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Patients' reactions to free choice of hospital in Norway, Denmark and Sweden

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Introduction

Free choice of hospital is a new trend in Northern European health systems. The right to choose a hospital was introduced in Denmark and Sweden at the beginning of the 1990s and in Norway in 2001 and is currently being introduced in England on an experimental basis. This raises important questions regarding the functionality of choice in public integrated systems and the consequences for other policy goals such as equity, democratic planning and expenditure control.

The effect of choice will depend on reactions on both the supply and the demand side, i.e. the relationship between patients and the public health care system. In this article we will focus on the demand side. We argue that patient behaviour is a function of multiple factors including the regulative structure, the degree of variation in service and quality and the amount of information available regarding such factors, and the patients' perceptions and preferences. Therefore the institutional conditions for choice strongly influence its utilization.

We address two related questions: 1) What does the available evidence tell about changes in patient's behaviour after the introduction of choice in Scandinavia? 2) How are patients' behavioural responses to choice influenced by the institutional design in the three countries?

Answering the first question provides an initial picture of the reaction patterns and trends regarding choice, although there are significant data limitations in all three countries. The following definition is the starting point for our study: elective patients at the basic level of treatment that actively chose or were consciously referred to another hospital than the one closest to their home. The definition includes only elective patients and not acute care patients or patients referred to hospitals in other areas for highly specialized treatment. Due to data limitations we had to limit our study to patients who chose a hospital in another administrative region than the one they lived in. A strong trend towards merging hospitals and departments and centralization of interventions at fewer hospitals is rapidly reducing the relevance of in-county choice and creates difficulties in creating time series data of in-county choice activity over time.

The second question is based on the idea of institutions as important parameters that guide the behaviour of actors in social systems (Scott 1995, DiMaggio & Powell 1993, Campbell 2003). We will look at both regulatory and normative institutions (Scott 1995) and the broader conditions around choice. This translates into the following working questions: First, what are the formal rules regarding choice? Are there limitations or restrictions that may present barriers to choice? Second, is there a need for a free choice of hospitals measured on objective criteria such as variations in terms of service (waiting times), quality and treatment practice? Third, do patients and referring doctors have access to information on such variations? Fourth, which preferences do patients and referring doctors have? Are they interested in choice and what are the typical reasons for utilizing choice? Fifth, what are the economic incentives for patients and referring doctors? We will consider each of these issues below.

The introduction of policies that enhance choice in Sweden, Denmark and Norway is a new phenomenon in the health care context wherein elective patients traditionally were restricted to using the nearest medical facility. In a European perspective, the new right for patients to choose freely as they do in the Scandinavian countries must be considered far-reaching (compare for example with the UK case that is much more restricted, Goddard M and Hobden C, 2003). The new rights to choose can be interpreted as a gradual change of the Nordic health care systems towards a more demand-driven system, reflecting some of the elements in New Public Management (NPM) (Pollitt & Bouckaert 2000, Ferlie, Ashburner, Fitzgerald & Pettigrew 1996, Kettl 2000). However, the reforms have been introduced with several objectives in mind: a leveling out of waiting times, the introduction of competition for patients in order to promote quality of health care, and providing the patients with a freedom of choice as an objective in itself.

It is not clear from these motives what the criterion of success for freedom of choice should be. In order to level out waiting times it will probably be necessary for many patients to choose a distant hospital, but great utilisation may be viewed as an indication of strong dissatisfaction with some hospitals, while limited utilisation may indicate high patient satisfaction. The Nordic experience presents a unique opportunity to study patient choice and the hospitals' reactions to patient choice in a situation with little or no interference from user payments, no incentives for the GPs to refer to certain hospitals, and strong economic incentives for the hospitals to attract patients.

NPM arguments for introducing choice are based on the idea that signals from users may force providers to adapt their supply, service and quality to the patients' preferences. The preconditions for this are that providers actually have the opportunity to adjust their strategies and that patients (or referring doctors) have access to information and are able to interpret such information. Both preconditions can be questioned in public health care systems. However, NPM proponents might argue that the signaling effect and the mere possibility of "losing" customers might have an effect even when conditions are less than perfect.

What does the available evidence say about changes in patient behaviour in response to choice?

We use: (a) awareness of the choice option as our first indicator and (b) patient movement across administrative (regional) boundaries as our second indicator. Finally we look at the available data on (c) variations in use by gender, age, socio-economic status, diagnosis and geography.

a. Awareness of freedom of choice

Norway

In-patient awareness of their freedom of choice is relatively high (69%) and growing (Christensen and Hem, 2004, p. 30). The first years after the new Patients' Rights Act (2001) came, there were complains in the media about the low awareness of free choice of hospital. That led to comprehensive information activities from the government. For

example, the government introduced a national web site with information on free choice of hospital and a telephone number, which has toll-free information. An indicator of results of the effort is that in the first three months of 2004 there were 7700 individuals that called the number and this number is continuously increasing (www.helse-ost.no/nyheter 01.03.04-31.03.04). Even though the government has made many efforts to make information easy to reach, studies show that most people still become aware of their new rights from newspapers (32%), while information from GPs comes second with 18% (Christensen and Hem, 2004, p 30).

Denmark

Elective in-patient awareness of their freedom of choice is high and growing (81% in 2000 and 87% in 2004) (EfB 2001, EfB 2005). The awareness differs by specialty and is the highest among patients referred to medical or departments of ophthalmology, to departments of otorhinolaryngology, or to outpatient clinics of rheumatology or orthopaedics. It is the lowest among patients referred to geriatric departments and among parents of children referred to paediatric departments (EfB 2003).

Sweden

Four times a year the Swedish Federation of County Councils (FCC) asks several thousands of people whether they know that they have the right to choose a hospital and only every second person (51%) agrees with this (Landstingsförbundet 2004). This share has been fairly stable during the latest years. Patients also have the right to choose a second opinion if they are seriously ill. The knowledge of this is also very low (Socialstyrelsen 2001).

In sum, the patients in Denmark have the largest awareness of their right to choose a hospital (80%), Norway following close with 69% and finally Sweden with 51%. It is interesting to see that the Norwegian figure is 69% even though choice was introduced almost a decade later than in Denmark and Sweden.

b. Utilisation of choice

In the following we will summarize the available evidence on utilization of choice in Denmark, Norway and Sweden. It must be emphasized that data availability is limited and that comparison across the three countries is complicated by differences in data definition and collection methods. Three problems are particularly important. First, national statistics (patient registers) in the three countries do not distinguish between true choice patients (as defined above) and cross-border movement as a result of referral to more specialized treatment, or due to agreements between administrative units. Second, national statistics do not register in-county and in-region choice, at least not in Denmark and Sweden. Health care is handled by different administrative levels in the three countries. The size and population differ significantly between the 15 counties in Denmark, the 21 counties in Sweden and the 5 regions in Norway. Norwegian data is sometimes based on county level and sometimes on regional level as will be apparent below. Danish and Swedish data are always based on county level choice.

Different attempts to overcome these problems for the three countries are presented

below, but overall this leads us to be cautious in comparisons and to focus on relative development trends rather than absolute levels.

Norway

In Norway studies exist of both cross-border patient movement and true free choice of hospital patient movement. A survey was made in order to identify how many of the cross-region patients were actually free choice of hospital patients and it showed around 50% (45% for 2003 and 52% for 2004) (Christensen and Hem, 2004). In NPR there were reported 93 000 elective hospital cross-border contacts in 2004. The number of true free choice of hospital patients consisted of 47000 hospital contacts in 2003 (almost 50% of cross boarder patients) (Christensen and Hem, 2004 p.3). The most common diagnoses using free choice of hospital are snoring, knee and hip operations. The number of users is low but increasing.

Huseby has made an analysis of cross border patient flows (not only true free choice patients) between different health regions and health enterprises from 1999 - 2002 (Huseby, 2004a). The analysis shows that patient export between health regions increased by 33% from 1999 to 2002, that is an increase of 22 000 visits (Huseby, 2004a p.2-3). In 2003, almost 125 000 in-patients and more then 400 000 bed days were conducted outside the patient residence area. Approximately 10% of all outpatient treatment and 20% of all elective indoor patients were done outside the patient residence area (Huseby, 2004b).

Table 1 below shows to what degree elective patients (in-patients and out-patients) have used hospitals outside their residence region. In total, 93 424 patients were remitted to other hospitals. (see Christensen and Hem, 2004).

Table 1. Number of elective treatment (in- and out-patients) for patients crossing a boarder concerning from where they belong in 2004 (Christensen and Hem, 2004, p. 17)

Type	of	Nr of
hospital		patients
Region hospital		48 241
Central hospital		26 578
Local hospital		18 605
<i>In total</i>		93 424
Private		18 054

In the next table we show patient flow: within home counties, within health regions, and into other regions. In the period from 1999-2002 Norway had both a division by county and a division by larger health regions. This was changed in 2002 when the Health reform was introduced.

Table 2. Number of patients before and after the implementation of free choice of hospital. In- and out-patient with surgery diagnoses (source NPR, Kristiansen and Sunnevåg, 2003 p 19).

County	of	1999-2000	2001-2002
hospitalisation			
Within the home county		173 599 (83,7)	178 808 (77 %)
Within the health region, but not home county		17 707 (8,5 %)	22 357 (9,6 %)
Into other health regions		16 051 (7,7 %)	30 939 (13,3 %)
Total		207 357 (100%)	232 104 (100%)

The largest increase in use of free choice of hospital is for the private providers. This is particularly for the urban areas. In these areas there is an increased use of private providers from 4.6% to 13.3% of all elective cross-border patients in urban areas from 1999-2000 to 2001-2002 (Kristiansen and Sunnevåg, 2003 p. 20). Number of visits at private commercial hospitals increased by 180% from 2002 to 2003 (Huseby, 2004a).

Denmark

A study based on data from the NPR showed a growth in the share of non-acute patients treated outside their home county from 8% in 1997 to 11.3% of the patients in 2003 (percentage non-acute basic level patients treated in other counties in percentage of total number of non-acute basic level patients) (Ministry for the Interior and Health, 2005). This number includes some patients who had to be referred to a hospital outside their home county because the relevant specialty was not available there. Therefore the number exaggerates the share of “true” choice patients somewhat, but no better measure of choice across county borders is available. The share of patients treated in other counties is considerably larger in Zealand (including the Copenhagen area) than in Jutland.

Another study showed that in 2004, 49% of elective in-patients, who were aware of choice, chose the hospital by themselves, including the patients who chose a hospital in their own county (EfB, 2005).

Patients adapt quickly to changes in their freedom of choice: when three counties introduced freedom of choice in 1991, the number of in-patients and bed days reached a stable level within two years, while the number of out-patient visits rose for several more years, probably reflecting ongoing change in the provision of health care (Birk and Henriksen, 2003).

Sweden

So far relatively few patients have chosen care at hospitals in other parts of the country.

A new study from the National Board of Health and Welfare (NBHW) shows that the patient flows between the county councils in Sweden increased only marginally from 1998 to 2002. The care performed outside the home county makes up 5-6% of total care (Socialstyrelsen 2005).

Table 3, Number of hospitalizations outside the home county

Year	Number of hospitalizations outside the home county and total number of hospitalizations	Share (%)	Share of total costs (%)
2002	81 878 of 1 444 779	5,7	7,1
2001	80 206 of 1 459 562	5,5	6,7
2000	79 586 of 1 476 218	5;4	6,5
1999	75 956 of 1 478 984	5,1	5,9
1998	82 389 of 1 537 780	5,4	6,1

It is impossible to tell from these numbers how many of the hospitalizations abroad represent “free choice” as defined above. Approximately half of the hospitalizations in other counties are due to acute cases (43 percent). The other half is mostly due to elective in-patients (47%) provided to other counties short of capacity. A small amount is due to true “choice patients” who have, on their own, chosen treatment outside their home county. The utilization differs significantly by county. The counties of Uppsala and Västra Götaland in central Sweden receive the greatest number of patients from other counties, while Norrbotten in the North receives the smallest number of patients. To summarize the Swedish case, few patients chose a hospital in other counties and the number has only increased marginally since 1998. However, for some counties the introduction of choice has increased their costs considerably, e.g. many of the patients in Halland County have sought care in nearby Gothenburg, resulting in costs of 200 millions SEK a year (Landstingsvärlden 2004).

In summary, the available data indicates that the number of cross-border patients in Norway was 93 424 in 2004 and of these 47 000 were true free choice of hospital contacts. Up to 13.3% of Norwegian elective patients were treated outside their home region in 2002. Up to 11.3% of Danish elective patients at the basic level were treated outside their home county. The exact share is not available, but it can be assumed that the correct figure is somewhat lower. Sweden had about 82 000 (5,7%) cross-border (both elective and acute patients) patients in 2002.

More importantly we see that there is a slightly increasing trend in all countries. The number of elective cross-border patients increased from 8,5% to 9,6% from (99-00) to (01-02) in Norway. There was almost the same percentage of increase in Denmark from 8% to 10.5% from 1997 to 2002 by elective cross-border patients. For Sweden the number of both elective and acute cross-border patients increased from 5.4% to 5.7%

from 1998 to 2000. For elective patients this was only around 2,5%, which indicates that utilisation in Sweden is extremely low compared to Norway and Denmark.

c. Patients background as a variable for choice of hospital

Norway

Godager and Iversen (2004) showed in their study that the most important variable for using free choice of hospital is the patient's degree of education. In addition, Norwegian female patients are more likely than males to consider choosing a hospital. (Godager and Iversen, 2004)

Denmark

Danish studies indicate that gender, specialty, age and social background influenced patient choice, Findings that female patients are more likely than men to choose by themselves were not significant (Birk et al, prepared for submittance). Most studies of choice do not control for specialty or case-mix. Gender may act as a confounder for case-mix, because birth giving may take place at a large number of small hospitals, creating the impression that women are especially likely to choose small hospitals. Specialty influences patients' utilisation of choice, because the share of elective patients influences the opportunities to choose and may influence the preferences for short waiting time or short distance to hospital. In one study short waiting time was the most important factor for patients referred to departments of ophthalmology, orthopaedics or otorhinolaryngology, while short distance was the most important factor for patients referred to departments of surgery, internal medicine or gynaecology/obstetrics (EfB 2003). Patients aged 20-39 years are especially likely to choose the hospital by themselves. Insignificant findings indicate that unemployed patients were less likely to choose than patients with employment, and patients with a long education are especially likely to utilise their right (Birk et al, prepared for submittance).

Sweden

Few data are available on socio-economic factors and choice behaviour for Swedish patients: persons with high education are more likely to choose and younger people are more active in choosing than older people (Anell and Rosén 1995).

How can we explain the observed responses?

Utilization patterns for choice in the three countries may be explained by a number of factors. We suggest that the following may be particularly important.

- a. *Regulatory framework.* Choice may be hindered by rules limiting the right to particular groups or situations. Choice may also be hindered by costs for patients (travel costs, user charges etc).
- b. *There may be limited variation in service level (waiting times), quality and treatment offers.* If waiting times, quality and treatment regimes are the same in all locations there is no objective need to exercise choice.
- c. *Variations in service, quality or treatment regime will only lead to choice if patients*

and referring doctors have information on the variations. The availability of information is thus a crucial factor for explaining choice behaviour.

d. The normative environment, tradition and habits may influence choice behaviour.

Patients may prefer proximity to home and family in spite of documented variations in waiting times and quality. Patients may appreciate the opportunity to choose, but still prefer treatment close to home.

e. The GP plays an important role as provider and interpreter of information in all the three countries. The GP is a key factor by widening awareness of choice and in actually exercising the choice option.

We will address these possible explanations in turn in the following sections.

a) Regulatory framework

In this part we will describe the existing formal rules regarding choice in the three countries. We will describe the extent of the regulation and the limitations.

Norway

In January 2001, free choice of hospital was implemented in the whole country (Patients' Rights Act Ot prp nr 12 (1998–99)). Included in the Patients' Rights Act together with rights to assessment, and second opinion and rights to treatment, were right to involvement and information, right to approval to health help, right to take part in medical journal, special rights for children and patient representatives' agreement. In other words, it was not only free choice of hospital that was introduced but also a whole package of patient rights (Vrangbæk and Østergren, 2004).

On December 2nd 2003, the law chamber of the Norwegian parliament passed changes in the previous Patients' Rights Act (Besl.O.nr. 23 2003-2004). There were three major changes to paragraph 2-1 relating to patients' rights to specialized health care. The first constitutes that the specialized health care service is to determine a time limit in line with sound medical practice, within which the necessary treatment needs to be provided. Second, if the regional health authority (RHA) responsible for the patient does not provide the necessary treatment within the time limit, the patient has the right to be transferred without delay to a private health care provider or to a health care provider abroad. Third, if the RHA not is able to provide adequate treatment at a Norwegian facility, the patient has a right to be administered the necessary treatment abroad within the time limit given.

The Patients' Rights Act is in other words a generous act for the patients. In order to use free choice of hospital the patient has to go through his GP to be referred to specialist care with regard to evaluation and treatment. The cost for the patient to get a referral is 15.6 Euros (125 NOK) during daytime and 26.3 Euros (210 NOK) in the evening. In addition the patient has to pay 27.6 Euros (220 NOK) each way in co-payment, while travel expenses are paid by the Regional Health Authority.

Initially the Act was deliberately misinterpreted according to the health authority, as

some believe. In media three different aspects have been discussed. First, the regions prioritized their own patients and it was not allowed to prioritize outside of geographic conditions. Second, public hospitals agreements with private providers. One health region, with many private providers, had a limit as to how many patients that could choose one specific private provider (a famous heart hospital). (Dagens Medisin, 04.11.04). Also, GP's responsibility has been discussed in media. Some GPs argued that it was not their responsibility to inform patients about free choice of hospital. Their reasoning was that it was too time consuming for them to advise patients about free choice of hospital.

Health regions that treat patients from other regions are usually compensated by 80% of average DRG-rates instead of the usual 60% average DRG-rates. In other words, is it financially more beneficial for the region to treat out-region patients then patients from their own region. The GPs' income is determined by capitation fees and fees-for-service paid by the county. The GPs' incentive to use "free choice of hospital" for their patients is to satisfy the patient and to keep the patient enrolled. Still, it is time consuming to inform patients about their free choice.

Denmark

On October 1 1992, the counties introduced freedom of choice throughout Denmark, and on January 1 1993, freedom of choice was introduced by law allowing the patients freedom of choice of public hospital at the lowest sufficient level of specialisation, if the receiving hospital was willing to accept them.

Fewer patients than expected utilised choice. Assuming that the limited utilisation was due to barriers to use, several governments extended patients' rights: by May 2005, elective patients are free to choose any public Danish hospital and a few hospitals owned by patient associations, if their GP (the "gatekeeper") finds indication for referral to hospital. The patient may choose any of these hospitals right from the time of referral and is free to change his/her mind later on. The choice extends to additional private hospitals and hospitals abroad if the patient is facing a wait of more than two months in the home county. The idea is to put additional pressure on the counties to maintain short waiting times.

Within eight days of receiving a referral the hospital must inform the patient about: the day of admittance, whether the hospital can receive the patient within two months, that the patient is free to choose another hospital, that the hospital must provide information about waiting times and patient volume at other hospitals, and the hospital must offer to refer the patient to another hospital.

Danish patients do not pay for visits to the GP, hospitalization or utilisation of freedom of choice except for travel costs beyond the nearest public hospital in the home county.

Counties who treat patients from other counties are compensated by 100% of average DRG-rates. When freedom of choice was introduced, the compensation was smaller, intended only to reflect the hospitals' marginal costs, to prevent rising costs in the

traditionally supply-driven sector (Vrangbæk and Beck, 2004). The counties are free to choose whether the revenue for choice patients should go to the hospitals directly or enter via? the county budget.

The GPs' income is determined by capitation fees and fees-for-service paid by the county. The GPs' sole incentive to recommend a specific hospital is to satisfy the patient in order to keep the patient enrolled, so the GP keeps the capitation fee. GPs may find that it is time-consuming to inform patients about their free choice.

Sweden

Several policies were introduced in Sweden at the beginning of the 1990s intending to enable patients to choose. This was a new phenomenon in the Swedish context wherein the patients had traditionally been restricted to using the nearest medical facility. Unlike the other Nordic countries, free choice was not laid down by law but adopted by the FCC in 1989. There was little political dispute about the issue, and all county councils, regardless of political majority, agreed on the proposal introducing free choice from the beginning of 1991 and entitling patients with some exceptions to seek care throughout the entire country at primary care centres and at certain hospitals or private clinics. In 2000, the FCC clarified and simplified the rules, updating the old recommendation and extending the policy. Many counties strongly opposed this revision. For instance, the four Northern (social democratic) counties found that they could not afford to pay for patients who chose care in other parts of Sweden. They also considered the policies to be unfair since only strong, young patients used them. After a heated debate the Swedish government threatened to legislate patient choice if the counties did not accept the revision. It was not until the summer of 2003 that all county councils accepted the new recommendation (Winblad Spångberg 2003).

The recommendation of free choice provides the patient with the right to choose the hospital or a specialist within the whole country, except for highly specialized care. Both private and public care is included in the recommendation. In a third (8 out of 21) of the counties, patients need a referral from a GP or a private physician to seek hospital care outside the home county. Patients from counties without an internal referral system only need a referral for inpatient care in other counties to prove that the care will be reimbursed by the home county.

There are no economic incentives for the GPs to refer patients to certain hospitals, the GPs never being responsible for the cost of referred patients. On the other hand, it may be time-consuming to inform patients about different caregivers and waiting times. How much the receiving hospital gets for admitting a patient from other counties differs among the counties.

Summing up, there are few formal hindrances for patients in all three countries to use their rights to choose hospital throughout the whole country. However, in all three countries patients need a referral. Norway differs from Sweden and partially from Denmark in the sense that the patient does not have to pay for transportation, which might be a considerable expense given the long distances in Norway compared to e.g. Denmark. Sweden is the most restrictive country; in some regions it has different kind of

restrictions, such as Västra Götaland that has discouraged its inhabitants from using their rights to choose by forcing them to wait six months before referring them to hospitals in other parts of the country.

Comparing the three countries we see that formal regulatory barriers on the demand side are limited. Explanations for the limited utilization must be found elsewhere.

b) Does variation in objective indicators of service, treatment patterns and quality indicate a need for choice?

Norway

Different profiles of the hospitals

Norway has an infrastructure with many hospitals. This means that the services differ between the hospitals. Even before free choice of hospital many patients moved to be closer to other hospitals since their nearest hospital did not have the necessary treatment or specialty. In addition, there are differences in ownership in Norway. There are three categories: nonprofit, profit and public. The majority are public hospitals, however nonprofit hospitals compared to the other Nordic countries are a rather large part. An assumption in relation to choice is that those hospitals can be more attractive to some patients as they often have a religious profile and in addition are often situated in nice areas. In other words, the nonprofit hospitals have a profile that can make them more attractive to some categories of patients.

Waiting time

Waiting time prognoses published every month show that there are differences between hospitals. The Norwegian Patient Register (NPR) has the responsibility for collecting and verifying patient data submitted by somatic and psychiatric institutions in Norway. However, it is important to be aware of the fact that all data mentioned are self-reported either by local health enterprises or by regional health authorities. The control function done by NPR is only on the registration process and not on the quality of the data in itself.

In Norway patients can choose either day care paid by the health region or day care paid by national insurance. Therefore, we show below waiting lists for both types of institutions (Table 4) and finally waiting time from initial examination to hospitalisation (table 5). We can see that waiting times differ markedly by hospital and by diagnoses. We have only found systematic variation regarding private hospitals that have the shortest waiting times.

Table 4. Average expected waiting times from GP referral to initial examination at category A* daycare (in weeks) June-2004, Average expected waiting times

from GP referral to initial examination at day treatment (in weeks) category B, June-2004

Cat A*	Average	Min	Max	Nr of hospitals **	Cat B*	Average	Min	Max	Nr of Hospitals **
Discus prolaps	14	1	28	49	12	1	11	11	
Knee replacement	13	2	52	44	-	-	-	-	
Hip replacement	10	1	40	52	-	-	-	-	
Cataract	14	4	50	8	13	4	24	24	
Varicose veins	16	2	60	51	13	1	52	52	
Hernia**	4	1	8	9	5	1	8	8	

* In Norway they differ between out-patient paid by health regions (category A - poliklinisk (daycare)) and paid by the National insurance (category B - dagbehandling (daycare))

** hospitals that has delivered data on this treatment

Table. 5. Average expected waiting times form initial examination to treatment (June 2004)

	Average	Min	Max	Nr of Hospitals
Diskusprolaps	12	1	32	39
Knee replacement	13	4	50	40
Hip replacement	11	3	26	50
Cataract	16	14	16	4
Varicose veins	21	1	156	28
Hernia	13	1	40	7

Finally, Kjerstad and Kristiansen (2005) show that patients using free choice of hospital wait an average of two months less for treatment compared to patients choosing the hospital closest to their home municipalities. This indicates that this is a reason to choose

a hospital.

Denmark

Waiting time

Waiting time prognoses published at least every three months indicate that large differences in waiting times for treatment at different hospitals persisted more than a decade after the prognoses were introduced.

Based on expected waiting times as posted on the official web site by the Ministry of the Interior and Health. The information on the web site is based on individual reporting from county hospitals.

Average figures are not adjusted for volume in each treatment facility. I.e. the figures do not necessarily present an accurate picture of how long the majority of patients can be expected to wait.

Table 6, Average expected waiting times from GP referral to initial examination at hospital (in weeks). First quarter 2004

	Average	Min	Max	Nr of Hospitals
Diskusprolaps	6,5	3	12	16
Knee replacement	7,2	1	30	36
Hip replacement	5,2	0	12	38
Cataract	9,8	1	42	19
Varicose veins	22,5	0	104	24
Hernia	5,5	0	52	43

Table 7, Average expected waiting times from initial examination at hospital to treatment (in weeks)

	Average	Min	Max	Nr of Hospitals
Diskusprolaps	6,5	2	14	16
Knee replacement	11,9	2	50	34
Hip replacement	5,2	0.0	12.0	38

Cataract	4,3	1	8	19
Varicose veins	15,4	3	52	24
Hernia	7,3	0	40	43

Based on expected waiting times as posted on the official web site by the Ministry of the Interior and Health. The information on the web site is based on individual reporting from county hospitals.

Average figures are not adjusted for volume in each treatment facility. I.e. the figures do not necessarily present an accurate picture of how long the majority of patients can be expected to wait.

Surgeons' indications

Small area variation analysis (SAVA) has shown differences between the indications at different departments and between surgeons: regional differences in use of caesarean section in two counties could not be explained by differences between the two populations or an increased rate of a single indication but were attributed to differences in obstetrical practice or expectations or demands from the pregnant women (Sperling et al., 1994).

Quality and service

Quality is measured in databases of clinical quality for a growing number of specialties and interventions (www.nip.dk). Yearly reports show that the results differ by department (The Danish Vascular Registry, 2002). Data on number of treatments performed at each department is published on a national web site as a rough indicator of quality.

Sweden

Different hospital profiles

The health care system consists of a primary care sector which employs GPs, nurses, auxiliary nurses, midwives and physiotherapists mostly working in private or publicly-run health centres treating diseases and injuries that do not require hospital care. More advanced health care is mostly provided in hospitals. In 1990 there were 89 emergency hospitals. By 2003, 76 hospitals (regional hospitals, central county hospitals and district county hospitals) provided somatic care to patients. During the 1990s the hospitals have become more and more specialised. Highly specialised care is concentrated in a few hospitals, while the majority of hospitals still perform the most common surgical procedures. The share of care provided by private health care provider increased considerably during the 1990s from a few percent to 10 percent, but there are still very few private hospitals.

Waiting time

In 2000, the county councils and the government launched a national database and web site on expected waiting times (for first examination as well as treatment) for about 23 different specialties, 7 diagnostic procedures and 23 treatments in elective care. The database is administered by the FCC. The database covers waiting times for elective

secondary care, i.e. hospital care and almost all hospitals report to the database. The figures are updated every month and the clinics are responsible for reporting changes. Some of the hospitals also report actual (retrospective) waiting times (www.skl.se/vantetider). It is important to be aware that the waiting times apply to nonprioritized first-visit patients. For prioritized patients, the waiting times are shorter.

Table 8. Expected waiting times (weeks) from referral by the GP to initial examination at a policlinic, June 2004

	Average	Min	Max	Nr of Hospitals
Discus prolaps	52	4	180	51
Knee replacement	53	4	180	76
Hip replacement	52	4	180	71
Cataract	33	8	222	42
Varicose veins				
Hernia	32	3	104	83

Table 9. Expected waiting times (weeks) from initial examination at the hospital to actual treatment, June 2004

	Average	Min	Max	Nr of Hospitals
Discus prolaps	24	4	104	44
Knee replacement	41	2	150	73
Hip replacement	31	2	80	71
Cataract	36	4	120	48
Varicose veins	71	3	400	75
Hernia	33	2	208	85

Tables 8 and 9 show that waiting times differ markedly by hospital or clinics and by diagnosis. We have not found systematic variation between waiting times in the regions. For diabetics and patients referred to departments of nephrology, 80% of the patients are expected to see a doctor within 3 months. For patients referred to plastic surgery or orthopedics, the corresponding figure is 20 percent (Landstingsförbundet 2003). The database was initiated in April 2000, and it is too early to evaluate its effects on patients' behaviour and on waiting times. During the first month the homepage was visited by more than 15,000 persons. Thereafter the number of 'hits' has varied from 1,500 to 2,000 a week.

Comparing the three countries, differences in waiting times persist in all three cases. Denmark has the shortest waiting time, while Sweden has the longest for almost all described diagnoses. In Denmark and Norway the waiting times has been decreasing in the last years while Sweden not has the same decrease. Theoretically existing waiting lists should provide a relatively strong impetus for utilizing choice unless other barriers exist. In the following we will elaborate on patient access to information on choice, waiting times and quality.

c) Is adequate information available for choosing? (Information on waiting times, treatment patterns and quality.)

Norway

Since the introduction of free choice of hospital in Norway comprehensive information activities have taken place in order to make the population aware of their new right. There is both a private and a public web site with information of free choice of hospital and waiting times and quality indicators for the different providers of health care. Two years after the new Act was implemented, over 400 patients visited the new public web site each day. Another indicator of a large search for information is the use of patient advisers. There are 5 patient advisers (one in each region) and they had 22 000 questions from May to December in 2003 (Dagens Medisin, 29.01.04).

A number of GPs argue that there are bureaucratic obstacles to sending patients to some hospitals and that they do not have time to investigate the different opportunities for patients. Some GPs do not have Internet access and therefore it is impossible to inform the patient (Dagens Medisin, 29.01.04). Others GPs refer to technical problems in using both Internet and the diagnose program at the same time (Aftenposten, 0309.2003).

A research study shows that 69% of patients on a waiting list and 87% of true free choice of hospital patients have awareness of free choice of hospital (Christiansen and Hem, 2004). A newspaper in Norway has also made a small telephone survey in 2004 on awareness of free choice of hospital. In this study only 1/3 Norwegians were informed about their rights of free choice of hospital (Aftenposten, April 10, 2004).

Quality indicators.

National quality indicators are used in Norway in order to be able to identify differences in quality between the hospitals. At the moment there are eight indicators for somatic care and 5 for psychiatric care and they show large differences between the hospitals. The development of indicators is still going on. So far the usefulness of the indicators for patients choice is being questioned (Østergren, 2004).

Denmark

Hospitals are mandated by law to inform patients of their rights to choose. In addition, the government has published information material available at most GP and practicing specialist offices. Since the introduction of choice the counties have sent waiting time prognoses to the GPs on a regular basis. In later years the prognoses have also been

available from the counties' homepages and a national homepage (www.ventainfo.dk and www.sundhed.dk). Data on hospital volume but not surgeon volume is available for many elective interventions from a national homepage (www.sundhed.dk). The counties inform GPs in their own area about which interventions their hospitals perform. Recently hospitals and departments have begun to describe their services in more detail.

Some databases on clinical quality enable comparisons of use of technique by department or clinician. In general, only anecdotal information on differences in indications is available to the patients and the GPs. A national database presents data on hospital-specific quality in some interventions (www.nip.dk). Several initiatives are under way to create greater transparency on quality matters (expanded clinical databases, accreditation, benchmarking, etc) by use of aggregated ("smileys") or disaggregated data. Data on patients' experience satisfaction are available at the hospital or department level (EfB, 2005)

The counties must employ independent "patient advisors" to assist patients with information about various hospital departments.

Sweden

The government has not launched any central information initiative about patients' rights to choose, because the right is not based in law but on a recommendation introduced by the FCC (Association of County Councils). Every County Council provides information on their homepages about the freedom of choice. The quality of this information varies considerably; some of the counties have direct links to basic information about the regulation accessible at the FCC's homepage. However, many of the county councils have clarified and extended this basic information, for instance by adding patient cases. The information provided gives no clinical information, such as ratings of care quality and treatment outcomes, and is therefore of little help to patients' decision-making.

Instead, information about care quality can be found in 40 national quality registries administrated by the National Board of Health and Welfare. The registries are managed and maintained by MDs and contain information on diagnosis, treatment and outcomes on every individual patient. The results of the registries are formally available for the public, but are in practice very technical and difficult to interpret to be useful for the individual patient without help from MDs.

Information on waiting lists is published by the FCC. All county councils have links on their home pages to this database providing the only standardized information on waiting lists in Sweden. None of the county councils provide any other information on waiting times.

Regularly updated information on waiting times is readily available in the three countries. The reliability of the data and the usefulness of expected average waiting times have been questioned (Stoop, Berg and Vrangbæk 2005). Data may be manipulated to serve different political purposes, and individual patients with non-standard needs do not easily fit the format. Nevertheless information is available and provides some basis for choice.

Meanwhile due to methodological concerns and diverging interests, limited information is available on quality. When information is available from clinical databases there are significant difficulties for patients in interpreting the data. This seems to present a potentially important barrier for choice that is not easily overcome. All three countries are currently sponsoring projects to develop more comprehensive and publishable quality data.

d) Patients' preferences with regard to choice. Do patients want to choose? What are the most important factors influencing choice?

Norway

In Norway there have been no studies carried out on how many are interested in choosing hospital. However there are studies on how much patients are willing to pay for using free choice of hospital. In one study, free choice of hospital users were asked if they would have used the service if it were more expensive. If the co-payment increased from 400 NOK to 600 NOK then 45% said that they would still be interested in using free choice of hospital. If the co-payment increased to 800 NOK, the percentage falls to 38% (Christensen and Hem, 2004, Figure 6).

What are important factors for choice? (High competence and good reputation.)

The next question is why patients want to use free choice of hospital? The two most important factors are the reputation of the hospital, and in particular, the competence level (Christensen and Hem, 2004, figure 6). Less important factors include quality information on the Internet and previous bad experience with the hospital. A study done in the south of Norway in 2001 showed similar results. Good doctors and good hospitals were ranked highest, then came waiting time and GP recommendation (Aftenposten 260501).

Denmark

Most healthy citizens assume that in case of disease they would choose by themselves and the choice would be determined by short waiting time and high quality: 82% of the participants in a telephone survey reported that they would be willing to travel out of the county in order to be treated at the hospital with the highest quality of care (PLS Consult 1999). Elective patients' actual preferences are more heterogeneous than healthy citizens' hypothetical preferences, patients facing a choice, being less willing to travel (Birk & Henriksen, resubmitted).

Distance, waiting time, quality and service.

Choice of the hospital closest to the home often represents a conscious selection: studies of inpatients show that short distance is the most important factor behind patients' choice (Vejle Amt 1999, Efb 2001, Efb 2005).

Waiting time is an important factor in 22% of elective patients' choice (Efb 2005). Waiting time may act as a confounder for uncertainty about the length of the waiting time; some patients are willing to accept a long waiting time, if they know exactly when they will be treated (Birk and Henriksen, resubmitted).

Patients' perceptions of the service and quality at various hospitals play a major role for the choice: in 2004 personal experience with one or more hospitals influenced 41% of Danish patients who chose by themselves, and the hospital's reputation influenced 41% of the patients' choice (EfB 2005) Patients generalised their experience with one department to the hospital as a whole and were therefore more likely to choose a hospital they were satisfied with again, even if they needed a different kind of procedure (Hansen 1994). Relatives' and friends' experiences with hospitals available played a major role for patients' choice of hospital, while the media were much less important (Birk and Henriksen resubmitted).

Sweden

No studies of patients' preferences for choice are available. However some studies indicate that patients want to choose the provider of care and consider this right to be important: a great majority want to choose their own GP and 66 percent considered it very important to choose the hospital. Only five percent found the right unimportant (Anell and Rosén 1995). When patients were asked about their actual choice behaviour, three out of four had wanted to be referred to a specific hospital, indicating that many patients want to choose when alternatives are available (Stockholms läns landsting 1993).

Looking across the three countries it seems that patients' preferences for proximity are a strong factor for choosing (or not choosing) hospital. Patients are unlikely to travel unless the nearest hospital has a very bad reputation or there are strong personal reasons for seeking quick access.

e) The role of the general practitioners. (Barrier or facilitator for choice?)

Norway

After the reform of the patient-list system in 2001, the GPs' role changed. The role is less as a gatekeeper than before, because they have increased incentives to make the patient satisfied in order to keep them on their list. Calsen and Norheim show in their study that GPs in Norway have experienced a shift in power in the physician-patient relationship, which favours the patient. The GP's consciousness of the gatekeeper role has diminished (Calsen and Norheim, 2003).

Another study made by SINTEF Unimed in May 2001 showed that every third GP does not want to have anything to do with free choice of hospital for various reasons (Aftenposten 260501). After this study, the Health Ministry emphasised that it is included in the GPs role to inform patients about free choice. We still do not know to what degree this has affected GP practice.

GPs play a rather large role in the choice process for patients. According to the free choice of hospital patients, 40% decided to use free choice of hospital together with or influenced by the GP and 13% decided to use free choice of hospital because of advice from a GP (Christensen and Hem, 2004).

Denmark

Patients report that the GPs play a major role for patients' choice. One study shows that the GPs choose the hospital on behalf of half of the patients. It also shows that GPs influence the choice of 30% of the patients (EfB 2005).

Sweden

A survey of a large number of GPs has shown that even among GPs with a positive attitude towards free choice, few GPs have implemented this in their daily practice. Few GPs have changed their behaviour in accordance with the policy directives, and patients only get help to choose the care provider if the patients ask for this. A case study in Stockholm County showed that from a formal perspective there were no direct limitations built into the economic incentive system preventing the GPs from helping patients to choose. However, the study showed that GPs' knowledge of local rules concerning these policies was very poor. The GPs assistance to patients about choice of hospital was positively correlated to their knowledge about the rules governing choice. A large share of the GPs found that the policies had changed the working conditions negatively. For instance, it was time consuming to inform about choice. The study also showed that GPs who felt professionally threatened by the policies were less willing to inform patients about their rights to choose (Winblad Spångberg 2003).

Interpretation of demand side reactions

Fundamentally, has patient behaviour changed after the introduction of the reforms? The analysis shows clear similarities between the countries. The results indicate that few patients have actually chosen other facilities for care; most patients still choose the nearest hospital or a hospital in their own region. A slow increase over the years is noticed though - more patients use their rights to choose hospital in another county/region – this especially seems to be the case in Norway and Denmark. Even if the statistics are limited we can notice that especially young and well educated persons use their choice of provider. Interestingly, Norwegian women use their rights to a greater extent than Norwegian men.

How then can we explain the apparently limited utilization of choice? Can it be explained by the awareness of the right to choose hospital? The picture differs among the countries here. Danish patients seem quite aware of their right. In Norway at least the patients on waiting lists are rather aware of free choice (69%), while only every second patient in Sweden is aware. Probably, the knowledge is even more limited about the specific rules, e.g. whether private care is included, or who pays for travel costs.

Can limitations in legislation explain the limited utilization? Not really, in all three countries extensive rights have been developed in order to improve patients' opportunities to choose hospital. In Norway and Denmark the rights to choose have been laid down by law, whereas Sweden has chosen a more soft regulation in which the County Councils' delegates have accepted the responsibility of providing a free choice for patients. Looking through the rules we see that the patients have a free choice of

hospitals in their entire countries. Travel costs are free in Norway (only a patient fee) and free for low income groups in Denmark. In a European perspective these rights are very far-reaching. Few formal barriers exist that could explain the low use of the choice.

Can lack of comprehensive and understandable information about waiting lists explain the negligible effects of the reforms? An important step in the analysis was to investigate if there exist differences in waiting times, quality of care, and hospital structures. Small differences could explain why patients don't use their right to choose. Vast differences, on the other hand, could motivate patients to use their choices. The analysis showed significant, unsystematic differences in waiting times and care quality. Subsequently, small differences among the alternatives may not explain why patients are not using their opportunities to choose.

All countries have set up web sites about waiting lists. A problem with these is that they show expected and not actual waiting-times, which must be considered as a good – but far from perfect – indicator of how long a patient must wait for a procedure. Another problem is that statistics are so far only available for the most common diagnoses in Denmark and Sweden and that some clinics for different reasons have been reluctant to leave information about their waiting times on the national data base. Nevertheless, the data bases must still be considered as an ambitious attempt to provide doctors and patients with information.

Can lack of comprehensive and understandable information about quality of care explain the negligible effects of the reforms? Patients need information about other outcome measures, e. g. quality of care, as a base for their choices. This kind of information is less well provided in all three countries and seems to be a more controversial issue than waiting times. For instance, in Sweden certain quality registries have been developed for and by the medical profession, however even if this information is available for the public, it is still very technical and difficult to use. Norway also presents certain quality indicators. One problem with these is that the information is at an aggregated level and some of the indicators are difficult to use as a base for choice of hospital. In addition to this, it is in order to question what purpose the quality indicators have while several of them are better to use for control and comparison between hospitals than for patient's choice (Østergren, 2004). In Denmark only a little information on quality is presented. All in all, even if some initiatives are taken much more is needed in order to create greater transparency regarding care quality. This must be considered as a barrier for patients' choice of hospital.

Can lack of preference to choice explain the negligible effects of the reforms? Studies from the Scandinavian countries show that patients do appreciate their opportunities to choose. Different studies from Norway and Denmark show that reputation seems to be an important factor when patients are asked why they have chosen a certain hospital. Still, studies from Denmark show that proximity is the most important factor regarding choice. Because of this, it appears as if patient choice is more seen as a safety valve to use when the closest alternative is perceived as not being good enough.

Finally, can the role of the GP explain the negligible effects of the reforms? There is evidence that the doctors themselves – and not the patients – decide where to refer the patients. Studies from both Norway and Sweden also show that GPs feel threatened by choice-patients and consider the reforms to be quite time-consuming. This could lead to under-information about the details of the policies, which is a threat for the patients since the doctors are the ones who are supposed to help patients choose.

To sum up, it seems as if few formal legislative or economic barriers exist for the patients concerning choosing a hospital. Instead, patients' limited knowledge about the reforms in combination with too little support from GPs and limited (or complicated) quality information can explain why few patients choose a hospital in other parts of the countries. What's more, when patients know their rights it seems that they prefer proximity to home and therefore choose the closest hospital or choose other hospitals in the same region – which can also explain the low utilization of choice between regions. In accord with the last argument, it is important to note that we have not studied choice within the same region/county. This means that patients that have used free choice of a hospital within their own regions have not been considered in the figures.

Discussion and perspectives for the future

Patient choice is a powerful idea that has swept across the three Scandinavian health care systems in the past decade. It provides greater flexibility for patients and introduces elements of market-like behaviour. The Danish Ministry of Health describes the purpose of choice as threefold: 1) choice is an (ideological) end in itself, 2) choice can provide flexibility for users and better distribution of resources, and 3) choice can provide better quality through competition. Similar statements can be found for Sweden and Norway.

The complexity of aims and aspirations for choice makes it unclear how the scheme should be evaluated. However, in all cases the results will depend on the choice behaviour at both the supply and demand side of health care systems, and the linkages between them. In this paper we have investigated some of the demand side responses to choice in Scandinavia. The picture that has emerged is of significant awareness of the choice option but a rather limited level of utilization. The utilization is unevenly distributed across geographical areas and patient groups. Generally this leads us to conclude that we live in a transition period, where new ideas of choice and individuality are gradually finding their way into the Scandinavian health sectors, and currently co-existing with the more traditional welfare state ideas of equity and public planning. Patient empowerment through choice is part of general turn of health systems from supply driven to demand driven entities. This may be a necessary move in order to retain legitimacy for the public health system in a period of increasing pressures for individualized solutions based on ability and willingness to pay. Choice may thus be interpreted as a political strategy to weaken demands for more radical changes by extending greater flexibility within the public health care systems in Scandinavia.

Finally, in this article we have described choice from a demand side perspective. We have described how patient behaviour changed after the implementation of free choice of

hospitals. Still, we have to be aware that choice also can be used from a regulating perspective in a public health sector. Free choice of hospital can help the government with a more effective use of hospitals if patients go where there is free capacity instead of waiting for the closest hospital. In that sense, choice can be understood as playing an instrumental role in meeting objectives such as responsiveness and efficiency in resource allocation between regions, hospitals or departments. The important questions are then: how have health care providers changed their perceptions and strategies and can we identify major change to the supply side of health care? These and many other questions will be addressed in a paper comparing the effects in the Scandinavian health sector supply side.

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