HiT Summary

Sweden

Introduction

Government and recent political history

Sweden is a monarchy with a parliamentary form of government. The King is Head of State but his position is only symbolic. There are three independent governmental levels – the national government (Riksdag), the county councils (Landsting) and the municipalities (Kommuner) – and they are all involved in health care. Elections are held every 4 years at all three levels. In addition, there are a number of central government bodies involved in the Swedish health care system. Overall goals and policies are set at national level, but it is the local authorities that are responsible for the provision of health care in Sweden.

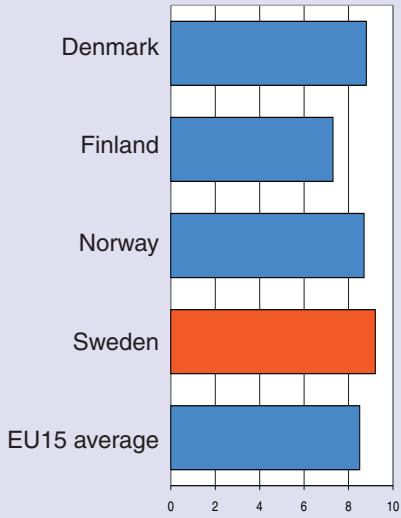
Population

The Swedish population reached 9 million in 2004. Approximately 83% live in urban areas. On average there are 22 inhabitants per km^2 of land area, with a high concentration of people living in the coastal regions and in the south of the country. Stockholm, the capital, is the largest city, and had 1 684 000 inhabitants in 2002. Like in many other industrialized countries, Sweden has a low fertility rate (1.64 in 2002), and this has resulted in negative natural population growth since the late 1990s. Real population growth, however, was 0.36 in 2003 because of positive net migration into Sweden. In 2003, 12% of the population were immigrants.

Average life expectancy

Life expectancy in Sweden is among the highest in the Nordic countries: 82.4 years for women and 77.9 years for men in 2003. During the past 30 years, the average life expectancy has risen by 5.5 years. Today Sweden has one of the world's oldest populations, with more than 17% of the population being aged 65 years or older and 5.2% aged 85 years or older. Disability-adjusted life expectancy was 73.3 years in 2002.

Fig. 1. Total health care expenditure as a percentage of GDP, comparing Sweden with selected countries and the EU average, 2002



Source: OECD Health Data 2004.
Note: EU: European Union; EU15: Member States before 1 May 2004.

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Leading causes of death

Mortality due to diseases of the circulatory system has been significantly reduced during the last 30 years, and this is one of the major factors contributing to the rise in life expectancy in Sweden. Diseases of the circulatory system, however, are still the leading cause of mortality, accounting for almost half of all deaths in 2001. Tumours were the second largest cause of death in the same year. Programmes developed to prevent accidents have been successful in Sweden. Currently, Sweden, Norway and the United Kingdom account for the world's lowest rates of mortality from traffic accidents. Similarly, work-related injuries and deaths have been significantly reduced during the past 50 years. The decrease is most prominent in the transport and construction sectors. Deaths due to mental illness, diseases of the nervous system, and diseases of the eyes and ears increased between 1970 and 2001.

Recent history of the health care system

In 1970, the responsibility for outpatient services in public hospitals was transferred from national level to county council level, and, during the 1980s, responsibility for the planning of health care was decentralized from national level to the county councils. The 1982 Health and Medical Services Act gave the county councils full responsibility for matters relating to health care delivery, i.e. they were made responsible not only for providing health care, but also for health promotion and disease prevention for their residents. In 1992, the responsibility for long-term inpatient health care and care for the elderly was transferred from the county councils to the local municipalities. A few years later, in 1996, the municipalities took over the responsibility of care for the physically disabled and for those suffering from long-term mental illnesses.

In terms of health care financing, in 1985 a reform was introduced whereby a per-capita reimbursement formula, adjusted for needs-related social and medical criteria, was adopted. Previously, health insurance reimbursement for ambulatory care was made to the county councils according to the number of outpatient visits. In 1998, in an attempt to curb the increasing expenditure on pharmaceuticals, the county councils took over financial responsibility for prescription drugs from central government. During the late 1990s, mergers across both hospitals and county councils took place with the objective of increasing efficiency and reducing administrative costs.

Reform trends

During the 1970s and early 1980s, the focus of health care reforms was on issues of equity; in the late 1980s, it was on cost containment; in the early 1990s, it was on efficiency; and in the latter part of the 1990s, the focus was on structural changes in the delivery and organization of health care. Reforms in the early 2000s have been in response to renewed concerns about cost containment. Decentralization of responsibilities (i.e. from national level to the county councils and municipalities) has been a central element of reform.

Health expenditure and gross domestic product

In 2002, Swedish health care expenditure was 9.2% of the gross domestic product (GDP), which exceeds the EU15 average (Fig. 1). Health care expenditure as a proportion of GDP remained stable during the late 1980s and 1990s. There was, however, an increase from 8.4% to 9.2% between 2000 and 2002.

Organizational structure of the health care system

The Swedish health care system is organized at three levels: national, regional and local. The regional level, through the county councils,

together with central government, forms the basis of the health care system. Overall responsibility for the health care sector rests at national level, with the Ministry of Health and Social Affairs. The National Board of Health and Welfare, a semi-independent public authority, has a supervisory function over the county councils, acting as the Government's central advisory and supervisory agency for health and social services. The Board supervises the implementation of public policy matters and legislation on health care and social welfare services. The Ministry of Health and the National Board of Health and Welfare collaborate with other central governmental bodies, the most important of which are the Medical Responsibility Board, the Medical Products Agency, the Swedish Council on Technology Assessment in Health Care, the Pharmaceutical Benefits Board and the National Institute of Public Health.

At regional level, 18 county councils, two regional bodies (Västra Götaland and Skåne) and one municipality not belonging to a county council (Gotland) are in charge of the health care delivery system from primary care to hospital care, including public health and preventive care. The county councils are grouped into six medical care regions. These regions were established to facilitate cooperation in tertiary care among the county councils.

At local level, there are 290 municipalities with their own areas of responsibility. The responsibilities of municipalities include issues concerning the immediate environment of the citizens, e.g. schools, social welfare services, roads, water, sewerage and energy. Besides providing financial assistance, social services in Sweden include provision of child care, school health services, environmental hygiene, and care of the elderly, the disabled and long-term psychiatric patients. The municipalities operate public nursing homes and home care. County councils and local authorities are members of the Swedish Association of Local Authorities and Regions, which represents their interests.

Planning, regulation and management

The county councils plan the development and organization of health care according to the needs of their residents. Their planning responsibilities also include health services supplied by other providers, such as private practitioners and physicians in occupational medicine. The county councils regulate the private practitioners' market in the sense that, by approving an establishment, they also approve public reimbursement of the practitioner(s). Most health care facilities are owned and operated by the county councils.

The Ministry of Health and Social Affairs draws up terms of reference for government commissions, drafts proposals for the Parliament with regard to new legislation, and prepares other government regulations. The National Board of Health and Welfare is the Government's central advisory and supervisory agency in the field of health services, health protection and social services.

Decentralization

The 18 county councils (and two regions and one municipality without a county council) form the basis of the Swedish health care system. Sweden has a long tradition of local self-government. Responsibility for health care is decentralized to regional and local governmental bodies, with the exception of overall goals and policies, which are determined at national level. The political responsibility for financing and providing health services lies with the county councils, whereas local municipalities are responsible for delivering and financing long-term care for the elderly and the disabled and long-term psychiatric care. The municipalities are not subordinate, or accountable, to the county councils.

Decentralization of responsibilities within the Swedish health care system does not only refer to legislative devolution between the central and local governmental bodies, but also involves decentralization within each county council.

Since the 1970s, financial responsibility has been decentralized within each county council, and the degree of decentralization, organization and management varies greatly among the county councils.

Health care finance and expenditure

Main sources of finance

The Swedish health care system is primarily funded through taxation. Both the county councils and the municipalities have the right to levy proportional income taxes on their respective populations. In addition to these taxes, the financing of health-care services is supplemented by state grants and user charges.

In 2003, 72% of the county councils' revenues originated from regional taxes. The remainder consisted of state grants (18%), user charges (3%) and other sources (7%). The proportion of total county council revenue mobilized through taxes has increased considerably over the last 20 years. Municipalities generate the major part of their revenues through local taxes (69% in 2003). During the last 5 years, user fees – as a proportion of total municipality revenues – decreased by 0.6%, whereas local taxes increased by 3.7%.

Complementary sources of finance

The social insurance system, managed by the Swedish Social Insurance Agency, provides financial security in case of sickness and disability. Subsidies for dental care and prescription drugs are also paid for by national social insurance. Insurance is mandatory and covers part of the individual's income loss due to illness and use of health care services. Most national health insurance is financed by employers' contributions; the remainder is financed by specific transfer payments from central government. Private health care insurance is very limited in Sweden: in 2003, about 2.3% of the population had supplementary insurance.

Health care benefits and rationing

No basic or essential health care or drug package is defined within the Swedish health system. Instead, there are some definitions as to what does or does not fall within the domain of health care, and there are general guidelines regarding priorities in the health care sector. Priorities should be determined according to three basic principles: the principle of human dignity, the principle of need and solidarity, and the principle of cost-effectiveness. In the event of sickness or injury, the patient is ensured medical attention from institutions that have the competence and resources to handle the situation. With the exception of reduced subsidies for dental care, there have been no major changes in the benefits package over the last 20 years. Patients have the right to choose their primary care physician without geographical restrictions.

Under the terms of the social insurance scheme, the patient pays the entire cost of prescribed pharmaceutical preparations listed in the national Drug Benefit Scheme, up to 900 Swedish kroner (SKr). Above this level, a rising scale of subsidy operates, with a high-cost ceiling of SKr 1800 over a 12-month period. Pharmaceuticals not listed in the Drug Benefit Scheme are only available following full payment by the patient. National social insurance benefits include sickness insurance, parental insurance (leave), a basic retirement pension, a supplementary pension, child allowance, income support and housing allowance.

Health care expenditure

Health care expenditure, expressed as US$ purchasing power parity per capita, was 2517 in 2003, which is slightly higher than the EU15 average of 2326. In relation to neighbouring countries, the Swedish value was lower than those of Norway (3083) and Denmark (2580), but higher than that of Finland (1943).

In 2003, 24% of public consumption expenditure originated from the county councils, 48% from the municipalities and 28% from central government. Of the total county council expenditure in 2003, 92% was directly connected to health and dental care services. Expenditure on care for the elderly and those with disabilities constituted 30% of the municipalities' total expenditure in the same year.

Health care delivery system

Primary health care

The purpose of primary care is to improve the general health of the population and to treat diseases and injuries that do not require hospitalization. Primary health care is also responsible for guiding the patient to the right level within the health system. According to a government decision in 1995, all physicians in primary care medicine must be specialists in general practice. The terms general practitioner, family physician or district physician vary depending on local political and organizational decisions, but all refer to specialists in general medicine within primary health care. General practitioners provide treatment, advice and disease prevention. The other practitioners directly employed at this level are nurses, midwives, physiotherapists and gynaecologists.

Each county council has the freedom to decide how to serve its population in terms of primary care. Primary care is mainly publicly provided. However, there are also private providers at this level and, in addition to provision at local health centres and family physicians' surgeries, primary care is supplied by private physicians and physiotherapists, at district nurses' clinics and at clinics for child and maternity health care. Private health centres and practitioners are relatively common in major cities and in urban regions. In 2003, Sweden had around 1100 health centres, of which approximately 300 were privately run.

From an international perspective, Sweden has relatively few physician contacts per person. During 2003, the number of outpatient (health centre units, public and private) contacts in Sweden was 2.8 per person.

Public health services

The National Institute of Public Health is responsible for running health-promotion and disease-prevention programmes at national level. The National Board of Health and Welfare has the specific role of supervising and monitoring the public health care activities of county councils and municipalities. The Centre for Epidemiology monitors and analyses the health status and the social situation of the population. Municipalities bear the responsibility for the major part of local environmental policy such as disease prevention and assessment of food quality and drinking water quality.

Preventive and population-oriented health care have been integrated into primary health care. At health centres, access to measurement of blood pressure and blood cholesterol is determined by the clinical situation or is available on request. Special health education programmes on tobacco, diet and alcohol are all generally carried out by general practitioners. General practitioners are also involved in providing some diagnostic services, in immunizing children and in performing paediatric surveillance. Midwives, district nurses and general practitioners provide family-planning services.

Secondary and tertiary care

For conditions requiring hospital treatment, medical services are provided at county and regional hospitals. In comparison with other European countries, in Sweden a relatively large proportion of the resources available for medical services is allocated to the provision of care and treatment at hospital level. Hospitals are divided

into district county hospitals, central county hospitals and regional hospitals, depending on their size and degree of specialization. For highly specialized care, Sweden has six large medical care regions, within which the county councils cooperate in terms of this type of provision. There are one or two regional hospitals per region, and they serve a population of 1–2 million inhabitants. The total amount of inpatient care decreased, during the 1990s, from an average of 1.6 days per person in 1994 to 1.1 days per person in 2000. The total number of beds per 1000 citizens decreased from 5.5 in 1993 to 3.0 in 2003, which marks a relatively sharp decline to one of the lowest numbers in the EU15 (Fig. 2, Table 1).

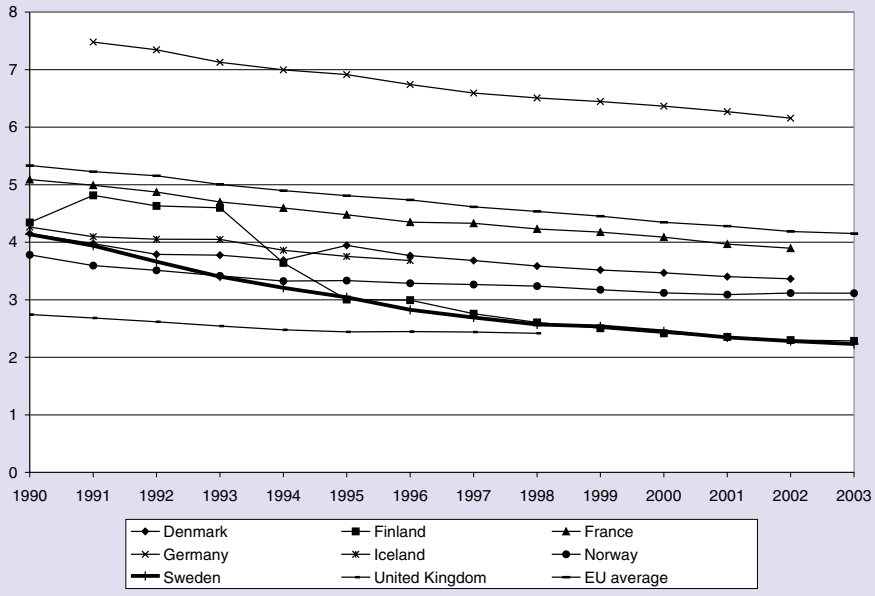
Social care

Municipalities are responsible for delivering and financing long-term care for the elderly and people with disabilities and for long-term psychiatric care. As of 1 October 2003, approximately 238 900 old-age pensioners were permanent residents in special housing (128 000) or were granted home-help services in ordinary housing (110 900). Of the home-help services granted to persons aged 65 years and older in 2003, approximately 9% of the total services were provided within the private sector.

Human resources and training

The number of staff employed in the health care sector, expressed per 1000 inhabitants, dropped from 46.7 in 1992 to 31.9 in 2002. The main reason for this reduction in staff was structural changes, i.e. a shift from hospital care towards primary care. The total number of hospital beds was reduced by more than 40% between 1993 and 2003. There are approximately three physicians per 1000 inhabitants, which is below the EU15 average. Across the counties, physician density varies from approximately 2.3 to 4.4 physicians per 1000 inhabitants. Sweden has a relatively high proportion of physicians working at hospitals in comparison with the other Nordic countries: more than 60% of all physicians work at hospitals. Expressed as health care personnel

Fig. 2. Beds in acute hospitals per 1000 people in Sweden and selected other countries, 1990–2003



Source: WHO Regional Office for Europe health for all database, June 2005.

per 1000 inhabitants, the number of physicians and nurses has increased, whereas the number of dentists and other health care personnel has been quite stable during the past decade.

Regarding the training of physicians, the number of medical students is limited, and every year approximately 1100 students begin medical training programmes. Medical education is entirely financed by central government. The training of doctors, dentists and other medical staff is linked to the university hospitals and other relevant parts of the medical services. Sweden has six medical schools at which physicians are trained. To become a registered physician, a student must successfully complete a study programme of five and a half years and, after that, there is a 21-month period of training in general medical care, followed by a written examination. After this, the physician is registered and is authorized to practise in the medical profession. Most physicians, however, choose to continue their studies in order to qualify as specialists; this requires 5 years of service in one of the 62 recognized specialist fields. There are approximately 30 nursing schools spread throughout the country. These schools are normally run by the county councils. Every year, the number of students beginning nursing training is about 5500. The study programme for nurses consists of 3 years of basic education, followed by specialist training.

Pharmaceuticals

All drugs sold in Sweden must be approved and registered by the Medical Products Agency. The Pharmaceutical Benefits Board has the responsibility of determining if a medicine or specific product should be subsidized or not. If a drug/product is to be subsidized, the Board, through negotiations with the manufacturer, sets the price. The state-owned National Corporation of Swedish Pharmacies (Apoteket AB) has the exclusive right to retail medicines to the general public, through community pharmacies. In addition, it operates hospital pharmacies under one-year contracts with the county councils. Expenditure on pharmaceuticals increased substantially during the 1990s. This was influenced both by an increase in the volume of prescriptions (prescription index) since 1988, and the introduction of new and more expensive pharmaceuticals. In Sweden in 2003, the per-capita expenditure on drugs (including sales of over-the-counter pharmaceuticals) was SKr 3518 (about €350).

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2004 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Denmark	3.2[a]	17.8[c]	3.6[a]	84.0[c]
Finland	2.2	19.9	4.2	74.0[i]
Norway	3.1	17.3	5.2	86.4
Sweden	2.2	15.1	6.1	77.5[h]
EU15 average	4.0[a]	18.0[c]	6.9[a]	77.0[c]

Source: WHO Regional Office for Europe health for all database, January 2006.

Notes: [a] 2003; [b] 2002; [c] 2001; [d] 2000; [e] 1999; [f] 1998; [g] 1997; [h] 1996; [i] 1995; EU: European Union; EU15: Member States before 1 May 2004.

Financial resource allocation

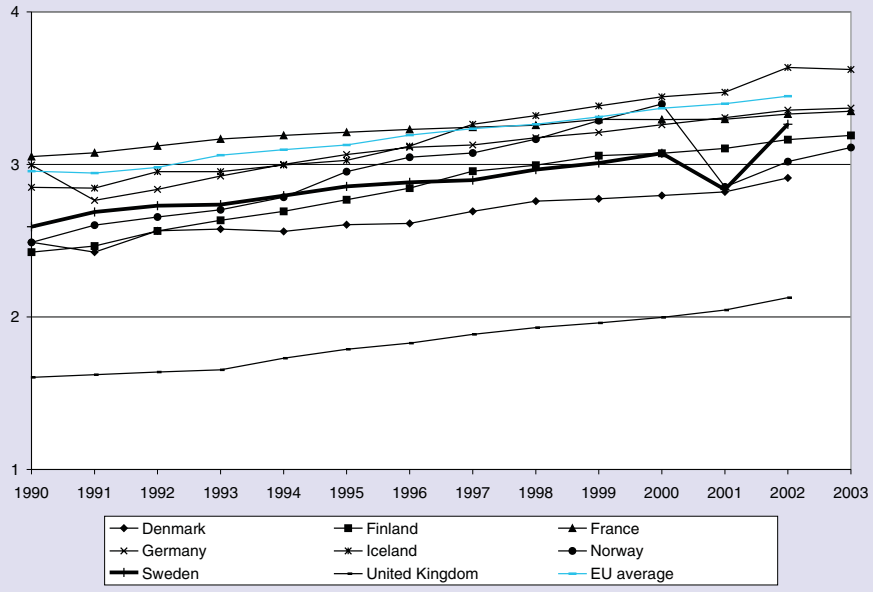
Payment of health care facilities

Resource-allocation principles vary across the county councils. Most county councils have decentralized a great deal of the financial responsibility to health care districts, through global budgets. Activities such as psychiatry, geriatrics and emergency services are normally financed through global budgets. In about half of the county councils, payments to both hospitals and primary care centres are based on global budgets. A small group of about five county councils continues to develop per-case payment, with expenditure ceilings for some services (primarily hospitals) and capitation models for primary care. Another small group of county councils push primary care payment in the direction of capitation, whereas global budgets are used for all other services. Payments, whether based on fixed per-case payments, per-diem reimbursements, global budgets, fee-for-service arrangements or a combination of these systems, traditionally are based on full costs.

Payment of health care professionals

As most of the providers in Swedish health care are publicly owned, physicians, dentists, pharmacists and members of other professional groups are mainly salaried employees. In 2003, physicians employed by the county councils earned SKr 48 100 (€5300) per month on average. This includes compensation for work performed and for being on call during non-regular working hours. The comparable figure for nurses was SKr 23 000 (€2600) in the same period. Dentists earned, on average, SKr 35 300 (€3900) per month. For comparison, the average monthly salary in 2003 for all employees in the county council sector was SKr 24 100 (€2700).

Fig. 3. Number of physicians in Sweden and selected countries per 1000 people, 1990–2003



Source: WHO Regional Office for Europe health for all database, June 2005.

Private health care providers and dental clinics use a mixture of salaries, capitation and fee-for-service payments for professional staff. The Swedish Social Insurance Agency reimburses private dentists and physicians.

Health care reforms

The 1982 Health and Medical Services Act emphasized a vision of equal health for all. The Act stated that the county councils were to be responsible for the provision of health care services, and both financial responsibilities and political resource-allocation decisions were decentralized to county council level. The 1985 DAGMAR Reform transferred the responsibility for the costs of both public and private ambulatory health care from the Swedish Social Insurance Agency to the county councils. The main objective of the reform was to establish county council control over new private establishments. As a result, the planning capacity of county councils was strengthened as they became cost-liable. County councils could actually plan annual budgets for both publicly and privately provided primary and specialist care services.

The purpose of the 1992 ÄDEL Reform, which was the most important structural reform that occurred during the 1990s, was to concentrate the planning and financial responsibilities for the elderly and people with disabilities by transferring the responsibility for providing long-term care to these patients from the county councils to the local municipalities. The reform has affected the health care structure in Sweden substantially. The 1995 Psychiatric Reform, aiming at improving the quality of life for psychiatric patients, made the municipalities financially responsible for these patients when they no longer require hospital care, i.e. when they have completed their medical treatment.

In 1997, an addition was made to the Health and Medical Services Act regarding priorities in health care. The Act stipulates that those patients who have the greatest need should have priority over other patients. Following the 1998 Drug Reform, the county councils were given full responsibility for the costs of prescribed pharmaceuticals. The reform has given county councils direct incentives to increase prescriber knowledge about pharmaceutical costs and existing consumption patterns.

The 1992 National Guarantee of Treatment aimed to reduce the long waiting times for 12 elective hospital treatments. Patients were given the right to seek care outside their own county council if waiting times exceeded 3 months. In the 1997 Revised Guarantee of Medical Treatment, access to primary and specialist health care services was regulated. A new National Treatment Guarantee was implemented in November 2005. The guarantee is based on the "0–7–90–90" rule, meaning instant contact (0 delay) with the health care system, seeing a general practitioner within 7 days, consulting a specialist within 90 days, and waiting no more than 90 days between diagnosis and treatment.

During the late 1990s, several reforms were implemented that targeted patients' fees: in 1997, the National Drug Benefit Scheme, which regulates co-payments on pharmaceuticals for patients, was separated from the cost ceiling for medical treatments. Perhaps the most important reform regarding patients' fees was the 1999 Dental Care Reform, which led to the implementation of fixed and nominal subsidies for different types of services, together with free pricing for providers. Previously, user charges were based on a fixed percentage according to the levels of expenditure, and prices were regulated by means of a national tariff. Providers raised their fees by 18%, on average, during the first year following the reform, and all of this additional cost had to be borne by individual patients.

Another set of reforms refers to the benefit package. In 1997, county councils were given the right to buy pharmaceuticals for inpatient care directly from pharmaceutical companies. In addition, a law was introduced that required

the appointment of at least one committee in every county council. Following the passing of the law on pharmaceutical committees and the 1998 drug reform, committees have been formed in every county council, and, in most counties, prescribing advisers inform prescribers as to the use and costs of pharmaceuticals. In October 2002, the Pharmaceutical Benefits Board was created; it has the responsibility of deciding if a medicine or specific product should or should not be subsidized. Furthermore, it was ruled that a prescribed drug, which qualifies for subsidy, should be exchanged for the cheapest comparable generic version available. In the 2002 New Dental Care Reform, high-cost protection schemes for patients above 64 years of age were implemented. However, charges for dental care can still be high, and about 60% of total expenditure for dental care is paid directly by patients.

Conclusions

While the overall goals and policies of the (largely tax-based) Swedish health care system are set at national level by the Ministry of Health and Social Affairs, responsibility for both the financing and provision of health care services primarily rests with the county councils and the municipalities.

Debate regarding the Swedish health care system during the early twenty-first century has to a great extent focused on the need for coordination of care, this being partly driven by county council cost containment. Since 2003, the tendency has been to concentrate specialist and emergency care within geographical areas, e.g. smaller county councils have started to cooperate regarding specialist care in larger regions, but the process is rather slow. The other area of focus is coordination of different levels of care, i.e. hospital care, primary care, institutional care and home-based care, with respect to the provision of services to the elderly and patients with co-morbidity. Furthermore, the division of responsibility (for the provision of health care services) between central government, the county councils and the municipalities, and the strengthening of central government control, have been the subjects of discussion. In 2003, the Parliamentary Committee on Public Sector Responsibilities was formed, with the aim of analysing the current separation of responsibilities between the three levels of government. The Committee is to deliver proposals for change no later than February 2007.

The Swedish health care sector has undergone several important reforms in recent decades. Generally, national reforms that have had an impact on the health care system have focused on three broad areas: the responsibilities of provision of health care services; priorities and patients' rights in the health care sector; and cost containment. Despite these reforms, challenges for the Swedish health care system remain, as listed below.

- There is a need for integration between hospital care, primary care and institutional care, especially in the provision of services for the elderly, people with disabilities and those with mental illnesses. In addition, there is a need to strengthen primary and home-based care and find a way of tackling the shortage of skilled personnel in the municipal sector.
- Cost containment in the Swedish health care system remains an important challenge, as it is for other countries.
- The responsibilities of central government, the county councils and the municipalities for the provision of health care services need further definition.
- Effective interventions are needed to tackle increasing social inequality in health in Sweden, especially with regard to dental care.
- There is a need to increase the availability, in reality, of choice of provider for patients.

The health status of the Swedish population is one of the best of in the world. The main strengths of the Swedish health care system

include the following: the provision of health care services for all, on the basis of need, democratic control and local accountability; control over total expenditure; and effective management of clinical activities. It is important to address the remaining challenges in order to achieve equity and, not least, efficiency – the principal objectives of the Swedish health system.

The Health Systems in Transition profile on Sweden was written by Anna H. Glenngård, Frida Hjalte, Marianne Svensson and Anders Anell from The Swedish Institute for Health Economics, and Vaida Bankauskaite, from the European Observatory, who also edited the report. The Research Director was Richard B. Saltman.

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The Health Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

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