interesting opportunity that arises with more open funding of healthcare is that various services and offerings can be more clearly tailored to different audiences. One opportunity is greater hospital specialization, but also greater specialization in the insurance industry. This also results in the possibility that healthcare can become patient-focused in its true sense: a group of services and competencies can be connected to patients with special needs.

For example in the Netherlands there are currently specially designed insurance products for chronically ill people such as diabetics, containing comprehensive care plans with various preventive and health promotion measures along with traditional care.

In the Netherlands there is another interesting example of a company that clearly addresses a particular group, namely Care for Women. The company was founded in 2000, and has gradually evolved from a concept for menopausal women to serve women of all ages. It has contracts with all of the insurance companies in the Netherlands.

Care for Women is a franchise with around eighty nurses who are franchisees. They offer their customers information, counseling and coaching in the areas of preventive care and healthy

lifestyles. In cases where customers need more skilled care they are referred to other healthcare providers.

Care for Women has developed different service concepts for women in cooperation with researchers and physicians: for a worry-free pregnancy, a secure childhood and enjoying menopause. For the company's partners in medical care and the insurance industry, this partnership has meant a greater customer orientation and clearer focus on women's needs and questions in healthcare. In the Netherlands – as in other countries including Sweden – there has been a debate about healthcare's inadequate response to women, and how women's needs are not sufficiently addressed.

The website www.careforwomen.nl contains information and various offerings such as the "Care for Women Card" that provides attractive discounts on products and services from several corporate partners.

Integrated programs for the chronically ill

One challenge for many chronically ill patients is that the illness runs a long course, requiring different measures at different stages. For many of these patients, the issue is being able to live a normal life with good quality of life as much as possible, while others are in a more difficult situation and the focus is on treatment.

One interesting opportunity that is now being developed in places including the US is an integrated program for patients with chronic illnesses. Earlier this year In 2010 United Healthcare launched the first health plan of its kind for diabetics, a program designed to reduce costs and give patients the ability to take control of their situation and prevent, or at least delay, the dangerous complications that can ensue when the disease gets worse.

The plan includes measures such as reduced costs for policyholders (or their employers) for medications and medical supervision. Patients on their part commit to follow a program that entails checking their blood sugar regularly, doctor visits, preventive screening and counseling on lifestyle and behavior.

The background of the program is that two thirds of the 24 million diabetics in the US don't follow their doctors' advice on preventing and treating the disease. The key of the program is partly detecting diabetes as early as possible; and also enabling patients to get involved in controlling their disease and improving the quality of their lives.

So far this service is relatively limited in scope, but it shows the way for how similar services could be designed in the future. This means that the focus is moved from medical procedures and medications to the patient's situation and their health/quality of life. The patient is involved as a co-producer, and the supplier shares the gains from innovation with the patient/customer.

SHL Telemedicine – Israel, Germany and the USA

SHL Telemedicine is an Israeli firm that also has operations in Germany and the US. SHL uses advanced telemedicine technology to help its customers achieve better health and quality of life. The company specializes in developing and marketing advanced online services based on telemedicine systems. SHL currently has 75,000 members, primarily with heart disease, high blood pressure and respiratory diseases.

SHL has developed several telemedicine services that mean that customers are able to use sensors to measure their physical condition: for instance EKG, blood pressure, weight and lung function. The information is sent from the patient's mobile phone to Monitoring Centers that are open around the clock, where trained medical staff have access to the member's medical data and can use the data and real-time measurements to provide counseling and support, or even make sure an ambulance is sent.

In Israel they also have a mobile intensive care unit consisting of several private ambulances equipped for intensive care with a doctor and paramedic aboard. Approximately 15 percent of all calls to the Monitoring Centers result in an ambulance going out.

A Swedish health industry – the next export success?

In the longer term, if there were more funding sources it should be possible to increase the prospects for creating an internationally competitive Swedish healthcare industry.

Our starting point here is that what is currently regarded as a bit of an industry in crisis has the potential to be transformed into a successful service industry that could have as much importance to the Swedish economy in the future as many of the industries that we've counted among Sweden's most important industries for a long time.

The Swedish healthcare system has great potential to become such an industry of the future: Sweden is a prominent industrialized country with world-leading knowledge in medical technology,

pharmaceuticals and medical care. Several Swedish medical companies, not least Capio which is one of Europe's leading private healthcare companies, are already performing well in foreign markets.

The problem is that the industry that produces healthcare is locked into a system that organizes production according to large-scale industrial principles. The system is not organized for a future where the possibilities for custom-tailored medical treatments are increasing and customers (patients) will have ever higher demands for service, flexible solutions and to be treated as individuals.

For this to happen, it is necessary to leave behind the industrial mindset that characterizes the healthcare sector today. In slightly simplified terms, you could say that the business concept of healthcare is to provide medical treatment in a supply-driven and rationed market.

Production has a strong monopolistic element, and is often organized in so-called large hospitals, which is rational at least in theory from the owner/funder's (i.e. the county council's) perspective, since it is possible to streamline costs, combine units, avoid duplication of work etc. On the other end it has turned out that the trend toward large-scale units has generated problems: they become bureaucratic, inflexible and harder to govern while diversity decreases and it hardly becomes easier to conduct patient-focused activities.

In a report to the Swedish government's Globaliseringsråd (Globalization Council), Professor Gunnar Eliasson has outlined how such an export industry could emerge. In Eliasson's opinion one fundamental prerequisite is to allow a greater role for private insurance solutions as a supplement to public funding. The basis for the transformation of healthcare from a sector in crisis to an industry of the future is to define who the customer is and what the product of healthcare is.

According to Eliasson, in the future the product of healthcare shouldn't be medical procedures, but rather treatment outcomes in the form of a definitely improved state of health. Of course this product is more difficult to measure and define – complications can occur, etc. But this transformation is basically about giving healthcare more responsibility for creating health outcomes in cooperation with patients.

This will be possible in a system that includes insurance components, since the insurance makes it possible to meet customers' demand for good health. This value is not expressed at all in today's taxpayer-funded supply-driven system. Health is regarded as a cost, even if it actually has very high

value, both for the individual in terms of quality of life and for society in the form of more people having a greater capacity for work.

It's difficult to say today, before the market even exists, exactly which services would be developed by this sort of health industry. It's clear that there will be major opportunities for service development in that new diagnoses, treatment methods and medications will make more advanced and customized therapies possible.

Private money a necessary good?

Swedish healthcare faces several important challenges; perhaps the most important is to secure long-term funding as demographics, medical advances and rising living standards make increasing demands on resources.

Expanding the private element in healthcare funding is a way to cope with the future financing of a growing commitment to take care of an aging population. In this context the entry of private money is often described as a necessary evil. This description is unnecessarily negative; additional funding sources beyond the government would increase dynamism in healthcare and provide incentives for change and innovation.

A continued commitment to choice of care and freedom of choice within the framework of the government-funded system is a good start in creating a healthcare sector that achieves more and better care for the money and puts the customer in a stronger position. The value of this can already be seen today when private healthcare firms develop new concepts, models and methods. Greater competition and transparency make the use of the taxpayers' money more efficient.

However taking full advantage of healthcare's potential for development and renewal requires us to take another step forward. Perhaps the most important goal of this is to strengthen the healthcare consumer's position in relation to the healthcare provider, which would be facilitated if there was competition for funding as well. Experience from the Dutch healthcare reform, where one customer in five changed insurers during the reform's first year, indicates that this is the case. An array of new consumer-oriented services is also beginning to emerge in the market. What these services, some of which are presented in this report, have in common is that they demand somewhat different skills than those traditionally found in the healthcare sector.

New services require a new focus – and new incentives

If we set about creating a summary statement of the major opportunities in developing new healthcare services, much of it has to do with a new focus – a focus that is much closer to the customer/patient than it is today.

The traditional focus and skills of healthcare –medical procedures and nursing care – will continue to be important and to develop in the future. But this is not where the major challenges lie in transforming the traditional healthcare sector into a health industry.

It's possible to draw a comparison with other service industries that have been transformed and have grown, such as the airlines and mobile telephony. Being able to fly safely or connect calls correctly are still critical competencies for SAS or TeliaSonera, but they are not what drives success in the market for these companies. It is other things, such as the ability to provide service, package and market attractive offerings that customers want to buy, or organize production in a way that is both cost-effective and efficient for customers.

As we've also seen in the examples above, it is a matter of new services that tailor care to customers' individual needs, provide the customer with the right information and connect the various players and competencies needed to create value for the customer. It's about organizing care in a way that suits patients and makes things easier for them, which is already being applied here and there, such as in cancer care at the Karolinska Hospital in Solna.

It's also about services that much more clearly involve customers in production and give them greater responsibility for the end result, their own health. This may be customers "caring for themselves" with new technology, as well as prevention measures.

It's a challenge to connect traditional healthcare skills (ordinarily organized into medical specialties such as orthopedics, renal medicine and oncology) with "new" skills in distribution, customer focus, development of service concepts etc. These are areas that traditional healthcare has not focused on, and where there is consequently a lack of advanced professional skills.

This type of development must be supported by new incentives. The healthcare consumers of the future will place demands for a customer orientation, information and services in the care sector that are just as high as in other service businesses. This requires that the resources for healthcare can be utilized more efficiently and in a way that better reflects healthcare consumers' values. Competition in the financing stage stimulates the creativity and dynamism required for new solutions to be developed.

Service innovation is driven when both new and existing players violate the industry's established rules of the game in order to create new value for customers, something that is hardly made easier if there is only one funding source (in principle) – which also "owns" the dominant players in the market, the public healthcare providers.

The same is true particularly for new entrepreneurs and their ability to finance their businesses. If the market for private companies grows – and consumers' willingness to pay for care and health is mostly channeled there – investors and owners will take greater interest in these companies. More variety in the forms of funding would make a larger market possible, which could in turn finance the development of more services in order to increase healthcare's customer orientation and improve care consumers' health, quality of life and influence over their own lives.

Almost no one wishes for the Swedish healthcare system to be entirely market-financed in the future. Instead the future lies in a combination of public and private funding. The goal is to create a system that is economically robust and able to fund future commitments, is perceived as fair and contains incentives for renewal and development of both the organization of healthcare and work methods as new services.

This is the perspective from which the debate on healthcare funding should be viewed. The present ideologically charged -- and occasionally strident – debate needs to be followed by a more nuanced and pragmatic discussion about how future funding needs can be met while at the same time strengthening the position of customers and citizens.

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Appendix: New healthcare services

Aetna Insurance is an insurance company in Hartford, CT USA. Its DocFind is a similar service where customers can search for specialists with good medical outcomes and compare quality and costs: <www.aetna.com/>.

Best Doctors in London is an international company with over 10 million member-subscribers in 30 countries. It has grown into a leading player in medical information field since its inception in 1989. Best Doctors' business model is quite simply to provide second opinions from leading specialists in different countries: <www.bestdoctors.com/bd/uk/index.php>.

Capio in Gothenburg is one of Europe's leading private healthcare companies and is already performing well in foreign markets: <www.capio.se/en>.

Care for Women, Amersfoort, NL, provides information and various offerings such as the "Care for Women Card" that provides attractive discounts on products and services from several corporate partners: <www.careforwomen.nl>.

CZ Health Care Insurance, Tilburg NL, has three million policyholders and is one of the largest insurance companies in the Netherlands. The company has a web service that lets customers search for healthcare providers (such as hospitals or doctors) and contains a database of information on wait times and medical quality. CZ also works with Best Doctors so that they can offer their customers second opinions: <www.citrix.com/English/aboutCitrix/caseStudies/

caseStudy.asp?storyID=21359>.

Fecit EU Care AB, Uppsala, helps individuals utilize care in other EU countries: <www.fecit.se/>.

The Swedish Social Insurance Administration can provide reimbursed for planned medical care abroad: <http:// www.forsakringskassan.se/nav/310e4f475d46945fa9a96b712477501c>.

HealthGrades in Golden CO USA is the leading company in the US in the ranking and grading of hospitals, nursing homes and doctors. Their website contains quality rankings and cost information on 5,000 hospitals: <www.healthgrades.com/>.

MinuteClinic, Minneapolis, MN, one of over 1,175 chains in primary care store in the US, <www.minuteclinic.com/en/USA/>.

Optum Health, (Optimizing Health and Well-Being), Golden Valley, MN, USA, offers clinically reviewed information and tools for customers to work on their health and lifestyles themselves: <www.optumhealth.com/Home/>.

Rediclinic, Houston, TX, one of 1,175 chains of primary care stores in the US: <www.rediclinic.com/>.

SHL Telemedicine, Israel, is an Israeli firm that also has operations in Germany and the US. SHL uses advanced telemedicine technology to help its customers achieve better health and quality of life. The company specializes in developing and marketing advanced online services based on telemedicine systems. SHL currently has 75,000 members, primarily with heart disease, high blood pressure and respiratory diseases.

The Miletus Foundation, a foundation started in 2006 that is jointly owned by the major insurance companies – who represent roughly 90 percent of Dutch policyholders. Miletus has developed the CQ Index - a standardized method of measuring customers' perception of quality in medical care – which is primarily used as a tool for insurance companies in the healthcare provider procurement process. The CQ Index is also used by healthcare providers and patient organizations: <www.stichtingmiletus.nl/>.

Teladoc Medical Services, Dallas, TX, offers its customers advice over the phone: <www.teladoc.com/home.php>.

Ten$_4$Health (Trans-European healthcare support network for Europe's mobile citizens), Bonn Germany, a project designed to develop web-based service packages to facilitate cross-border healthcare within the EU.

Ten$_4$Health is operated by three insurance companies (including the Dutch company CZ) and eleven hospitals in five member countries: Austria, Belgium, the Czech Republic, Germany and the Netherlands: <http://ec.europa.eu/information_society/activities/eten/ cf/opdb/cf/project/index.cfm?mode=detail&project_ref=ETEN-046307>.

WebMD – Better Information, Better Health, New York, <www.webmd.com/ default.htm>.