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The liberalization experiment

*Understanding the political rationales leading to
change in pharmacy policy*

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Abstract

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In 2009, a pharmacy policy reform was introduced in Sweden whereby the state owned community pharmacy monopoly was abolished. As a result two thirds of the pharmacies were sold. As there were no longer restrictions on ownership and establishment, new pharmacies and new owners appeared. The overall aim of this thesis is to contribute to a more nuanced understanding of the stated and the underlying rationales for the reform, specifically, to understand how key stakeholders view the reform, and the future role of the community pharmacy. Document analysis was the method used to study the preparatory work, plenary debates, and interviews with stakeholders from political, professional and patient organizations.

The government directive stated that the reform would lead to improvement of availability and efficiency, a pressure on prices and a better use of medicines. However, the results show that during the reforms' preparatory phase, the rationales changed and only availability remained throughout the process. Diversity on the market was added later as a rationale. The effects of the reform were perceived in similar ways by the different stakeholder groups. The views on the reform was more negative after the reform.

Interviewees who were previously in favor of the reform were surprised that diversity had not been achieved; that the counseling in the pharmacies had deteriorated and that the availability of medicines decreased after the reform. Interviewees from political organizations had a more business-oriented view of pharmacies/ists, while participants from professional organizations had a more healthcare-oriented perspective.

Finally, this thesis studied the diversity rationale behind the pharmacy reform and compared it to the primary care reform. The results show that, in both cases, policy makers definitions of diversity were vague and unclear, which appear to have complicated their implementation.

Since the pharmacy reform neglected to investigate alternative means of achieving the goals/rationales, it can be argued that the reform was ideologically based and had a preconceived understanding as to how the community pharmacy sector should be regulated. There are several reasons for drawing this conclusion: the reform was launched despite the original rationales being considered as impossible to fulfill, and, except for abolishing the monopoly on state-owned pharmacies, the stakeholders did not seem to know what the reform would lead to, except increasing the number of pharmacies. The latter could have been achieved without the reform as the government had control over the state-owned pharmacy monopoly.

Keywords: pharmacy policy, reregulation, liberalization, Sweden, pharmacist, pharmacy

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It is easier to do many things than to do one for a long time.

Quintilianus

To Martin,

*my discussion partner,
my windbreak,
and my love*

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

- I Wisell, K., Winblad, U., Kälvemarm Sporrang, S. (2015) Reregulation of the Swedish pharmacy sector — A qualitative content analysis of the political rationale. *Health Policy*, 119: 648-653.
- II Wisell, K., Winblad, U., Kälvemarm Sporrang, S. (2016) Stakeholders' expectations and perceived effects of the pharmacy ownership liberalization reform in Sweden: a qualitative interview study. *BMC Health Service Research*, 16:379.
- III Wisell, K., Kälvemarm Sporrang, S. (2016). The Raison D'être for the Community Pharmacy and the Community Pharmacist in Sweden: A Qualitative Interview Study. *Pharmacy*, 4:3.
- IV Wisell, K., Winblad, U., Kälvemarm Sporrang, S. (2019). Diversity as salvation? – A comparison of the diversity rationale in the Swedish pharmacy ownership liberalization reform and the primary care choice reform. *Health Policy*, *in press*.

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Preamble

“If clinical pharmacy¹ is so marvelous as all the professors at the University ceaselessly are telling us students, why doesn’t it exist everywhere?”, I said to my future supervisor Sofia, when I first met her. This thought had been nagging me for some years. I didn’t know anything about the intriguingly complex world of qualitative research. I see this as the beginning of this Ph.D. adventure – even though the Master’s thesis: “The existence of clinical pharmacists in hospital settings” is quite remotely connected with the scope of this thesis. However, this was the moment where it all began. This was the first time I took a step from pharmaceutical falling powders, to take an interest in developing the roles of the pharmacist.

When the opportunity came up a year later to apply to a Ph.D. program about the underlying rationales for the abolishment of the Swedish state-owned community pharmacy monopoly, I thought it sounded very interesting and rewarding. It sounded like an excellent opportunity to merge my political engagement with my interest in medicine and health.

The scope of this thesis has since then developed as such: First, to put the pharmacy policy change in a larger context. Secondly, to try to grasp why policy makers might launch grand reforms, with the potential of affecting the health of the population.

To write a thesis is an adventure, someone said. I rather compare it to a dwindling mountain hike, with deep valleys with pouring streams, exhausting climbs that I almost Sisyphean am climbing up again. Then, the undoubtedly breathtaking view, which gives the opportunity to contemplate and feel the unimaginable fresh mountain air. A little later, when you turn around, this mountain is seen only as a small part of a never-ending unscalable mountain landscape! To put it in another way: Research requires a lot of time (sic!) spent alone in your room, doing the exhausting and diligent work, besides some inspiring meetings and seminars, to gradually conquer the sometimes opaque skills and culture of research, to have the opportunity to develop clarity of thought, and hopefully bring something new to the world.

¹My understanding of the concept back then: Activities performed by a pharmacist in a multi-professional team in hospital settings, aiming at improving the patients’ regime.

Background

In 2009, two major changes in pharmacy policy took place in Sweden. First, the state-owned Swedish pharmacy monopoly was abolished allowing for private alternatives (Government of Sweden 2009). Second, non-prescription medicines were released to be sold also outside of pharmacies (Reje 2008).

There are several aspects that indicate that the state-owned Swedish pharmacy monopoly functioned quite well: There were no obvious complaints from the population. Also, none of the 39 government investigations within pharmacy policy performed during the 20th century (Ministry of Health and Social affairs 1998) suggested an abolishment of the state-owned pharmacy monopoly. Anderson (Anderson 1995) argues in a similar way.

Despite this, the monopoly was abolished in 2009, and a pharmacy sector was created with almost no ownership regulations (stipulating who could own a pharmacy), or establishment regulations (stipulating where a new pharmacy could be opened). One effect of this reform is that the number of pharmacies has increased from 925 in 2009 (Growth Analysis 2011) to 1,465 in 2019 (Swedish Medical Products Agency 2019).

This liberalization of regulations in the community pharmacy sector was more comprehensive and far-reaching than most other pharmacy reforms taking place in other European countries at the same time.

After this major reform, some reports from authorities have been published, mostly dealing with availability of community pharmacies and medicine costs (Swedish Competition Authority 2010; Swedish Agency for Health and Care Services Analysis 2014; The Swedish Agency for Public Management 2013). However, no studies have investigated the underlying rationales for the reform, or whether the market construction or the perceived effects are in line with what was expected. The overall aim of this thesis is to fill this gap; thus, the focus is to understand the rationales for, and the perceived effects of this major change in regulation of the community pharmacies in Sweden.

Pharmaceutical policy and pharmacy policy

Pharmaceutical policy is a concept defined as the activities and regulations that deal with the use and provision of medicines (Morrow 2015). Important aspects in pharmaceutical policy are to regulate the development of medicines in the direction toward becoming safe and effective. Other aspects are to make

regulations that promote an effective use of medicines, as well as an equity dimension (Mossialos and Oliver 2005; Traulsen and Almarsdóttir 2005).

A community pharmacy is a pharmacy where the ultimate goal is to improve the health of the population (Moullin et al., 2013). The ideal is a pharmacist that takes the full “professional responsibility for the patients’ welfare” (Hepler and Strand 1990; Montgomery 2009). To put focus on community pharmacy, the term *pharmacy policy* is here defined as all rules and regulations governing the community pharmacies. Pharmacy policy includes the regulations concerning aspects that take place within the pharmacy, e.g., how to stock the medicines, dispensing, counseling, reimbursement of patients and pharmacies (Moullin et al., 2013).

Pharmacy policy also includes regulations of more structured activities such as ownership regulations and where a pharmacy could be placed. Ownership regulations govern who is allowed to own a pharmacy, and how many pharmacies are allowed to be owned by each person/organization. The strictest ownership regulations within Europe are in Finland, where only pharmacists are allowed to own a community pharmacy (The Association of Finnish Pharmacies 2016). Second, geographic placement regulates the number of pharmacies that are allowed within an area. This number, for instance, could be related to how densely populated the area is (Mossialos and Mrazek 2003; Mossialos and Oliver 2005).

Furthermore, pharmacy policy regulates where and pursuant to which restrictions medicines are allowed to be sold/dispensed. First, it regulates which medicines patients can buy without a prescription. Second, it regulates which non-prescription medicines need to be placed behind the counter in the pharmacy. Third, it regulates which non-prescription medicines can be sold in supermarkets (Lluch 2009; Mossialos, Mrazek, and Walley 2004). In some countries, e.g., Spain, medicines are only sold in pharmacies (Vogler, Habimana, and Arts 2014). In other countries, e.g., Sweden, there is a long list of non-prescription medicines that are allowed to be sold in supermarkets (Swedish Medical Products Agency 2017; Martins, van Mil, and da Costa 2015).

Finally, pharmacy policy regulates the amount of reimbursement received by the pharmacies (Lluch 2009; Mossialos, Mrazek, and Walley 2004). In many countries, the pharmacy receives a reimbursement for each medicine that is dispensed, either a fixed fee or in proportion to the cost of the medicine (Mossialos, Mrazek, and Walley 2004). In other countries, specific services are reimbursed – ranging from public health services (e.g., smoking cessation) to services inspired by pharmaceutical care and prescribing pharmacists (Martins, van Mil, and da Costa 2015). In practice, all pharmacy policies also consider the costs of services (Almarsdóttir and Traulsen 2006).

Pharmacy policy is complex and varying. Both the amount and the focus of regulations differ. One reason for this is that the activities performed in a community pharmacy vary between different countries. First, some activities performed within community pharmacies are health care: e.g., empowering

and informing the patient before visiting the prescriber/GP, being a safety net for the rest of health care by suggesting modifications in the patients' medicine regime, and answering questions that patients have about their medicines. Second, some activities are logistics: storing of medicines, providing the prescribed medicine to the patient. Third, some activities are commercial transactions: e.g., selling perfume free dendrite shampoo and make up. These three perspectives combined make community pharmacies unique, and regulation complex.

The rationales for the differences in pharmacy policy in various countries are underpinned by different societal values. The proponents of strict regulations claim that they contribute to a certain level of quality (e.g., through ownership regulations) (Gross and Volmer 2016; Lluch 2009; OECD 2001a), or put equity in focus (e.g., geographic placement) (Mossialos and Mrazek 2003; Mossialos and Oliver 2005). They also state that regardless of the number of pharmacies, the same amount of prescriptions should be dispensed. Hence, if more pharmacies are opened, each pharmacy would handle fewer prescriptions, and will instead focus more on other things than dispensing medicines. This leads to a move away from the pharmacists' societal duty to dispense medicines.

Those in favor of not having regulation of ownership often argue that a pharmacy sector without ownership regulations would be more efficient (Lluch 2009; Mossialos and Mrazek 2003), and that competition will increase the quality standards (Lluch 2009; OECD 2001b; Ministry of Health and Social Affairs 2010).

Health policy regulations

According to the WHO, Health policy refers to “decisions, plans, and actions that are undertaken to achieve specific health care goals within a society” (World Health Organization 2019). In order to achieve the goals, regulations are often used.

The regulations within a specific policy sector reflect the underlying values in a society. Within the healthcare sector, these values are autonomy (the right to make informed choices about one's health), equity (an equal distribution of healthcare), and efficiency (maximize health/access at lowest possible cost), according to the WHO (Saltman and Figueras 1997). Within many countries and parts of healthcare sectors, the regulation reflects a balancing act between these three different values (Atim 1999; Braithwaite, Travaglia, and Corbett 2011; Frenette, Saint-Arnaud, and Serri 2017; Giacomini, Kenny, and DeJean 2009; O'Shea and Kennely 1996).

In Sweden, the healthcare prioritizations are also underpinned by the ethical principles – human dignity, equity, and cost effectiveness (Ham 1997; Linköping University 2016; Swedish Parliament 2017). According to Folland et

al. (Folland, Goodman, and Stano 2013), when efficiency is emphasized, the overall rationale for regulations in the healthcare sector is to ensure that the health of the population is optimized at the lowest cost possible.

According to the WHO (Saltman and Figueras 1997), there are four main ways to regulate a healthcare sector. The first way is to regulate it as a market-based system, where government involvement is set to a minimum. Even when healthcare sectors are constructed as markets, regulations exist. In this case, regulations are used e.g., in order to protect against market failure because of information asymmetry (i.e., the patients are unable to make rational decisions since they do not have all the information) (Akerlof 1970). The second way is to let external experts monitor the activities within healthcare. In this kind of healthcare system, the regulations are very detailed (Fischer 1990). The third way to regulate is through professions, where professional bodies as well as individual members of professions control the activities. The fourth way to control the activities is to involve the citizens in formulating healthcare, through e.g., elected representatives (Saltman and Figueras 1997). These different ways of regulating healthcare show the complexities thereof. All changes in a health policy could result in unintended unexpected consequences, which are described below (Merton 1936).

Regulations and externalities

Regulations are extensively used within healthcare, e.g., in order to compensate for market failures (Carroll 2017). First, the information asymmetry (Akerlof 1970) makes it hard for patients to choose the most efficient alternative. Second, since third party payers, e.g., taxpayers, often finance the healthcare sector, there is a wish not to have to finance something that does not lead to improved health of the population at the lowest possible cost. Thirdly, regulations are a way to try to avoid unexpected effects.

When a regulation is introduced, changed, or removed, it is common that this leads to unwanted side-effects, i.e., other than those intended. This phenomenon of unexpected consequences (which can also affect other people than the person or the organization involved in the activity) is named and defined differently: *externality* (Black, Hashimzade, and Myles, 2017; Helbling, 2010), *unanticipated consequence* (Merton 1936), or third party *government failure* (Friedman and Friedman 1990).

In this thesis, the word “externality” is used as an unexpected negative or positive consequence, resulting from a change of a regulation. Externalities are difficult to avoid, since it is difficult for policy makers to foresee all possible effects of a certain regulation. There are however some strategies that can be used in order to avoid negative externalities.

One way to dampen the effects of negative externalities in healthcare is to use the highly trained professionals working there to estimate whether a situation needs extra attention. Since all situations and patients in healthcare are unique, it is very difficult to construct regulations that consider all the possible situations that could occur. Therefore, using a trained professional could be a way to regulate, e.g., which patient needs to receive more advice (Cilliers 2000).

Intense regulations could transform a previous primarily altruistic professional (with the patient's best interest as a primary goal) into a person with (unintended or intended) self-interest as the objective for her/his actions (Miller and Whitford 2002).

One example of this was when health care queues in the U.K. were regulated (in order to shorten the queues). After two years, the queues for e.g., the first visit to an ophthalmologist had shortened. However, at least 25 persons had become blind. The reason for this was that each patient was allowed the same amount of time. The queues were shortened, but those with the most complex eye problems did not get the attention they needed (Bevan and Hood 2006; Grand 2010). This is an example where a change in regulations might have changed the motivation of the medical profession: from altruistic profession members who put the patients' health in the first place, to "administrators," only caring about the budget.

Because of the risk of externalities, Friedman and Friedman (Friedman and Friedman 1990) argue that when a new area is to be regulated, it is up to the proponent of the regulations to conduct investigations to prove that the regulations would not have any negative effects on third parties.

The abolishment of the state-owned pharmacy monopoly in Sweden in 2009 was a major change in pharmacy policy, and how the Swedish pharmacy sector is regulated. The reform included both a liberalization of the ownership restrictions as well as geographic placement. This process could be seen as a liberalization process, typically associated with the New Public Management. A general description of the core ideas within New Public Management, and a closer description of the more relevant parts of these ideas, is therefore relevant in this thesis.

New Public Management

The New Public Management (NPM) is a collection of ideas originally derived from the private sector, about how public organizations should be governed.

The exact characteristics of NPM are defined differently in various contexts. However, one principal feature of NPM is to *create competition* in order to decrease the cost (Boyne 1998a; Hood 1991) and hence increase the efficiency (Pollitt and Bouckaert 2011).

The ideas of NPM have been used by social democratic, liberal, and conservative governments. Privatization reforms, inspired by the NPM, have been implemented throughout the world since the beginning of the 1980s. In Sweden, both the pharmacy reform in 2009 and the primary care choice reform in 2010 were inspired by the NPM. Other examples are the privatization reforms in the U.K. implemented by the Thatcher Administration (Pollitt and Bouckaert 2011). However, it is the competition introduced that is important for the proposed increased efficiency, not whether ownership is public or private (Boyne 1998b).

Except for becoming more efficient, some proponents of introducing the NPM argue that it makes the welfare state become stronger and less bureaucratic. In contrast, others argue that the NPM makes it possible to diminish the size of the state. Regardless of these differences, most proponents of the NPM conclude that it is an efficient way to allocate resources (Lane 2000).

One effect of introducing competition in the public sector is that the power is transferred to the public, who, according to the NPM, make more rational decisions than a few bureaucrats in charge of the services (Boyne 1998b). The idea is that patients generally will choose the provider with the best quality, and that companies with low quality will be forced out of business. Also, when low functioning healthcare companies are forced out of business, efficiency increases, since the public get more quality for the same amount of money.

According to Walsh (Walsh 1996), competition increases efficiency through four different mechanisms. First, overproduction is reduced. Second, the working methods are scrutinized and improved. Third, the customers' accumulated choices lead to more rational decisions and fourth, cost consciousness is increased.

Even though NPM has been used in various contexts, countries, and by politicians with different ideologies, it has been criticized.

First, the mechanism for quality improvement is debated, since these choices are deemed hard to make. The difference in knowledge, i.e., the information asymmetry between the healthcare provider and the customer/patient makes the mechanism of choice difficult in the healthcare sector (Vrangbaek et al., 2012; Windrum and Koch 2008). Second, when NPM was introduced, the ethical principles of the professions were hard to translate to the economic reimbursement associated with NPM. You measured what you could measure, instead of what you wanted to measure. Third, critics argue that NPM increases bureaucracy and control, since everything the professions perform has to be measured through economic incentives (Bondeson and Jones 2002; Zarembo 2013). The main focus is quantitative measurement of professional activities, and to measure the results (Boyne 2003; Hood 1991; Pollitt and Bouckaert 2011).

Despite these control mechanisms, NPM reforms are often supposed to lead to diversity and innovation (Wisell, Winblad, and Sporrang 2015), for exam-

ple, managers are given a great degree of freedom to decide how to use resources. This is supposed to lead to innovative organizations, which are said to be flexible and often have a certain amount of autonomy from any central administration. The argument is that they will be more likely to adapt to the needs of the consumers (Osborne and Gaebler 1992) and thereby increase customer satisfaction (Peters and Pierre 1998).

With NPM, power is removed from professions to administrators that decide how their work should be performed. The other way to allocate resources within healthcare is to use professions.

Professions

Professions are occupations that perform tasks that are valuable to society (Cruess, Johnston, and Cruess 2004); however, the precise definition of the term profession is debated (Adams and Miller 2001; Cruess, Johnston, and Cruess 2004; Freidson 1999). Some characteristics are common for most users of the term, i.e., a high status occupation using scientific knowledge as a basis for their work, with control over their own work tasks (Freidson 1994; Gabe, Monaghan, and Gabe 2013). Another characteristic is a license to work (Starr 1982), which could be withdrawn if a specific member of the profession does not live up to the standards of the profession and the professional organization.

A term often discussed in relation to professions is *professional monopoly*, which is specific tasks that only the profession is allowed to perform. A professional monopoly is given to a profession when society judges that the knowledge that the profession possesses is so specific and important that the profession exclusively should be allowed to perform the specific service/task (Larson 1977). According to some, the main virtue for individual professionals is to answer to the specific needs of the patient or the client. However, this approach on professions is not entirely bereft of personal driving forces but includes a will to gain a good reputation within the professional community, and also (but not primarily) to earn profit (Parsons 1939).

Classical professions, for example, include lawyers and doctors (Abbott 1988), and semi professions include teachers, nurses, and pharmacists (Adams and Miller 2001; Denzin and Mettlin 1968; Krejsler 2005). However, the role of a profession is not static, but it can change when the values of a society change. Nonetheless, through a professionalization process, professions could gradually gain certain professional attributes. The opposite is the process of de-professionalization (Bondeson and Jones 2002), where professions gradually lose certain attributes, such as certain power over their work situation (e.g., which patients to treat first).

De-professionalization occurs for several reasons: development of other professions that could perform the tasks, a more active patient/client, or an

overall change in the values of a society, which, e.g., leads to more governmental control (Reed 1987).

The role of the community pharmacist

Society has granted a professional monopoly to pharmacists to dispense medicines in community pharmacies. The term means that the pharmacist has the responsibility for the collection, technical, and pharmaceutical control of the medicine (Shah and Chewning 2006). The Swedish law also states that the pharmacist should make sure that the patients know how to take their medicine, and ensure that the medicine is suitable for the patient (Shah and Chewning 2006; Sveriges Apoteksörening and Apotekarsocieteten 2015). After the discussion with the patient, the pharmacist could discuss the regime with the prescriber. This might lead to modifications of the regime. Through these measures, community pharmacies/pharmacists are supposed to lead to better medicine use in the population (NEPI 2008).

Within the community pharmacy sector, a de-professionalization process has been going on since the beginning of the 20th century: the community pharmacist has lost several of its professional monopolies, compounding storage and procurement of pharmaceuticals to the pharmaceutical industry, wholesalers, or special pharmacies designated only for extempore medicines (Traulsen and Bissell 2004). The only part of the professional monopoly left then for the community pharmacists is the above-mentioned dispensing of medicines.

However, at the same time, a professionalization trend has been present, adding to pharmacists' professional role. For example, the community pharmacist uses his or her knowledge by counseling patients to a greater extent (Mossialos et al., 2015). In some countries, the community pharmacists have taken on a public health role, providing e.g., vaccines (Burson et al., 2016) and different screening tests (Goza et al., 2017; Sandhu et al., 2016), or toward the role of a pharmacist by prescribing medicines in the community pharmacy setting (Reid et al., 2017).

The setting

The Swedish healthcare system and the community pharmacies

The Swedish healthcare system is comprehensive, tax funded, based on solidarity, and of a universal character (Anell, Glenngård, and Merkur 2012). The responsibility for health care is shared between the county councils and the municipalities (The Swedish Institute 2018). The Swedish healthcare services are performed by county councils, municipalities, and private companies. The private companies are both for-profit and nonprofit companies; however, the private Swedish healthcare sector generally has a small nonprofit sector. Internationally, most studies of for-profit compared to nonprofit companies in elderly care show lower quality in for-profit than in nonprofit companies (Comondore et al., 2009; Harrington et al., 2001; McGregor 2005). Examples are fewer employees per caretaker, and lower quality in companies organized in chains (Harrington et al., 2001).

Also, according to the Swedish law, the community pharmacies are a part of the Swedish healthcare system. Pharmacists, for example, have a license that could be withdrawn if they do not put the patients' well-being first. This authorization could be withdrawn if they do not work for the best interests of the patient (The National Board of Health and Welfare 2018). Besides healthcare services, a wide range of merchandise are allowed to be sold in the Swedish community pharmacies.

Changes in pharmacy policy and regulations in Sweden

Two major changes in pharmacy policy can be noted in Sweden: the nationalization of the pharmacy sector in 1971, and its liberalization in 2009 (see Table 1 for an overview of the reforms).

The changes in pharmacy policy in 1971

Before 1971, all community pharmacies were owned by individual pharmacists (Balgård 2012). In 1971, all community pharmacies were bought by the state and incorporated into a state-owned community pharmacy monopoly (named Apoteksbolaget, and later Apoteket AB) (Claesson 1989).

Already before this nationalization, the prices were the same throughout the country, and an economic redistribution system existed where money was transferred from more to less profitable pharmacies. New pharmacies were only allowed to open after the pharmacist had received a grant from the King's administration. The rationale for allowing a new pharmacy to be established was to locate them only in places where it was deemed a need for the population (Lönngren 1999).

In 1971, the organization of pharmacy owners signed a deal with the Swedish state about the takeover, to which the owners did not protest to any large extent. Some reasons for this was that they were heavily compensated, and it was difficult for them to get support for complaints, since the party in cabinet (the Social Democrats - *Socialdemokraterna*) had more than 50% of the seats in the parliament (Börjesson 2002). Also, all the Swedish parties (except the Conservatives - *Moderata samlingspartiet*) stood behind the nationalization, and believed it was a rational decision. It is noteworthy that the word "monopoly" does not seem to have been used during this time. Instead, one editor, in a newspaper associated with the liberal Swedish party, wrote that the nationalization was very welcome, since it would mean an abolishment of the private "pharmacy [i.e., pharmacist] monopoly" (Nilsson, Ohlsson, and Svensson 1982).

The policy makers agreed that the pharmacies were well functioning even before the nationalization. However, some aspects were thought to have improved. One rationale for the nationalization was to put some pressure on the prices. Large companies were seen as more effective than smaller, and policy makers considered the state as being a rational actor to set the prices. Another rationale was to develop a closer connection between the pharmacy sector and the rest of the healthcare sector (Ministry of Health and Social Affairs 2009) Moreover, the state had decided to start subsidizing medicines, and hence desired have power over the pharmacy ownership (Nilsson, Ohlsson, and Svensson 1982).

During the 20th century, 39 different government investigations had been conducted relating to the pharmacy policy, e.g., concerning better use of medicines, safety, and pricing. However, none of them suggested a total abolishment of the state-owned pharmacy monopoly (Ministry of Health and Social affairs 1998).

	Pharmacy ownership in the Swedish pharmacy sector	
2019	The pharmacy sector consists of 1,465 pharmacies	
2010-2015		
2009	The state-owned pharmacy monopoly is liberalized (two thirds of all pharmacies are sold) and new was established. A reform on the generic medicines was launched in order to finance the liberalization.	
2009	The pharmacy sector consists of 925 community pharmacies	
2006-2009	Preparatory work before liberalization of ownership and establishment	
2006	General election with a change in government (from social democrats to a center-liberal government)	
1971-2006		

	The process	The regulations concerning non-prescription medicines in Sweden
	A few large pharmacy companies are present, and about 200 small pharmacy companies. About one third of the pharmacies are state-owned	A large range of non-prescription medicines are allowed to be sold outside of community pharmacies
	Consolidation in the market. Some of the large international pharmacy chains are merged	
	Eight different clusters are sold to private actors. Six large pharmacy companies were formed and about 200 individual pharmacy companies. About one third of the pharmacies are state-owned	
	All pharmacies are organized in a state-owned pharmacy monopoly	Non-prescription medicines sold only in community pharmacies

Table 1. An overview of some reforms in the Swedish pharmacy sector.

The changes in pharmacy policy in 2009

In 2009, two major changes were made in the pharmacy policy in Sweden. First, the state-owned pharmacy monopoly was abolished (Government of Sweden 2009). Second, a large array of non-prescription medicines were released to be sold in general supermarkets (Reje 2008).

When these changes in the pharmacy policy were decided upon, similar changes had already been made in neighboring countries. For example, ownership restrictions had been abolished, with the consequence that more countries had no, or almost no ownership restrictions (Anell 2005; Gross and Volmer 2016; Martins, van Mil, and da Costa 2015; Vogler, Habimana, and Arts 2014; Wisell, Winblad, and Sporrang 2015). Examples include Iceland and Norway, where the ownership and geographic placement regulations were abolished in 1996 (Iceland) and 2001 (Norway). The ownership regulations went from being strictly controlled by the state to very little ownership regulations in both countries (Anell 2005). Before the abolishment of the ownership restrictions in Norway and Iceland, the pharmacy sector consisted of individual pharmacists, having the professional monopoly to run and own the pharmacies.

When the pharmacy monopoly was abolished in 2009, the Swedish state sold two-thirds of all community pharmacies to private owners. The pharmacies were divided and sold in groups, consisting of a different number of pharmacies (Swedish Competition Authority 2010). The reason for this measure was to avoid the oligopoly-formation seen in the Norwegian pharmacy sector (Vogler, Habimana, and Arts 2014). No restrictions were placed on establishing new pharmacies, so additional pharmacies were opened. Furthermore, almost no restrictions were introduced on who was allowed to own a community pharmacy – only prescribing physicians and manufacturers of medicines are forbidden to own community pharmacies in Sweden (Ministry of Health and Social Affairs 2009).

Before the abolishment of the state-owned monopoly, the Swedish pharmacy sector consisted of 925 pharmacies (Growth Analysis 2011). In 2018, there were 1,455 community pharmacies in Sweden, whereof 228 were run by (mostly single) entrepreneurs, and 409 pharmacies were still owned by the state. The rest (818 pharmacies) consisted of large pharmacy chains, owned by large firms (Swedish Medical Products Agency 2018).

The liberalization of the community pharmacy sector in Sweden was more comprehensive and far-reaching than most other pharmacy reforms taking place in other European countries at the same time, and it is important to know more about its background and consequences.

After these major reforms, several governmental reports have been presented that investigate specific effects (Swedish Competition Authority 2010; Swedish Agency for Health and Care Services Analysis 2014; The Swedish Agency for Public Management 2013). However, no investigations have

been done on understanding the underlying rationales, or on determining if the perceived effects are in line with what was expected by the reform.

Aims

The overall aim of this thesis is to contribute to the understanding of the rationales (stated and underlying), the stakeholders' expectations, and the perceived overall outcome of the liberalization of the Swedish pharmacy sector in 2009.

The specific research questions are:

- What were the stated and the underlying rationales for the abolishment of the state-owned community pharmacy monopoly?
- How were the effects of the abolishment of the pharmacy monopoly perceived by key stakeholders?
- How are the present and future roles of community pharmacies and pharmacists perceived by key stakeholders?

Methods

When little is known about an area of interest, and an understanding of *how* and *why* is wanted, qualitative methods are generally suitable (Pope and Mays 1995; Sofaer 1999). The overall aim of this thesis is to increase the understanding of: the rationales leading to the abolishment of the state-owned community pharmacy monopoly as well as the stakeholders' expectations, and the perceived overall outcome. Hence, qualitative methods were used (Denzin and Lincoln 2005; Malterud 2001; Miles and Huberman 1994).

The findings in Paper I led to the formulation of the research questions in Papers II and III, and the findings in Paper II led to the research questions in Paper IV.

Document analysis (Papers I and IV)

In Paper I and Paper IV, qualitative document analysis (Bowen 2009) of written political documents (preparatory work in Paper I, preparatory works and written plenary debates in Paper IV) was used to answer the aims of the studies. The analyses of the documents in both studies were performed with a combination of deductive and inductive approaches (Pope, Ziebland, and Mays 2000), described in more detail below.

Material

Since the aim was to understand the official rationales for the pharmacy policy reform, the material chosen in Paper I was the preparatory work leading up to the ownership liberalization reform (Government of Sweden 2009; Ministry of Health and Social Affairs 2006; Swedish Parliament 2008a).

In Paper IV, one of the underlying rationales for the pharmacy reform – diversity – was analyzed and compared to those of the primary care reform. Both the preparatory works (Ministry of Health and Social Affairs 2006; Swedish Parliament 2008a; Government of Sweden 2009, 145; Ministry of Health and Social Affairs 2007; Swedish parliament 2008; Government of Sweden 2008) and the written debate protocols (The Swedish Parliament 2017) preceding the two reforms were used as material. The comparison was conducted for several reasons: first, the primary care choice reform was made almost simultaneously with the pharmacy liberalization reform. Second, the reforms have several similarities, e.g., competition was introduced in both sectors.

Analysis of the material

The first analyses of the material in Papers I and IV were done deductively. In Paper I, the deductive analysis began with the initial rationales of the Directive (Ministry of Health and Social Affairs 2006), and in Paper IV with the three specific aims of the paper.

In Paper I, all the preparatory work (Directive, Official Government Report and Government Bill) were read, and relevant passages were extracted and condensed. Initially, the rationales stated in the Directive were deductively used as categories. During the reading of the documents, new rationales were inductively identified. Several meetings were held between the researchers during this process. In these meetings, the categories were discussed and modified if necessary.

In Paper IV, the material was searched for the word diversity with synonyms (plurality, variation, innovation, re-thinking, specialization, new ideas, and differentiation). A search was conducted for these terms in the preparatory work and the written plenary debate protocols regarding the pharmacy reform and the primary care reform. Relevant passages were extracted.

It was then obvious from the extracted texts from the primary care reform that “freedom-of-choice” was a rationale for wanting diversity. Thereafter, a search was done for this term in the material regarding both reforms.

After the deductive phase of the analysis in Paper IV, the extracted data were inductively put into sub-categories, e.g., “Different ownership characteristics” and “Specialization.” During this process, several meetings were held between the three researchers.

Interviews (Papers II and III)

In Paper II and Paper III, semi structured in-depth interviews were performed with key stakeholders (six political, three professional, and three patient organization representatives) in order to answer the aims of the studies.

Study population

The selection of organizations and participants to be included was made as a combination of purposeful (Coyne 1997) and snowball sampling (Noy 2008; Powers and Knapp 2011). The purposeful sampling came from several different sources.

First, an interview was held with a pharmacy market consultant, in order to get an overview of the process leading to reform. Secondly, all the written responses from all the stakeholder organizations that wrote a response to the Government Official Report 2008:4 (Reregulation of the Pharmacy Market) were read. This measure was undertaken to identify organizations with strong

and elaborate viewpoints. Thirdly, all political parties who were in government when deciding upon the pharmacy reform were represented, as well as the largest opposition party. Finally, snowball sampling was used as the participants interviewed were asked about which other organizations they considered as being relevant to include. Participants from those organizations were then included. All the organizations contacted agreed to participate. All participants were key persons at the national level, and were the most knowledgeable within their organizations.

The person contacted within an organization was given the opportunity to recommend someone else if they did not consider themselves as being knowledgeable enough regarding the topics of the interview. Two of the persons contacted referred to another person within their organization that they thought was better suited to participate in the study. All other participants that were contacted agreed to participate themselves.

Interview guide

An interview guide was constructed, based on questions raised from the results in Paper I. The interview guide covered subjects, including the political debate before the ownership liberalization reform, the perceived effects of the reform, and the role of the community pharmacy and pharmacist (see Appendix 1). For each participant, the interview guide was slightly modified, making it possible to include questions that emanated from their respective response to the Government Official Report 2008:4 (Swedish Parliament 2008a).

Data collection and analysis

All the interviews were performed face-to-face by the author of this thesis, in a place chosen by the participants (11 out of 12 interviews were performed in the participants' own work place). The participants and the interviewer were the only persons present during the interviews. The interviews were audio recorded and transcribed verbatim. The semi-structured format allowed the participants to elaborate on specific issues, not directly asked about. Probing was used to facilitate this process.

The data collection and analysis of the interviews were made in steps, partly inspired by Malterud (Malterud 2012): first, four interviews were performed, transcribed verbatim, and independently read by two researchers. Themes were developed in an inductive manner (Miles and Huberman 1994). A consensus meeting was held, where the themes were discussed. Subsequently, four more organizations were contacted, and four interviews were conducted. A second meeting was held, during which all the data were analyzed again and the themes were developed in more detail.

Finally, four more organizations were contacted, interviews conducted and transcribed, and complementary analyses conducted. It was decided that the

material should be divided into two parts: one part dealing with the liberalization of ownership and the effects of the reform, and the other part dealing with the role of the community pharmacy and the pharmacist.

Summary of findings

Paper I

The aim of Paper I was to increase the understanding of the rationales for one major change in pharmacy policy in Sweden in 2009. The reform in focus is the abolishment of the state-owned pharmacy monopoly. In this paper, 1,285 pages of preparatory work documents (Directive, Official Government Report and Government Bill) were analyzed.

The results show great differences in the rationales between the beginning and the end of the preparatory work (see Table 2). In the beginning of the preparatory work, rationales such as pressure on prices, efficiency, availability, and (to a lesser extent) a better use of medicines were presented. At the end of the preparatory work, the only rationale still remaining was *availability* (defined as an increased number of pharmacies and their opening hours). One new rationale – diversity – had been added as a rationale for the reform.

Original rationales	Final rationales
Efficiency	-
Pressure on Prices	-
Better use of medicines	-
Availability	Availability
-	<i>Diversity on the market</i>

Table 2. Rationales in the directive compared to rationales at the end of the preparatory work

The initial rationales were in line with the NPM — increased efficiency and pressure on prices were two of the main rationales for the reform — and competition was the mechanism for improvement.

Noteworthy that possible implications for the health of the population were not discussed in the documents. This is unexpected since pharmacists, according to the law, are considered as healthcare personnel when working in a community pharmacy, and the ultimate goal of all healthcare activities is an improved health of the population.

Paper II

The aim of Paper II was to investigate the underlying rationales for, and perceived effects of the pharmacy reform. This aim was chosen as a consequence of the great changes in the rationales shown in Paper I.

The consultation responses found in the Official Government report were initially read, and organizations with strong and elaborate responses were included. In the consultant responses, the organizations included generally expected that the liberalized pharmacy sector would lead to more pharmacies, better service, development of innovative ideas, and more focus on improving usage of medicines.

Stakeholders from 12 different key organizations (see Appendices 1 and 2) were interviewed. The participants were from political (government and opposition), patient, and professional organizations.

The participants mentioned that some of the expectations had been fulfilled: the pharmacy sector now had more pharmacies. Some participants pointed at better service, but also more focus on commercial goods. However, the participants perceived that the liberalization had surprisingly not led to a development of innovative ideas. They also believed that there was less availability of prescription medicines and less connection between pharmacies and the rest of the healthcare sector. Not all respondent groups, however, mentioned the same effects.

At the time of the interviews (March-October 2013), most of the participants had the same attitude toward the reform, compared to prior to the reform. However, a few of the participants that had been positive to the reform prior to the liberalization, spontaneously mentioned that in retrospect they had regrets about the reform.

None of the participants from political organizations mentioned that important rationales for the reform were: efficiency, pressure on prices, or better usage of medicines, i.e., arguments mentioned as being of importance in the preparatory work.

The non-prescription medicines reform (made in conjunction with the liberalization reform) was spontaneously mentioned by some of the participants, even though no question was asked about it. A considerable number of participants from the political organizations confused the liberalization of ownership and the reform on non-prescription medicines. This could be interpreted as that key stakeholders in the liberalization debate might have had a limited understanding of the pharmacy sector.

Paper III

The aim of Paper III was to investigate key stakeholders,' i.e., political , professional, and patient organizations,' views on community pharmacy and community pharmacists. The results show three main viewpoints:

- a) Community pharmacies and pharmacists as health care. Different perspectives existed amongst the participants: first, pharmacists possess a unique expertise (e.g., a safety net for the rest of health care). Second, pharmacists have a unique expertise but should work in other places than pharmacies. Third, pharmacists should only have a superficial role in health care.
- b) Community pharmacies and pharmacists as business, i.e., predominantly commercial organizations.
- c) Community pharmacies only as distribution centers for medicines.

The results show differences between participants that were pharmacists/from professional organizations and participants that were politicians: the first group generally had a more health care-oriented view. Participants that were politicians, generally expressed a more business-oriented view.

Another result in Paper III is that different participants in the study show varying comprehensions of some central aspects – e.g., “being part of the healthcare sector.” In order to get a meaningful discussion, it is vital to try to understand the underlying comprehensions of expressions.

Participants from political organizations expressed that it is the pharmacists' task to take the lead if they want a change in the development of community pharmacies. However, the participants from professional organizations did not seem to be united or willing to take that lead.

Paper IV

The aim of Paper IV was to further understand how policy makers used the concept of *diversity* as an underlying rationale in the pharmacy reform and the primary care reform (see Table 3).

The results show that there were 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 the content of the work.

The rationale for wanting diversity was that policy makers saw it as a way to transfer power from the politicians to patients and personnel. The reforms were seen as a way to make it possible for the personnel to develop their ideas, by letting them decide what they believed to be the most rational use of resources.

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 argumentation of the policy makers lacked several steps, e.g., how the introduction of competition should lead to diversity (and in the end better health).

One difference between the two reforms is that in the pharmacy reform, the choices introduced were seen as a way to improve health (however, discussions were lacking on *how* this was supposed to happen. In the primary care reform, better health is not mentioned as a rationale for wanting patients to be able to make choices. Another difference was how specialization in the work-content was described: knowledge was in focus in the primary care reform, while performing tasks was in focus in the pharmacy reform.

<i>Aim</i>	<i>Category</i>	<i>Sub-categories</i>
Diversity defined		
	Ownership characteristic	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)

Table 3. The main aims and results in Paper IV

Discussion

In the Swedish pharmacy reform, the liberalization seems to have been so important that the reform was performed, even if the preparatory work concluded that the goals initially set were impossible to fulfill.

The liberalization of the Swedish pharmacy sector in 2009 was a unique event. The changes were made from one extreme position – a state-owned pharmacy monopoly – to another: a pharmacy sector with almost no restrictions on ownership or establishment.

The main focus of this thesis is to understand the rationales leading to this major change in the pharmacy policy. The expectations of the reform, as well as the perceived overall outcomes, were studied, together with how the rationales for the reform developed during the preparatory work.

One of the principal findings in this thesis is that the Swedish pharmacy reform in 2009 was mainly ideology-based. Despite an abundance of rational arguments *against* the reform, private ownership became more important than economy and health. Hence, the reform was introduced based on a moral belief, rather than on rational reasoning. It seems to have been more important to get multiple owners than to enhance the quality of the patient-pharmacist interaction or patient health.

Other overall findings were that there was a lack of focus on health aspects, and that the policy makers tended to view community pharmacies mainly as businesses, rather than part of health care.

Below, these main findings and other findings are discussed, followed by a discussion on the methods used in this thesis.

An ideological reform

As described above, the pharmacy reform was mainly based on ideology. This is described in the thesis by the following: First, the reform was not launched because the state-owned pharmacy monopoly was considered to have great flaws (Paper 2).

Second, the reform was carried out despite major changes in the rationales prior to the reform (Paper I). Even though the three initial rationales, i.e., efficiency, pressure on prices, and better health, were abandoned, the reform was launched.

Third, there was – as in other NPM-associated liberalization reforms as shown by e.g., Lægreid et. al and Windrum and Koch (Lægreid, Roness, and Verhoest 2011; Windrum and Koch 2008) – scarce evidence that the proposed

reform would lead to the effects that occurred later in the process (e.g., diversity) (Papers II and IV). In practice, the reform had several unexpected outcomes, such as no development of innovative ideas and less focus on improving use of medicines (Paper II).

Fourth, there are indications that the reform took place without the necessary research on the possible consequences of the liberalization of the pharmacy sector. The effects of the reform could have been foreseen and elaborated on, to some extent. There are several examples of other liberalized pharmacy sectors that show decreased availability of less frequent medicines (Paper II) and no development of new ideas (Paper IV). For example, Vogler et al. (Vogler, Arts, and Habl 2006; Vogler, Habimana, and Arts 2014) indicate that less frequently used medicines are often not available in a specific pharmacy in liberalized pharmacy sectors. If a more thorough consequence analysis were to have been performed, these effects could have been foreseen.

Thus, the reform was implemented despite the above-mentioned arguments. This shows that the reform was not based on rational arguments but mainly on an ideology. As the findings show, privatization *per se* seemed to be an important rationale in the abolishment of the monopoly. The idea of how it *ought to be* was prioritized over what was probably *going to be*, based on the evidence at hand.

Underlying attitudes affecting policy formation

This thesis also adds to the understanding of how underlying attitudes toward a phenomenon can affect policy formation within the area (Paper III). The policy makers seem not to have viewed community pharmacy as part of the healthcare system. This might offer an explanation as to why the proponents of liberalization were not taking into account how the reform might affect the health of the population (Papers I and II). The conflict between business and healthcare is an old and well-described one in the pharmacy sector (Kronus 1975; Resnik, Ranelli, and Resnik 2000), and in this case the business perspective seems to have taken over.

As mentioned above, Papers I and II show that the rationales changed considerably between the beginning of the preparatory work and the end. Below follows a discussion about how the rationales changed over time.

Changes in rationales over time

The reform took place even though two of the major rationales – efficiency and pressure on prices – were abandoned even before the reform was executed (Paper I).

The only rationale that is consistent throughout the preparatory work is availability. Except for availability, neither the original rationales – availability, better use of medicines, efficiency, pressure on prices – nor the added rationale diversity, seem to have been fulfilled.

Availability

The only rationale that was present all the way through the preparatory work, i.e., availability, was achieved with the reform if defined as more pharmacies (and opening hours). However, as Paper II shows, the perceived availability of prescription medicines in the pharmacies was lower than before. A liberalization of ownership and establishment in the pharmacy sector usually leads to more pharmacies being opened (Vogler, Arts, and Sandberger 2012). Since the amount of prescription medicines is the same, it is however a logical consequence that each pharmacy will get a smaller sale and hence probably a smaller stock of prescription medicines, and that availability of prescription medicines in each pharmacy will be less.

Changes in regulations often have unforeseen effects – externality effects. Hence, liberalization of the pharmacy sector also has externality effects (Vogler, Arts, and Habl 2006), where a decrease in equity is one example (since a lot of new pharmacies have been opened in large cities). This could be viewed as liberalization of an establishment criteria leads to more pharmacies, but not evenly distributed within a country. The main issue however is not primarily the clustering of pharmacies in densely populated areas, but that areas with few inhabitants do not have access to pharmacies (Lluch and Kanavos 2010; Vogler, Arts, and Habl 2006).

Better use of medicines

Since community pharmacies are part of the healthcare sector, according to law (The National Board of Health and Welfare 2018), it is noteworthy that health effects were not discussed prior to the liberalization (Ministry of Health and Social Affairs 2006).

The original rationale ‘better use of medicines’ is missing as a final and underlying rationale for the reform (Papers I and II). Also, it is evident that a perceived effect of the reform is that collaboration between pharmacies and other parts of healthcare has diminished (Paper 2).

Since community pharmacies are a part of healthcare (The National Board of Health and Welfare 2018), it could be argued that the ethical principles underlying Swedish healthcare, i.e., equity, human dignity, and cost effectiveness (Ham 1997; Linköping University 2016; Swedish Parliament 2017), are aspects to be considered when investigating and implementing a reform of the pharmacy policy.

However, equity, human dignity, and cost effectiveness are missing in the pharmacy reform; the equity dimension is missing, both as an initial rationale and a final rationale (Paper I). Moreover, cost effectiveness seems to also not be part of the final or the underlying rationale for the pharmacy reform (Papers I and II). Furthermore, human dignity is also not mentioned in either the preparatory work, parliamentary debate protocol (Paper I), or the interviews (Pa-

per II). A possible explanation for this might be that the political representatives have a more business-oriented view toward community pharmacies, compared to most professional- and patient organization representatives (Paper III), and hence do not associate pharmacy policy with healthcare policy, but rather an industrial policy.

Efficiency and pressure on prices

There is not much evidence that privatization reforms always lead to cost savings, and even strong proponents for privatization reforms conclude that this is the case (Savas 1987).

Efficiency and pressure on prices were original rationales in the Directive of the pharmacy reform. However, these rationales disappeared during the preparatory work (Paper I).

This might be because key political stakeholders did not delve into the special economic conditions that are valid in the pharmacy sector, as explained below. Instead, they seem to have had unrealistic expectations of what a liberalization of ownership and establishment might lead to. In addition, they seemed to have believed that the NPM was applicable to the Swedish community pharmacy sector without modifications.

There are some possible explanations for why the NPM is not applicable in this specific case. The first is that the sector represents an imperfect market – which is a market that differs from an ideal market in several ways. One difference is that there is an information asymmetry between the healthcare provider and the patient. Another difference is that professional monopolies prevent the patient from buying what they want, since a prescription is needed. Also, prescription medicines are, to a great extent, reimbursed by the state and not paid for by the patient. Therefore, the possible effect of a pharmacy sector, functioning as a very liberalized pharmacy market is hard to imagine. As concluded by Mestre Ferrándiz: “The one who decides neither pays nor consumes, the one who pays neither decides nor consumes, and the one who consumes neither decides nor pays” (Mestre Ferrándiz 2001).

The second explanation is that an economy of scale is important in the pharmacy sector. As a result, large pharmacy chains have advantages in a liberalized pharmacy sector. For example, in the Norwegian pharmacy sector, an oligopoly was formed rather quickly after the liberalization, and the same can be said for Sweden, although measures were taken to avoid this, for example, vertical integration of the pharmacies was not allowed in the Swedish pharmacy sector. The Norwegian sector is dominated by three large international pharmacy chains, and a similar trend is present in the Swedish sector (Bergeå Nygren 2014; The Swedish Pharmacy Association 2016). The ownership liberalization reforms in Norway (in 2001) and Sweden (in 2009) were performed from very different starting points: Sweden had a pharmacy sector consisting of only one pharmacy company owned by the state, while each Norwegian pharmacy was owned by an individual pharmacist. Despite

the reforms in Sweden and Norway having different starting points, the results are converging. These examples show the difficulties in designing a liberalized pharmacy market with competition between companies, without creating an oligopoly.

Diversity

Diversity was not an initial rationale in the Directive of the pharmacy reform. However, the results in Paper II indicate that the stakeholders in favor of the liberalization reform believed that an abolishment of the pharmacy ownership monopoly would, which is in accordance with the NPM, lead to diversity. It was expressed that the underlying idea of privatization was to create opportunities for ideas to be developed, hence diversity.

Diversity was desired in two different ways: ownership and specialization (Paper IV). The Swedish pharmacy and primary healthcare sectors, however, do not show a great deal of diversity regarding any of these. For example, there are very few nonprofit organizations in these sectors, but mainly large companies (Dagens Samhälle 2015). Some of the participants believed that the pharmacy reform had not led to diversity, which seemed surprising to them (Paper II).

There are several mechanisms that offer possible explanations for the perceived difficulties in obtaining the desired competition-induced diversified healthcare sectors that was wished for.

First, the lack of nonprofit organizations in the Swedish healthcare sectors might offer one explanation for the scarcity of diversity regarding specialization in the content of the work (see Table 3). Traetteberg and Sivesind (Traetteberg and Sivesind 2015) argue that nonprofit organizations, to a greater extent, can adjust to special patient groups and contribute to social innovations. This is because publicly owned providers, and large for-profit companies aim for the whole population, while nonprofit companies generally are smaller, and hence can focus on a special market segment (Traetteberg and Sivesind 2015).

The second explanation is the focus on measuring the outcome, e.g., the “open comparisons” (Swedish Association of Local Authorities and Regions 2019), by measuring different aspects of healthcare, stressing that the outcomes from different providers should be alike. These outcome measurements could make it easier for the customer to choose a healthcare provider; however, it could be questioned whether it spurs diversity. Windrum et al. (Windrum and Koch 2008) argue that in order to have diversity, changes that are initiated from the bottom of an organization are needed. When the focus is on the outcome, then top-down initiated changes are encouraged instead.

Third, there is a discrepancy in knowledge between the patient and the provider. This makes the patient dependent on the healthcare provider, and difficult for the patient to make a judgement on the quality of care. The NPM presupposes that customers (in this case patients) play an active role, and make

well-informed decisions (Lubalin and Harris-Kojetin 1999). In the pharmacy sector, an active patient would demand different medicine management services, and has the capacity to judge the competence of the pharmacist. It could be argued that this is not the case as patients generally lack knowledge regarding what they could demand. Also, expectations on community pharmacies and pharmacists are generally low, and patients often seem content with a low level of professional service. Further, it seems as though the patients' willingness to pay for professional services in the community pharmacy setting is low (Sriram et al., 2015). Lastly, patients often lack motivation to choose (Anderson 2003), even if they have the capability to do so.

Alternative ways to increase availability

The only rationale that remained from the beginning of the preparatory work, until the reform was launched was availability (Paper I). Thus, it seems that this was the most important rationale for the policy makers during the liberalization of the pharmacies. However, there are potentially several alternative ways to achieve availability, that were not considered in the political process. A description of these alternative ways to increase availability is presented below.

Modification of the regulatory document

During the period with a state-owned pharmacy monopoly (1971-2009), a regulatory document defined how the pharmacy company should operate (Swedish Parliament 2008b). An alternative way to increase availability, defined as increased number of pharmacies, could have been for the national government to prioritize the opening of more pharmacies and/or increase opening hours (e.g., in rural or socially deprived areas).

An alternative way to obtain improvement of availability of medicines could, for example, have been to regulate that medicines had to be delivered to the pharmacies several times each day, diminishing the time that the patient had to wait. There is, however, always a balance between the cost and availability of pharmacies, as well as medicines (Swedish Agency for Health and Care Services Analysis 2014).

Establishment criteria

The possibility of regulating where the community pharmacies should be located was briefly discussed in the preparatory work. Availability of community pharmacies in remote areas could have been ensured e.g., through establishment criteria for new pharmacies. These kinds of regulations are used in other countries with privately-owned, and stricter control of ownership of community pharmacies, e.g., Spain, Denmark, and Finland (Lluch 2009; Vogler, Arts, and Sandberger 2012).

Ownership criteria

The possibility to regulate ownership more strictly was not considered as an alternative, either in the preparatory work, or in the parliamentary debate prior to the community pharmacy reforms in 2009. An alternative way to increase availability could have been to allow only pharmacists to own pharmacies, or restrict the number of pharmacies that each owner could own. Noteworthy that e.g., Estonia – a country with a previously liberalized pharmacy sector – has plans to restrict pharmacy ownership to only pharmacists in 2020 (Gross and Volmer 2016).

The balance between business and healthcare

Community pharmacies generally balance between goals from the health policy sector and business objectives (Resnik, Ranelli, and Resnik 2000). When changes are made in the balance between health care and business goals, it follows that the position of the community pharmacy pharmacist is affected. As shown in Paper III, this is also the case in Swedish pharmacies (Paper III). Political stakeholders even view community pharmacies mainly as a retail business, and not as a part of health care (Paper III).

Health policy strives to provide as good health for the population as possible, whereas the objective of the business sector is to earn money. As mentioned above, the number of prescriptions is the same regardless of how the pharmacy policy is designed; hence, the number of prescriptions per pharmacy is lower with more pharmacies, making income from prescription medicines relatively lower for the pharmacy. For pharmacies to increase their income, this could be done mainly through an increased sales of non-medical products (or non-prescription medicines – risking an overuse).

If the pharmacy sector develops toward selling more non-medical products, the consequence can be that society ends up educating pharmacists that are then used in a sub-optimal way; thus, instead of dealing with issues aiming at improving the patients' medicine use (and in the end public health), the pharmacists become used to selling products that are not related to health.

This is problematic as the society will end up not using the tax money in an optimal way and patients will not become as healthy as they could. A shift or focus toward less professional activities can also be seen in other areas where NPM-inspired reforms have been implemented, e.g., in telephone nursing (Kaminsky et al., 2014).

Traulsen et al. (Traulsen and Almarsdóttir 2005) argue that policy makers' views on a profession affect how the public sector in general, and professions specifically, are regulated by policy makers. A consequence of this assumption is that the pharmacy profession needs to take an active part in influencing these views, initiating policy changes, and engaging in the policy making process.

The NPM presupposes that the patient makes choices, and when a pharmacy sector with multiple companies is present, patients are able to make choices. This leads to a transfer of power to the patient – and to the personnel since they can choose a different employer. One question that arises is whether policy makers wish that the power transferred to patients and personnel (from politicians) in NPM-inspired reforms should also result in a transfer of power from the profession to the patient? Patients making choices within healthcare could potentially mean that patients make choices based on e.g., their convenience, rather than on what is best for their own health. In that way, the evidence-based knowledge that professions within healthcare have could be undermined.

When changes in the balance between health care and business goals are made, it follows that the position of the community pharmacy pharmacist is affected.

The position of the pharmacist/pharmacy owners

The pharmacy sector, which was created after the liberalization, was not designed in order to put focus on the pharmacist profession and its competencies. Instead, almost anyone could now own a pharmacy, and the focus was mainly to increase the number of pharmacies.

One way to obtain more autonomy for pharmacists is to have a pharmacy sector where ownership is restricted to pharmacists. This is the case in e.g., Finland and Spain (Choosehealthcare.fi 2018; Lluch and Kanavos 2010). The rationale for restricting ownership to pharmacists is to get as high quality as possible (Vogler, Habimana, and Arts 2014). Jacobs et al. (Jacobs, Ashcroft, and Hassell 2011) argue that the mechanism for quality enhancement is that the pharmacists would do what is best for the patient, and in that way ensure a high quality of service. This kind of “pharmacist-centered” pharmacy sector was (as shown in Paper I) not discussed in the preparatory work. Some of the rationales for wanting diversity, e.g., specialization in the content of the work (shown in Paper IV), might have been easier to reach with a pharmacist-centered pharmacy sector.

For a professionalization process to occur, one factor that needs to be fulfilled is that the profession is granted a wider professional monopoly (Larson 1977, 199). For this to happen, the profession needs to: first, know what it wants; second, be somewhat united; and third, be able to articulate what their jurisdiction should be.

At the time of the liberalization, the Swedish pharmacists were divided into two different unions: the larger Sveriges farmaceuter (*The Swedish Pharmacists*) and the smaller Farmaciförbundet (*The Swedish Pharmaceutical Union*). Sveriges farmaceuter was a strong proponent for the pharmacy reform, while Farmaciförbundet was against the reform.

When the new pharmacy policy was constructed, it was not in line with the wishes of the pharmacist union that was in favor of the reform. One rationale

for them was that the liberalization would lead to better use of medicines, e.g., through pharmacists in the community pharmacies being better utilized (The Swedish Pharmacists 2006). The policy makers, however, had very different rationales (Papers I and II) for the reform. Despite the different viewpoints, politicians used the unions' will to abolish the monopoly as an argument in the debate. The professional organization was not as positive after the reform (Paper II).

One conclusion to be drawn from this is that an organization needs to think about whether they have the ability to influence the design of a reform, and not only whether a reform should be executed.

Reasons for the great changes in pharmacy policy

There are several possible explanations, related to pharmacy owners and pharmacists, for the great extent of the changes in Swedish pharmacy policy in 2009. Paper I shows that the policy makers did not consider any other alternatives than a pharmacy sector with no restrictions on ownership and establishment.

A contributing factor for this radical change might be that Sweden, during 1971-2009, had no professional pharmacist organization (although two unions), and only one pharmacy owner – the government itself. In other countries that have undergone changes in their pharmacy policy, the associations of pharmacy owners are usually important actors (Kaae et al. 2009), as are professional/pharmacist professional organizations. This absence might have contributed to the extent of the changes, and the relatively small resistance, here in Sweden.

When a profession is not united, e.g., organized in two different unions (like in Sweden), it might be easier for policy makers to implement extensive reforms without resistance. This was also seen in e.g., Iceland, where a non-united profession lost their professional monopoly due to e.g., internal strife (Morgall and Almarsdóttir 1999).

The change in the pharmacy policy in 2009 was comprehensive, and led to the abolishment of a state-owned pharmacy monopoly, which had been constructed about 50 years before. Below follows a brief description of the similarities regarding the rationales for the two reforms.

Similarities between the reforms in 1971 and 2009

In 1971, the state-owned Swedish pharmacy monopoly was created, and in 2009 it was abolished. There are a number of similarities between the changes in the pharmacy policy in 1971 and 2009. First, in both cases, the policy makers did not express that the pharmacy sector had great flaws. Second, many of the initial rationales prior to the two reforms were the same: pressure on prices, efficiency, and better use of medicines. A state-owned pharmacy monopoly was seen as a way to put pressure on the prices for both the patients and the

state, since it was assumed that the individual pharmacies had too much profit. Also, a monopoly was seen as a way for the state to make pharmacies more closely connected to health care. It was argued that if the state-owned all the pharmacies, the state could decide on what the pharmacist and the pharmacies should do (Ministry of Health and Social Affairs 2006; Nilsson, Ohlsson, and Svensson 1982). Third, both the reforms in 1971 and in 2009 were very comprehensive. In 1971, all the community pharmacies were bought by the state, and simultaneously, the professional monopoly for pharmacists was abolished. In 2009, two-thirds of the community pharmacies were sold. At the same time, there was no introduction of restrictions on establishment, and almost none on ownership.

Thus, it seems that pharmacy policy in Sweden has a tendency to change drastically. Also, it seems that the rationales for comprehensive reform in the Swedish pharmacy policy in these two cases had very similar rationales, even though the two reforms had different ideological backgrounds and led to very different pharmacy sectors.

Methodological considerations

This thesis focuses on a major change in pharmacy policy in Sweden, namely the abolishment of the Swedish community pharmacy monopoly in 2009. The focus is not particularly on outcomes, but on the political process and the rationales for the reform.

The preparatory work and the written plenary protocols were used as data, as well as qualitative interviews from policy makers and other stakeholders. One strength of this thesis is that Papers I and II try to understand the same reform, but from different perspectives. This shows that the results are not only coincidental (Flick 2008). First, different data material are used: document analysis (Paper I) and semi-structured interviews (Paper II). The document analysis in Paper I shows that diversity is one rationale for the liberalization. Also, diversity is an underlying rationale in the interviews (Paper II). Second, three different stakeholder groups are interviewed in Papers II and III, making the results more nuanced.

Another strength is that all participants in Papers II and III were interviewed face-to-face by the same interviewer, and the interviewer also had interviewing experience.

Snowball sampling has been criticized for only allowing a certain part of participants to be included in a study (Shafie 2010). In Papers II and III, a combination of purposeful- and snowball sampling is therefore used (both within the organizations and regarding what organizations should be contacted).

Another limitation of Papers II and III is memory bias. The interviews were performed about four years after the change in the pharmacy policy in 2009.

However, the interview guide was partly based on their organizations' written consultant responses. By using the consultant responses, it helped the interviewees to remember the facts and diminished the risk of memory bias.

One potential problem in interview studies is that the interviewer will affect the responses given by the participants. Depending on the characteristics of the interviewer (e.g., age, professional power, the environment of the interview) (Richards and Emslie 2000), the answers given by the participant will differ. In this case, the interviewer was a pharmacist. This could mean that the participants, because of effects of social desirability, answered more positively regarding questions that dealt with pharmacists. However, the participants were all chosen for their specific knowledge within the area, and were interviewed in their professional roles. The participants were also more used to being interviewed than e.g., individual patients, and were not dependent on the interviewer. The place for the interview was chosen by the participants themselves – making them more comfortable in the interview situation.

A limitation of Paper I is that only the first author read the whole material in detail, and searched for the relevant words in Paper IV. However, the suggested themes were discussed in several consensus meetings with co-authors, and disagreements were discussed until a consensus was reached.

In Paper IV, one limitation is that the same amount of written debate protocols was not used for the search regarding the two reforms. In the pharmacy reform, all the protocols that included the word “pharmacy” were assessed, whilst only the written debate protocols regarding the primary care reform were searched, and only the ones that dealt with the reform *per se* were assessed. There were two reasons for this: first, it was obvious that in the case of the pharmacy reform, most of the statements relevant for this study were made in the debate protocol directly related to the decision in the parliament. Second, the amount of written debate protocols dealing with the primary care reform (or other related reforms) was too large to be manageable.

The trustworthiness of this research

Quality in qualitative research cannot be measured by any statistical or mathematical formulas. Instead, there are other aspects that are used to assess quality. Which aspects should be considered, and what terms should be used vary between different scholars (Denzin and Lincoln 2005; Emden and Sandelowski 2002). Here, I use the term trustworthiness, as suggested by Graneheim and Lundman (Graneheim and Lundman 2004). Trustworthiness is an overall term that describes the extent to which the research should be trusted. According to Graneheim and Lundman (Graneheim and Lundman 2004), there are several ways to obtain a high trustworthiness.

First, there is *credibility*, which concerns e.g., how the aim aligns with the material, and how the material are collected. The aim of Paper I and Paper IV

was to understand the official rationales for the pharmacy reform; thus, preparatory works and plenary debate protocols were used, where the official views could be found. In Papers II and III, the participants were chosen with a combination of snowball and purposeful sampling. This increases credibility, since the organizations themselves could identify the most knowledgeable persons within their organizations. The sampling method made it possible to include participants with several perspectives (political, professional, and patient organization representatives), in order to get a more nuanced picture. Quotations are used in all of the papers, a factor that further increases credibility. Also, the co-researchers discussed the analyses thoroughly.

Second, there is *dependability*, which deals with how the data changes over time, and how the researcher develops the analysis. In Papers II and III, themes were developed gradually during the reading of the text. For example, the eighth participant contributed with an extensive amount of information about how the change in pharmacy policy could affect public health. This led to a new reading of the material, and eventually to the creation of a new category. Also, the participants were given slightly different questions based on their organization's written responses on the Swedish Government Official Report.

Third, there is *transferability*, which covers the extent to which the research can be transferred to other contexts. This liberalization refers to a state-owned pharmacy monopoly creating a pharmacy sector, with almost no ownership and establishment criteria. However, when a change in pharmacy policy is made in a country with a pharmacist-monopoly (with ownership and establishment criteria), and all these regulations are abolished, it would also be an extensive liberalization. The starting point is different, but the end result can be almost the same, as seen in e.g., Norway, where an oligopoly was formed (Anell 2005). Hence, even if the Swedish reform was unique, it is possible for other countries to learn something from this research.

Transferability is further increased through a thorough description of the setting. Furthermore, the usage of the NPM as a frame for the analyses could make it easier to apply the findings to other settings.

Future studies

Policy change is an ongoing process. One contemporary example is that the Swedish Government² launched a new official government report (Ministry of Health and social affairs 2017) (*Nya apoteksmarknadsutredningen*) in 2017. It would be interesting to compare the rationales of the Social Democratic Government to those of the center-right government back in 2009. Could this new official government report be viewed as a consequence of the changes in

² A change in government took place in Sweden in 2014, changing from a Liberal-Conservative Government to a Social Democratic-Green Government.

pharmacy policy in 2009, a part of the reform, or a separate reform? Is this new reform a “fix what they broke,” approach or is the government using the competition introduced in the pharmacy sector in 2009 as a tool to reach the overall goals of community pharmacies – i.e., better health of the population?

Another possible future study is to investigate if and how community pharmacists want their role to develop, also in comparison to other countries with differing pharmacy policy designs. Another aspect would be to study the attitudes of other health professionals regarding using pharmacists in order to improve the health of the population. When barriers are identified, it will be possible to find ways to overcome them.

These aspects, in combination with the fact that the business aspect of community pharmacy seems to become more important, make this field interesting.

How can this research be used?

A goal of this research was to increase the understanding of the change in pharmacy policy, and evaluate how knowledgeable stakeholders within the field contribute to and understand the reform. The ultimate goal is to get a more initiated discussion in society about how liberalization reforms are prepared and implemented.

This dissertation can hopefully contribute to the discussion of how a large change in society is made, e.g., through an increased understanding of how and why the rationales of a reform change over time.

I would like to contribute to this discussion in the following three ways:

First, to increase the understanding of the underlying rationales for the liberalization of ownership, and the whole change in the pharmacy policy in Sweden in 2009. Also, if carefully applied, some conclusions can be drawn for other countries and areas.

Second, to inform policy makers and other stakeholders in order to contribute to a more rational policy making. A more rational policy making could be achieved if the possible consequences of the reform are investigated more thoroughly, such as comparing with other countries or policy areas. This, according to Parsons (Parsons 1995), is an analysis *of* policy, where research is used in an instrumental way (Huberman 1990).

Third, in a more conceptual way (Caplan 1979), change the way policy makers see community pharmacies. I hope that this thesis can increase the awareness of, and contribute to the discussion about, the future roles of community pharmacies and pharmacists.

These different perspectives mean that an instrumental view on use of evidence, with a more positivistic view on policy making as a rational process is combined with a hope of a conceptual change in the view of community pharmacies and community pharmacists.

The results, hopefully, can help policy makers to create conditions and regulations that further improve pharmacy policy, with the ultimate goal to increase patient health.

Conclusions and implications

This thesis contributes to the understanding of the rationales, expectations, and perceived outcome of the liberalization of the Swedish pharmacy sector in 2009.

The stated rationales for the reform changed during the preparatory work; however, there were underlying rationales. In the interviews, none of the participants from the political organizations mentioned the initial stated rationales for the reform – efficiency, pressure on prices, or better usage of medicines – i.e., arguments mentioned as being of importance in the preparatory work.

One conclusion to be drawn is that instead of investigating alternatives to achieve the goals, which could have been to only allow pharmacists to own pharmacies, or imposing regulations on where the pharmacies could be located, there seemed to be a pre-understanding, considering how the community pharmacy sector should be regulated.

The effects of the reform were perceived in quite the same way by different stakeholder groups, and not as positive as prior to the reform. The stakeholders believed that the reform had, surprisingly, not resulted in a development of ideas, and led to less availability of prescription medicines, and less connection between pharmacies and the rest of the healthcare sector. As expected by the key stakeholders, the pharmacy sector now consists of more pharmacies. However, there seems to not have been any examination of the possible negative consequences of getting more pharmacies.

The key stakeholders' views on community pharmacies/pharmacists differed; politicians generally had a business-oriented view. Hence, another conclusion to be drawn is that community pharmacies are not generally viewed as a part of health care.

The findings reflect that the pharmacy reform was carried out mainly on an ideological basis. There are several reasons for this conclusion (Flick 2008). First, the reform was launched despite the original rationales being considered as impossible to fulfill, and hence were changed profoundly in the preparatory work. Second, the stakeholders did not seem to know what the reform should lead to, except to abolish the state-owned pharmacy monopoly and get more pharmacies.

Another lesson to be learned is the importance of more thorough investigations prior to a reform, especially concerning possible future difficulties/challenges. If this is done, the probability of ending up with a reformed or liberalized sector functioning as was desired could possibly be increased.

Implications for policy makers

Policy makers need to know and understand the rationales for a reform. If the means instead become the goal, there is a possibility that the effect will not be what was desired. In the case of the pharmacy policy, health is one reason for having medicines in special places (pharmacies). It is of paramount importance that knowledgeable civil servants and representatives of the field, e.g., professional organizations, unions, and other stakeholders are involved in the process prior to a reform.

Implications for the pharmacy profession

The pharmacy profession needs to be clear on what their rationales are for a change in the pharmacy policy. This should be done e.g., by formulating and presenting possible future roles of the pharmacist to the policy makers.

The profession needs to be more proactive in the future and show that a pharmacy sector and the role of the pharmacists could be designed in many different ways.

Pharmacists also need to be more explicit on what they want to achieve with a pharmacy policy. Also, it is imperative to think through what the negative consequences (for the profession as well as the health of the population) might be following a change in pharmacy policy.

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No man is an island.

John Donne

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Varför skedde omregleringen av apoteksmarknaden?

Avhandlingen handlar om den stora förändringen av Sveriges apotekssektor 2009. Mellan 1971 och 2009 ägdes alla apotek i Sverige av staten, men 2009 upplöstes apoteksmonopolet. Varför skedde det? Vad ville politikerna uppnå genom att sälja två tredjedelar av alla apotek? Det är bland annat det som jag undersöker i den här avhandlingen. Till min första artikel har jag därför läst allt förarbete – alla de skriftliga politiska dokument som föregick reformen – och sedan analyserat materialet.

Förarbetet bestod av 1285 sidor, och innehöll direktivet, den offentliga utredningen och propositionen före omregleringen av apoteksmarknaden. I den första delen av förarbetet – direktivet – anges bättre tillgänglighet, effektivisering, prispress och bättre läkemedelsanvändning som skäl för reformen. Men under förarbetets gång försvinner flera av skälen, så i slutet finns bara bättre tillgänglighet kvar, definierat som att Sveriges apotek ska bli fler. Ett skäl har också tillkommit: diversitet på apoteksmarknaden.

Eftersom skälen i så stor utsträckning förändrades, ville jag undersöka vad de bakomliggande skälen till reformen var. För att komma vidare valde jag att djupintervjua personer som hade stor insikt i apoteksomregleringen. Både personer från politiska organisationer, professions- och patientorganisationer blev intervjuade. Organisationerna fick själva välja ut den inom organisationerna som skulle intervjuas. Skälet var att det är de som bäst vet vem som har mest kunskap om omregleringen, vilket inte alltid sammanfaller med att ha en ledande position.

Intervjufrågorna baserades delvis på de olika organisationernas remissvar med avseende på omregleringen. Ett mål bland patientorganisationerna var att omregleringen skulle leda till bättre användning av apotekaren och receptariens kunskaper, men i intervjuerna framkom att de ansåg att rådgivningen på apotek istället har blivit sämre efter omregleringen. I intervjuerna framkom även att ett mål med omregleringen var att få mer diversitet, och att apotekarna och receptarierna inom apotekssektorn skulle få utveckla sina idéer. De som varit för omregleringen var dock förvånade över att apoteken efter omregleringen var så lika varandra. Bland deltagarna från patientorganisationer fanns även uppfattningen att omregleringen lett till att patienterna hade svårare att få tag på sina mediciner.

Inställningen olika makthavare har till öppenvårdsapotek och apotekare/receptarier kan påverka hur regleringarna inom apoteksområdet utformas. Därför valde jag att även ställa frågor om intervjudeltagarnas syn på apotek och apotekarens/receptariens yrkesroll på apotek.

Öppenvårdsapotek styrs både av regler och idéer från affärsvärlden och från hälso- och sjukvården. Denna splittring märktes väl i intervjuerna. Deltagare från politiska partier hade en mer affärsinriktad syn på apotek och apotekare/receptarier. Deltagare från professionsorganisationer, eller deltagare som var apotekare, hade en mer hälso- och sjukvårdsinriktad syn. Men även bland de som hade en mer hälso- och sjukvårdsinriktad syn fanns det olika uppfattningar om vad en apotekare/receptarie på öppenvårdsapotek är och bör vara. Vissa ansåg att apotekaren/receptarien har en unik spetskompetens, medan andra ansåg att kompetensen och den önskvärda rollen är mer bred. En slutsats var att ingen verkade vilja ta ledningen för utvecklingen av apotekarens och receptariens yrkesroller på apotek.

I den sista artikeln i avhandlingen valde jag att gå vidare med att undersöka diversitets-begreppet. Vad menade politikerna med diversitet, och hur tänkte man sig att det skulle uppnås? I denna studie jämförde jag även med en annan reform på hälso- och sjukvårdsområdet, som genomfördes nästan samtidigt: vårdvalet. Materialet som användes var såväl förarbetena som de riksdagsdebatter som föregick de båda reformerna. Resultatet visar att begreppet diversitet definieras som antingen skillnader i ägarskapsegenskaper eller i innehåll. Det innebär antingen skillnader i storlek eller i ägarskap, eller i skillnader i vad de olika apoteken/vårdcentralerna gör.

Exempel på diversitet är apotek som utför tester i olika grad. När det gäller vårdcentraler angavs olika vårdcentraler som är specialiserade mot en specifik sjukdom. Ett annat intressant fynd var att patientens hälsa inte var i fokus vare sig i omregleringen eller i vårdvalet.

Efter att detaljerat ha undersökt skälen till omregleringen, satte jag även mina upptäckter i ett sammanhang. En slutsats var att omregleringen av apoteksmarknaden främst gjordes av ideologiska skäl. Reformen genomfördes trots att inga uppenbara brister fanns, och trots att alla motiv i direktivet utom tillgänglighet försvann i förarbetet. Dessutom finns det väldigt lite evidens för att reformer som denna leder till diversitet (som var ett viktigt bakomliggande skäl för reformen). Istället verkar privatisering i sig vara ett viktigt skäl för reformen.

För att undvika att reformer i framtiden ska leda till oväntade och negativa effekter, är det viktigt att före en reform förutsättningslöst undersöka vad den skulle kunna leda till. Om vi ser på omregleringen som en liberalisering märker vi lättare att det finns andra länder eller kanske områden som vi kan jämföra med. I den här avhandlingen har jag sett omregleringen som en reform som starkt påverkats av New Public Management – och sådana reformer har

gjorts över hela världen. Så även om Sverige är unikt, och Sveriges apoteksmonopol var unikt, hade man kunnat finna paralleller från andra platser. På så sätt hade man kunnat förutse flera av effekterna omregleringen fick.

För att politiker i framtiden ska kunna genomföra reformer på ett mer ändamålsenligt sätt, behöver de kunniga och aktiva rådgivare från professionen. En uppmaning som jag skulle vilja rikta till apotekar- och receptarieprofessionen är att våga formulera tydliga mål, och ta ansvar för utvecklingen av professionen. För det kan bara professionen själv göra – inte politikerna.

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Appendices

Appendix I. Topics covered in the interview guide

Occupation, experience in pharmacy

Pharmacies—could you tell me what pharmacies mean to you?

What is the vision regarding the role of pharmacies in society?

What is the vision regarding the role of the pharmacist in society?

What did your organization want to achieve with the re-regulation? /What did your organization want to retain from the pharmacy monopoly?

What was the most important rationale for the re-regulation? Why?

How should that be achieved?

Has the re-regulation of the pharmacy market affected the pharmacies?
How?

Has the pharmacies possibilities to contribute to a better health of the population been affected? How?

Has the increased number of pharmacies affected the health of the population? How?

Has the change in the pharmacy market, with more but smaller pharmacies, changed the role of the pharmacist?

Appendix II. Organizations included in Papers II and III

National Pensioners' Organization (PRO) - Organization for senior citizens

The Swedish Association for Senior Citizens (SPF) - Organization for senior citizens

The Swedish Rheumatism Association (Reumatikerförbundet) - Organization for rheumatism patients

New Conservatives (Moderaterna) - Governmental party at the time of the reform

The Liberal Party of Sweden (Folkpartiet) - Governmental party at the time of the reform

The Center Party (Centerpartiet) - Governmental party at the time of the reform

The Christian Democrats (Kristdemokraterna) - Governmental party at the time of the reform

The Social Democrats (Socialdemokraterna) - Non-governmental political organization

Swedish Association of Local Authorities and Regions (SKL) - Non-governmental political organization (The umbrella organization of the local governments)

Swedish Pharmaceutical Society (Apotekarsocieteten) - The goal of the organization is to further pharmaceutical research and to promote high professional standards.

The Swedish Pharmaceutical Union (Farmaciförbundet)

The Swedish Pharmacists (Sveriges farmaceuter) - Labor union

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