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Diversity as salvation? – A comparison of the diversity rationale in the Swedish pharmacy ownership liberalization reform and the primary care choice reform

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ABSTRACT

Widespread liberalizing reform of the Swedish community pharmacy and primary care sectors took place in 2009–2010, including opening the market to private providers. One important rationale for the reforms was to increase diversity in the health-care system by providing more choices for individuals. The aim of this study was to increase the understanding how policy makers understood and defined *diversity* as a concept, and as a rationale for the reforms. The method used was document analysis of preparatory work and plenary parliament debate protocols. The results show that policy makers held vague and unclear definitions of diversity, which complicated its implementation. Diversity was sometimes seen as an effect of competition–a goal–while in other cases it was seen as a condition to be met in order to achieve competition–a means. Thus, policy makers viewed diversity both as a goal and as a means, making the underlying mechanisms unclear. The findings also revealed that policy makers failed to consistently demonstrate how the introduction of competition would lead to diversity.

1. Introduction

Diversity is a concept often used in health care to address the diverging needs of groups of patients, related for example to ethnicity, gender, socioeconomics, diagnosis, or sexual orientation [1]. Many governments in Europe have tried to increase diversity as an important means of adapting to consumers with varying health-care needs. Diversity in the provision of health-care services is intended to give patients the freedom to choose what is important to them. In practice, some consumers demand easy access to health services while others prefer a provider that is highly specialized or skilled in some specific way. Hence, diversity is not per se a goal but can be used to e.g. enhance health care outcomes (better health) or to satisfy different preferences (consumer satisfaction). It is thus important that policy makers are clear about what they want to achieve with increased diversity as different goals might imply different actions.

In this study, two Swedish health-care reforms in which diversity was among the main rationales are analyzed: the primary care choice reform [2] and the pharmacy liberalization reform [3]. The two reforms were proposed and carried out in 2006–2014 by the Swedish government, a coalition of four center-right parties. All four parties were in favor of the reforms. Both reforms were highly inspired by the new public management (NPM) movement [4][5,6] with the intent of increasing user participation and efficiency in health-care. Providing differentiated (diverse) services can be considered a way of increasing efficiency by providing higher quality for less money [7–11]. In Sweden, in contrast to many other countries, the NPM reforms have been salient also during the last decade, particularly within healthcare. NPM reforms have mostly taken the form of a marketization, primarily the introduction of competition. The main critique raised against the NPM reforms within health-care did not take place in Sweden until 2013 (i.e. after the reforms described in this article were launched). Since then the critique has increased exponentially, particularly among the medical professionals [12].

However, the goal of *diversity* does not seem to have been fulfilled. Most primary care centers and community pharmacies look the same and provide similar services after the reforms. This fact makes it interesting to investigate how policy makers viewed diversity, what they believed it would result in and how it would be achieved. Did they, for example, promote more diverse services in order to achieve better health outcomes? In this study we explore how policy makers at the national level formulated and made use of

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Table 1
Analyzed material.

Pharmacy reform	Primary care reform
Preparatory work	*Preparatory work*
Terms of reference, pharmacy reform, 2006:136	Terms of reference, Freedom of Choice Act, 2007:38
Official government report, pharmacy reform, 2008:4	Official government report, Freedom of Choice Act, 2008:15
Government bill, pharmacy reform, 2008/09:145	Government bill, Primary care reform, 2008/09:74
Plenary parliament debate protocols	*Plenary parliament debate protocol*
All parliamentary sessions 2005/2006–2009/2010	Protocol regarding primary care choice reform (February 19, 2009)

the diversity concept. How did, policy makers, for example, understand and define diversity in the preparatory work preceding the reforms? How was the concept of diversity used in relation to perceived problems and desired results; and why did the reforms not result in greater diversity?

The specific aims of this study were to (1) increase understanding of policy makers' actual definitions of diversity; (2) investigate if diversity was considered to be a goal or a means; and, (3) compare the diversity rationales of the two reforms.

1.1. Setting

Health care in Sweden is divided between 290 municipalities, which are responsible for the care of disabled and elderly people, and 21 county councils, which are responsible for organizing and delivering health-care services [13]. The Swedish health-care system is funded to a large degree by taxes [14] and covers most prescription medicines [15] and community pharmacy services [13]. Sweden has traditionally had a large public sector and high taxation that supported, for example, a state-owned pharmacy monopoly prior to 2009.

1.1.1. Primary care

Swedish primary health care is provided through primary care centers, usually consisting of 4–10 general practitioners and other health-care professionals [16]. The Primary Care Choice reform (hereafter, the primary care reform) introduced to patients the option of choosing a health-care provider. The Freedom of Choice Act, official government report (2008:15) *(LOV att välja – lag om valfrihetssystem)* [17] was written after a governmental investigation and resulted in two government bills [2,18]. These bills addressed a broad range of services, including primary, disability, and old-age care for people.

Besides introducing choice for the patient, the primary care reform also allowed any health-care company that met certain base requirements, set up by each county, to establish anywhere in the county. Furthermore, patient choice governed reimbursement to health-care companies [19,20]. This was a fundamental shift from a system in which primary care centers had been allotted a yearly budget by local governments. Today, 43% of the primary care centers are privately owned.

1.1.2. Community pharmacy

Community pharmacies in Sweden were owned by the state until 2009, following the governmental investigation [21] and government bills [3]. This pharmacy liberalization reform (hereafter, pharmacy reform) released ownership and establishment from state control, introducing competition between pharmacies. As a result, two thirds of existing pharmacies were sold to private owners, and no restrictions on establishment of new pharmacies was introduced [22].

2. Materials and methods

The method used in this study was a combination of inductive and deductive qualitative content analysis [23]. The material used is shown in Table 1.

Table 2
Categories and subcategories in the results.

Aim	Category	Subcategories
Diversity defined		
	Ownership characteristics	Kind of owners
		Size of companies
		Number of owners
	Specialization	Work content
		Communication
Rationales for diversity		
	For the patient	Freedom of choice
		Improved health
	For the personnel	Development of ideas
		Choice of employers
		Better working conditions
Diversity as a goal or means		
	Diversity as a goal	Competition → choice → quality → development of new ideas → diversity
	Diversity as a means	Diversity → development of new ideas (innovation)

In Sweden, committee *terms of reference,* written on behalf of the government, state the goals of a reform. The subsequent *official government report* is an investigation into how and whether or not the goals of the reform can be achieved. This report is reviewed by various organizations, including national authorities, county councils, and municipalities. Next, a government bill is drafted and referred to the Council on Legislation *(lagrådet).* After the Council on Legislation reviews the report, the government bill is presented to the Swedish parliament. Before voting, politicians debate the government bill. The preparatory work and plenary sessions of the Swedish parliament totaled 3929 pages for the two reforms (preparatory work 1792 pages and plenary sessions 2136 pages).

Relevant passages were identified by searching the material for the term diversity, related terms and synonyms (plurality, variation, innovation, rethinking, specialization, new ideas, and differentiation), and the term freedom of choice.

Relevant debate protocols on the pharmacy reform were identified by searching for the term pharmacy in all debates from parliamentary sessions during 2005/2006–2009/2010 [24]. All debates on the pharmacy reform and the written debate protocol for the primary care reform [24] were read in full, and relevant passages presented by the governing parties were included in the analysis. The government used diversity as a central rationale; therefore, only those arguments were included.

Data was first deductively categorized in relation to four specific aims: "Policy makers' actual definition of diversity," "Rationales for diversity," "Diversity as a goal or means," and "Differences between the reforms." Next, data was further (inductively) categorized into subcategories; see Table 2. Thus, the coding reflected both the a priori categories as well as unanticipated findings that were presented in subcategories.

The first author collected the data and made the initial analysis. The categorization was thereafter discussed in consensus meetings with all authors.

3. Results

First, we describe how diversity was defined in the documents, followed by the stated rationales for wanting diversity. Next, we present diversity as a goal or means. Finally, the diversity rationales of the two reforms are compared.

3.1. Policy makers' actual definitions of diversity

The first research question sets out to investigate policy makers' understanding of the concept of diversity. Two major understandings of the concept were identified: aspects related to ownership (size of companies, kind of owner, and number of owners) and service specialization.

3.1.1. Ownership characteristics

Kind of ownership, such as nonprofit and for profit, was one aspect to be varied in order to achieve diversity in the primary care reform. The reform "gives increased opportunity for small companies, nonprofit organizations/foundations, and cooperatives of different kinds to get into to the market" (Official Government Report, Freedom of Choice Act, 2008:15). This aspect of the definition was also prevalent in the plenary parliamentary debate.

Policy makers believed that difference in company size was important in achieving diversity. This was illustrated in the terms of reference regarding the primary care reform: "The proposal should support a diversity of companies, both regarding size and orientation" (Terms of reference, Freedom of Choice Act, 2007:38). The importance of attracting small companies to the sector (in addition to large ones) was also raised as a rationale in the preparatory work of both reforms.

Increasing the number of owners was stressed as an explicit goal in both reforms. "It is of paramount importance that the system is organized in a way that counteracts that a few actors should gain a monopoly-like position in the market" (Terms of reference, Freedom of Choice Act, 2007:38). The same argument is presented in the plenary parliament debate preceding the pharmacy reform: "We have been keen to assure that it should be a distributed ownership, that it shouldn't become an oligopoly" (Plenary parliament debate, Pharmacy reform, November 25, 2005).

3.1.2. Specialization

The other major understanding of diversity was that community pharmacies and primary care centers should become specialized either regarding work content or improved patient communication. In the material, all these measures were intended to attract new patients.

Work-content specialization is described in two ways: In the primary care reform, personnel in different units might specialize in a specific type of care of, for example, elderly people, or a specific disease, such as diabetes. "The hope is that the patients could choose a general practitioner with special knowledge of a specific disease that they recently got" (Plenary parliament debate, Primary care reform, February 19, 2009). In the pharmacy reform, on the other hand, the desired content specialization is expressed in terms of pharmacies focusing on the performance of specific tests and services: "[Pharmacies should] develop services like measuring blood pressure and control of diabetes, and what they want to do concerning life style changes" (Plenary parliament debate, pharmacy reform, April 29, 2009).

For communication specialization, companies might compete in the knowledge of a specific language or better communication with patients. This is illustrated in the preparatory work of the primary care reform: "It could even happen that some companies specialize; for example, it could be imagined that knowledge in certain languages could be a means of specialization" (Official Government Report, Freedom of Choice Act, 2008:15).

3.2. Rationales for diversity

Two major rationales were presented in the material: diversity for the sake of the patient, and diversity for sake of the personnel. Both rationales were seen as a transfer of power to patient and personnel, respectively.

3.2.1. For the patient

Two rationales were expressed in the material as to why increased diversity would benefit patients: Diversity would increase freedom of choice, and it would improve general health. These two patient-related reasons were not equally strong for both reforms. Freedom of choice was an explicit rationale in the primary care reform, and it was presented early on in the terms of reference: "Increase the freedom of choice and the power of elderly people, and people with disabilities" (Terms of reference, Freedom of Choice Act, 2007:38). The ability to choose, and to regret a choice and make a new one, is seen as utterly important to the patient. Diversity was thus seen as an important prerequisite for choice: Given more variation, people could enact their choices.

In the pharmacy reform, on the other hand, the freedom-of-choice rationale was not visible at all in the preparatory work. Still, this argument appeared in the Plenary parliament debate: "People are different, and it is a good thing that you can choose in different ways" (Plenary parliament debate, pharmacy reform, May 8, 2008).

The second patient-related rationale for diversity was to improve the general health of the population. It was stated in the preparatory work of the pharmacy reform that increased diversity would lead to a better use of medicines: "The community pharmacies should be encouraged to develop services and customer concepts that lead to better use of medicine and patient safety" (Government bill, Pharmacy reform, 2007/08:07). In the plenary parliament debate, it was explicitly stated that better health was a reason for the reform: "The bottom line is to make it possible for more people to use their creative resourcefulness in order to. . . make each and every one healthier" (Plenary parliament debate, pharmacy reform, May 8, 2008).

In the primary care reform, on the other hand, improvement of health was not included as a rationale for diversity. "The citizens could thereby, in an easier way, get their needs met." (Official Government Report, Freedom of Choice Act, 2008:15). The intent was that their needs would be better met when they were allowed to choose among alternatives.

3.2.2. For the personnel

Two major rationales were presented as to why reform would benefit health-care personnel, both of them related to a transfer of power from politicians to personnel.

First, the reform would make it possible for personnel to develop their own ideas and decide what would be the most rational use of resources. "GPs, nurses and everybody else in day-to-day health care. These people should be given more power over their work and power to develop themselves and the activity that we pay for collectively" (Plenary parliament debate, Primary care reform, February 19, 2009).

Second, the reform would make it possible for personnel to choose where to work and for whom, in other words, not only for public employers. Also, the reform was seen as a way to improve gender equality by making it easier for women to start companies. "A lot of people, especially women. .. look forward to being able to choose between different employers or. . . to start their own pharmacy" (Plenary parliament debate, pharmacy reform, April 8, 2008).

Table 3
Differences between the reforms.

Diversity defined
Ownership characteristics
- Size as presented early in the primary care reform
- Ownership form as described in the primary care reform
Specialization
- Knowledge in primary care centers, in the primary care reform
- Testing in community pharmacies, in the pharmacy reform
Rationales for diversity
Freedom of choice
- For freedom of choice in the primary care reform
Better general health
- A means to better general health in the pharmacy reform

The reform would also provide better working conditions in terms of both rationales above. Employees in private companies were found to be less sick and to believe that they had more power over their work. "The employees state that they have other incentives and opportunities to exercise influence on their working conditions in private companies" (Official Government Report, Freedom of Choice Act 2008:15).

3.3. Diversity as a goal or means

In the material on the primary care reform, diversity was seen both as a goal and as a means. Sometimes, diversity was an effect of competition—a goal—and at other times it was a condition that needed to be fulfilled to obtain competition—a means.

When diversity was a goal, competition would allow patients to choose the alternative of the highest quality, which would lead to the development of ideas (i.e., innovation) and eventually result in greater diversity. "The enterprise is through competition in quality stimulated to development and profiling, which is an incitement to greater diversity and efficiency" (Official Government Report, Freedom of Choice Act 2008:15). Yet when diversity was a means, it resulted in competition. "Create a diverse body of suppliers that the patient could choose between, which would lead to competition and improved quality." (Official Government Report, Freedom of Choice Act 2008:15).

In the preparatory work prior to the pharmacy reform, diversity in the sector was mainly seen as a way to stimulate new ideas. "To introduce competition in a sector is according to the government an effective way to achieve increased diversity." (Government bill, Pharmacy reform, 2007/08:07).

3.4. Differences between the reforms

Policy makers' actual definitions of diversity differed in the two reforms (see Table 3). Diversity through varied ownership, such as nonprofit organizations and cooperatives, was raised in the primary care reform. In the pharmacy reform, only the introduction of private alternatives was discussed.

In addition, the expressed desire for varied company size had been identified early on in the terms of reference of the primary care reform, while in the pharmacy reform; it appeared later on, in the government bill.

Another difference in the materials of the two reforms related to how work-content specialization was described. In the primary care reform, personnel would be focusing on different kinds of knowledge (e.g., specific diseases), while in the pharmacy reform, personnel would be performing different tasks, e.g. perform tests (e.g., blood pressure measurement).

The rationale for diversity also differed between the two reforms. Diversity in order to obtain freedom of choice was the primary goal throughout the preparatory work and debates preceding the primary care reform. Yet freedom of choice was only briefly mentioned as a rationale in the plenary parliament debate of the pharmacy reform.

One rationale for diversity in the pharmacy reform was an outcome of improved general health. It was discussed in the preparatory work of the pharmacy reform, but not mentioned in the primary care reform.

4. Discussion

The results show that national policy makers had two different understandings of the concept of diversity. The first understanding was that diversity meant that ownership characteristics should vary, such as the kind, size and number of owners. The second understanding was that diversity meant specialization in content of work. The results also show that policy makers framed diversity as important for both patients and personnel, and that the term was used both as a goal and as a means.

In practice, however, the two reforms studied here have not led to diversity in either of the two ways defined by national policy makers, that is, varied ownership characteristics and specialization of services. From having been a public monopoly, the Swedish health-care sector is a near oligopoly today, with privately owned pharmacies and primary care centers that are generally large and few, centrally governed owners (some of which are private), there are no clear specialization trends in the two sectors. Few pharmacies specialize, for example, on patients with specific diseases [25].

So, what are the other reasons for the lacking diversity?

First, the results reveal that policy makers had vague conceptualizations of the diversity concept. Diversity was seen as allowing companies of varying size and work-content specialization to establish. There were several rationales: Diversity was a patient's possibility to choose, or the personnel's ability to develop ideas and choose among employers; it was also intended to improve the general health of the population. According to Sabatier and Mazmanian [29], it is difficult to achieve successful implementation when policy goals are neither clearly formulated nor ranked.

Second, national policy makers stated that diversity and new ideas (i.e., innovation) would develop as a consequence of caregivers meeting patients. Competition, they stated, would make caregivers more prone to adapt to patient needs. This adaptation would lead to diversity and innovation. The potential effect of competition is similarly argued by public management scholars [4] (including NPM scholars) [5]. However, this mechanism is questioned by scholars such as Lægreid [30], who has found a lack of innovation in, for example, state agencies following this kind of reform. According to Windrum [31], this is because NPM reforms entail an increase in control systems that favor innovations initiated high up in the organization. In other words, they improve efficiency in the production of existing services rather than develop new concepts (i.e., work content) on the lower levels of the organization.

Third, since the reforms, most providers belong to large, centrally governed chains or companies with little or no freedom for local managers to deviate from central guidelines or instructions. NPM-inspired reforms are expected to lead to more power for managers to manage, but the experienced effects are the reverse [32].

Fourth, diversity was both discussed as a goal and a means. When diversity is described as a goal, competition and choice are expected to lead to greater quality and the development of new ideas, with diversity as an end result. But when diversity is seen as a means, it becomes a prerequisite for developing new ideas. Thus, it appears policy makers did not clearly determine whether diversity was a goal in itself or not; hence, it is unlikely that the reform was designed with diversity as a central goal.

These discrepancies may partly explain why these reforms do not seem to have led to greater diversity in ownership or the development of new ideas (innovation or specialization) in these Swedish health-care sectors.

Framing is a term used to describe how, in this case national policy makers, choose certain parts of reality to define a problem in order to reach underlying goals [26]. In politics, framing can be used to present a problem and a solution in a way that makes the problem seem central and the solution appropriate [27]. Regarding both reforms in this study there was no direct demand from the population for more diversity. Still, policy makers framed the issue in the following way: they identified problems (not enough innovation and specialization, not enough choice for patients, not enough possibilities for personnel) and came up with solutions such as privatization and diversity in ownership. In doing so, policy makers created an acceptable reason for carrying out the reforms. Hence, the reforms were mainly driven by ideological concerns. Thus, the reforms were introduced despite no perceived flaws in the sectors, and also despite evidence that this kind of liberalization would probably not lead to diversity [28].

The word "health" is mentioned only once in the primary care reform material [33], opening to debate the focus of health-care policy. In the pharmacy reform, increased diversity was more explicitly mentioned as a way to improve health—but discussion of *how* this was to happen is lacking, and policy makers did not specify how pharmacy reform should lead to better health.

Policy makers did discuss power transfer both to patients and personnel, but they neglected to include whether power should be transferred from personnel to patients.

When the power of choosing is transferred to patients, policy makers argued, it would favor the health-care provider of the highest quality. However, to make informed decisions about their health, patients need sufficient knowledge and insight of their illness and treatment options. This is a transparency not easily provided by the health-care system [31], and it can lead to the strongest or most well-articulated customers getting the best service [34], which could lead to greater inequity [6,35]. It could be argued, therefore, that the concept of diversity conflicts with one of the initial paragraphs of the Swedish Health Care Law *(Hälso- och sjukvårdslagen)*, in which it is stated that the whole population should be given health care under the same conditions [36]. Power transferred to patients may also lead to medical consequences, such as a patient demanding a certain prescription and threatening to go to another primary care center if it is not provided.

5. Conclusions

A major rationale of the two Swedish reforms in pharmacy and primary care was to increase diversity in each sector. The result from analyzing the preparatory documents preceding the reforms show that the policymakers had vague conceptualizations of the diversity concept. For example, diversity is seen either as a goal in itself or as a means to achieve innovation. Regardless of whether diversity is seen as a means or a goal, it is surprising that patient health was never in focus in the preparatory work or parliamentary debates on primary care reform. Instead, the debate mainly concerned ownership and specialization.

Conflict of interest

The authors declare no conflict of interest.

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