

## Introduction

### Government and recent political history

Sweden is a monarchy with a parliamentary form of government. The governing process works on three democratically elected levels: the parliament at national level, the 21 county councils at regional level, and the 289 municipalities at local level.

### Population

The estimated population is 8.9 million (1999) and it is unevenly distributed, as 84% of the population live in urban areas.

### Average life expectancy

Sweden has among the longest life expectancy at birth in Europe: 77.5 for men and 81.1 for women (2000). Average life expectancy rose during the 1990s and Sweden has the world's oldest population, with almost every fifth person aged 65 years or older (2000).

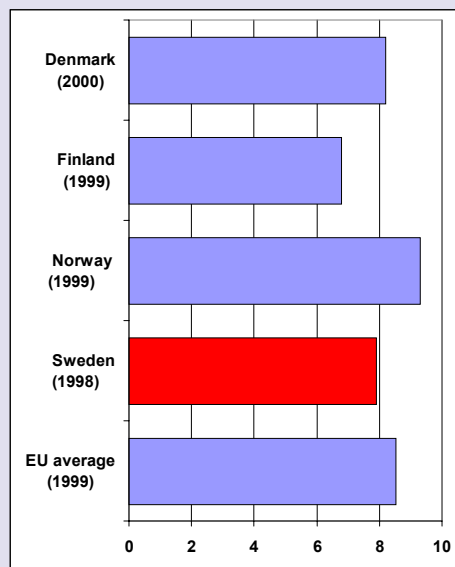
### Leading causes of death

Even though mortality due to cardiovascular diseases has declined, it accounted for approximately 50% of all deaths in 1998. The same year, the second largest cause of death was cancer (25% for men and 22% for women). Mortality due to mental diseases and diseases in the nervous system, eyes and ears increased between 1987 and 1997.

### Recent history of the health care system

The Swedish health care system began in 1882 when the county councils were established. In

Fig. 1. Total health care expenditure as % of GDP, comparing Sweden, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

1928, they became responsible for providing hospital care and in the 1930s they were gradually given responsibility for various non-hospital health care services. The first important step towards universal coverage for physician consultations, prescription drugs, and sickness compensation was taken in 1946 with the National Health Insurance Act. In the postwar era, the Swedish health care sector began to expand, particularly in the hospital sector.

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In 1970, outpatient services in public hospitals were taken over by the county councils and during the 1980s, they were gradually given responsibility for health care planning.

## Health expenditure and GDP

Total expenditure on health as a percentage of GDP in Sweden amounted to 8.4% in 1998, slightly less than the European Union (EU) average of 8.6%. In 1999, private health care expenditure represented 16.2% of total health care expenditure. In 1998, Sweden's health care expenditure in US \$PPP per capita was 1746, slightly lower than the EU average. This is due to a major decrease of expenditure levels during the 1990s.

## Overview

The Swedish health care system has responded to increasing economic pressure by launching several major structural reforms, for example internal market reforms were initiated in the late 1980s, and in 1992 residential care for the elderly was transferred to municipalities. Both changes seem to have resulted in improved management and organization of the system. However, other unexpected problems have emerged, e.g. co-ordination problems in the implementation of reforms, excessive decentralization to local actors, high transaction costs or insufficient capacity at the municipal level. Since the late 1990s, a second wave of innovative reform initiatives is addressing these and other related problems.

## Organizational structure and management

The Swedish health care system is a regionally-based, publicly operated health service. It is organized in three levels (national, regional and local).

### National level

The principal responsibility of the Ministry of Health and Social Affairs is to ensure that the health care system runs efficiently and according to its fundamental objectives. The National Board of Health and Welfare (NBW) acts as the government's central advisory and supervisory agency for health and social services. All health care personnel come under the supervision of this agency. The Medical Responsibility Board decides on disciplinary measures when necessary.

There are also other central government bodies to which the Ministry and the NBW are associated, namely the Medical Products Agency, which controls and evaluate the quality, use and cost-effectiveness of pharmaceutical preparations; the National Institute of Public Health, which promotes health and prevents diseases; the National Corporation of Swedish Pharmacies, which owns all pharmacies and maintains a countrywide distribution system; the National Social Insurance Board (NSIB), which guarantees uniformity and quality in the processing of insurance and benefits and the Federation of County Councils, a national interest organization for the county councils.

### Regional level

The county councils are in charge of the health care delivery system, from primary care to hospital care, including public health and preventive care. They have overall authority over the hospital structure and they also regulate the private health care market. The county councils are usually divided into health care districts, which normally consist of one hospital and several primary health care units that are further separated into primary health care districts. The 21 county councils are grouped into six medical care regions, which were established to facilitate cooperation in tertiary care.

### Local level

Municipalities are responsible for social welfare services, which include child care, school health services, care of the elderly and the disabled, and

long-term psychiatric patients. They also operate public nursing homes and home care services.

### Planning, regulation and management

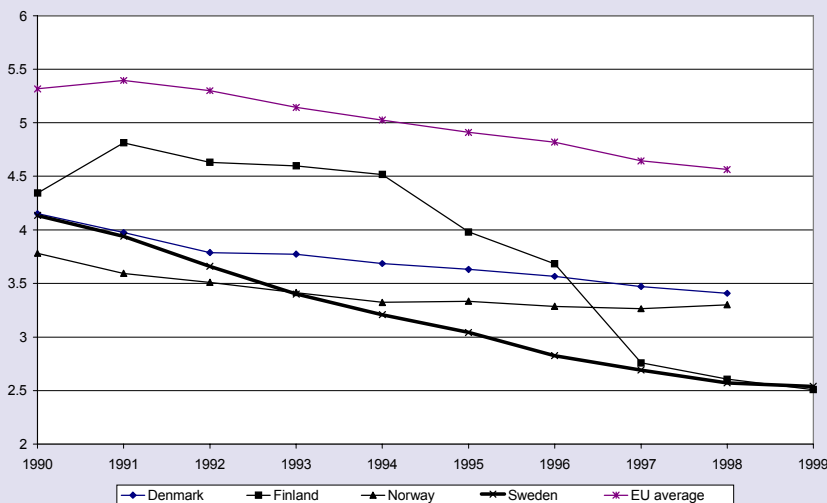
In the 1970s, health care planning was managed through long-term plans whose ideology was focused on judgements and demands made by the medical profession's representatives (without considering the needs of the residents). The 1982 Health Care Act reinforced county councils' responsibility over health service provision and financing. It also required them to exercise planning capacity according to the needs of the residents. By the end of the 1980s, cost-containment had become an important planning issue so that developments in the 1990s in several county councils were in the direction of planned markets. However, serious concerns about the effect of market-based mechanisms on social equity and efficiency shifted the focus from competition to cooperation within and among health care institutions in the second half of the

1990s. County councils also regulate the private practitioner's market.

### Decentralization of the health care system

Except for some national policy development, legislation and supervision, the responsibility for health care is decentralized to local governments. The county councils are responsible for financing and providing health services, while local municipalities are charged with delivering and financing long-term care for the elderly and the disabled, and for long-term psychiatric care. The local municipalities are not subordinated or accountable to the county councils. In the 1980s, the county councils decentralized financial responsibility to health care districts, which later transferred that responsibility to hospital department and primary health care centre levels. The lack of experience in managing units through transfer pricing and an underdeveloped accounting system have been impeding factors

**Fig. 2. Hospital beds in acute hospitals per 1000 population, Sweden, selected countries and EU average**



Source: WHO Regional Office for Europe health for all database.

for control of decentralized financial responsibilities.

## Health care financing and expenditure

### Main system of finance and coverage

The Swedish NHS is mostly financed by regional taxes (which in 1999 covered almost 70% of total public health care expenditure), and provides coverage for all residents, regardless of nationality. The social insurance system, managed by the National Social Insurance Board, covers individual income losses due to illness and also pays for about a fifth of health care costs, such as cross-boundary flows, a part of pharmaceutical and dental care expenditure and patient fees over a high cost-protection limit. A significant part of these payments is made out of

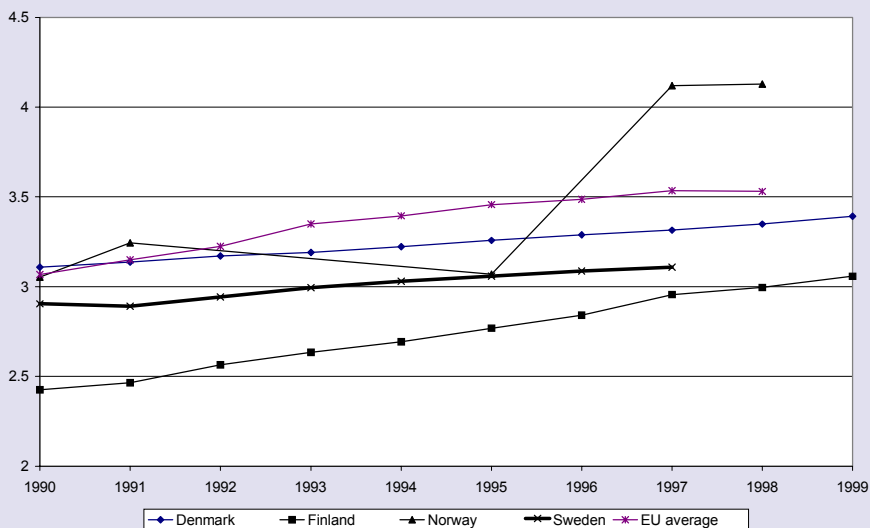
the state contribution to the national insurance fund. The central state also contributes directly to health care financing, redistributing funds among regional and local government through earmarked and general grants. This represents some 10% of total health care expenditure. Patients' co-payments had an increasing role in health care financing through the 1980s and 1990s and, in 1999, they represented 2% of total public expenditure.

### Complementary sources of financing

There are three sources of revenue for health care in Sweden: taxes (central, regional and local); the national social insurance system; and private expenditure (i.e. out-of-pocket payments and private insurance).

Each county council determines its own fee schedule for out-of-pocket payment in outpatient care, although the national parliament has set fee ceilings on the total amount any one citizen can pay in any 12-month period. For inpatient care,

Fig. 3. Physicians per 100 population, Sweden, selected countries and EU average



Source: WHO Regional Office for Europe health for all database.

normally a fee of €8.5 per day is charged, although reductions are applied to pensioners and low income groups. Children under the age of 18 are not usually charged. Central government's ceiling for out-of-pocket payments means that an individual's total charges on health care for a period of a year can be up to a maximum of €99, not including inpatient care. In addition, patients paid 23% of total expenditure for prescribed drugs, although there are also ceilings for co-payments in this field which are administered by the National Corporation of Swedish Pharmacies. Dental care requires out-of-pocket payment only for individuals 20 years of age and older.

Voluntary insurance is very limited in Sweden and typically provides only supplementary (elective) coverage to the public health system. In about 90% of cases, it is the employer that pays the fees in order to avoid employees' long-term sick leave.

### **Health care benefits and rationing**

No basic or essential health care package has been defined. Instead, there are three major ranked principles for priorities of the health care sector (human rights, need or solidarity, and cost-effectiveness). There are also groups of priority for political/administrative reasons. However, there is uncertainty regarding the extent to which these are followed in practice so that in the end it is the health care personnel who make the final decisions.

### **Health care expenditure**

During the beginning of the 1990s, a combination of a recession and cost containment led to decreasing real health care expenditures. The health care expenditure share of GDP decreased from 8.8% in 1990 to 8.4% in 1998. The public share of total health expenditure decreased from 89.9 in 1990 to 83.8 in 1998, which is mainly explained by increased patient co-payment. During the 1990s, the pharmaceutical expenditure as a share of total health care expenditure increased substantially, due to both an increase

in the number of prescriptions and the introduction of new and more expensive drugs. In 1999, secondary and tertiary health care accounted for 62.3% of county councils' total health care expenditure; 22.4% was spent on primary health care; 9.5% in psychiatric care and the remainder (5.8%) was spent on geriatric care.

## **Health care delivery system**

### **Primary health care and public health services**

The primary health care (PHC) services deliver both basic curative care and preventive services through local health centres and hospital outpatient departments, among which patients can choose. Sweden has less PHC compared to other European countries, since 46% of all outpatient visits are made at hospitals instead of health centres. General practitioners must be specialists in general practice and for private health care providers to be publicly funded, an agreement of cooperation has to be made with the county council.

Municipalities play a central role regarding preventive measures and, at the national level, the National Institute of Public Health has existed since 1992. This is a body responsible for managing health promotion and disease prevention, with a special focus on decreasing health gaps among different social groups.

### **Secondary and tertiary care**

This is provided through regional hospitals, central county hospitals or district county hospitals depending on their size and degree of specialization. Since the early 1990s, full patient choice is guaranteed. There are six administrative health care regions who cooperate to provide highly specialized care through regional hospitals.

Total inpatient care decreased during the 1990s from 12.4 beds per 1000 population in 1990 to 5.2 in 1997. At the same time, outpatient

care increased. This is due to new and more effective treatments (i.e. day-care surgery) and in large part, to the Adler 1992 reform, which transferred responsibility for elderly patients with completed clinical treatment to the municipalities.

During the 1980s, long waiting time for certain treatments resulted in the growth of private providers. In 1997, waiting times were introduced with the purpose of forcing the PHC and specialist care levels to offer health care services within specific timeframes (otherwise care must be offered in another county council). Regarding links between general practitioners and specialists, new methods have been introduced in some county councils in order to improve cooperation, such as joint development of care programmes. Finally, several measures have been put into place to control and improve quality of health care services, e.g. the development of national quality registers.

## **Social care**

Social welfare services, care of the elderly and the disabled, and psychiatric patients are the responsibility of the municipalities. Since 1992, when residential care for the elderly (nursing homes) was transferred to local governments, they have full responsibility for long-term care for the elderly and the disabled. In addition, about 50% of the municipalities have received transfers from county councils in the field of home care. Municipalities charge for the services they provide, although fees are subsidized, are usually income-related and cannot exceed real costs. During the 1990s, emphasis on internal markets has led to the progressive contracting out of municipal services.

## **Human resources and training**

In 1998, 92% of all employees working in health were publicly employed. The number of employees in the health sector increased substantially during the 1970s and the early 1980s, although in the early 1990s it stagnated. In 1997, the number of physicians was about 10%

lower than the EU average. There is a shortage of physicians in isolated rural areas and a general shortage of nurses with specialist skills across the country.

## **Pharmaceuticals**

Compared to other EU countries, Sweden has low pharmaceutical expenditures. However, these costs increased during the 1990s (especially among the elderly) mainly due to new drugs (which were often more expensive) and the increasing demand from an ageing population. The State has the exclusive right to conduct retail trade in drugs through the National Corporation of Swedish Pharmacies (NCSP), which maintains countrywide distribution, decides on the number and location of sale outlets and runs all hospital pharmacies. Reimbursement for drugs is made directly to the NCSP from the National Social Insurance Board (NSIB) – which sets reimbursement prices – and from the public and private health care providers. The Drug Benefit Scheme establishes a ceiling on co-payments of about €200 for each twelve-month period. The extent to which private insurance or companies cover drug expenditures is unknown but can be considered insignificant. Finally, the latest pharmaceutical reform (1998) aimed at gradually giving county councils full (financial and other) responsibility for pharmaceuticals, after a transition period during which the social insurance system will continue to subsidize pharmaceuticals.

## **Financial resource allocation**

In 1998, around 80% of the total expenditure in the county councils were directly connected to health care. Highly specialized acute regional care (tertiary) and secondary care accounted for 62% of total expenditure; 10% were costs for psychiatric care; 6% for geriatric care and 22% were for primary health care.

The allocation formula that determines state grants to county councils for health care is based on weighted capitation, according to sex, age, civil status, occupation, income, housing and other indicators of health needs.

## Payment of hospitals

Most county councils have decentralized a great deal of the financial responsibility to health care districts through global budgets. In highly-specialized regional hospital health services, retrospective patient related fee-for-service reimbursement is common, while primary health care providers are usually paid through global budgets or capitation. Finally, county councils are financially responsible for ambulatory care, both public and contracted out.

## Payment of physicians

Physicians at public facilities are employed by, and receive a monthly salary from the county councils. They also receive extra payment for non-regular working hours and a fixed fee per patient in their list. Private practitioners are paid fee-for-service.

## Health care reforms

At the national level, the most important health care reform has been the introduction of internal markets. In addition, the 1990s reforms have also extended the responsibility of county councils

and municipalities within the health care system. First, responsibility over regulation of the private health care market, and over pharmaceuticals, were devolved to county councils in 1995 and 1998 respectively. These were the only domains of public health care that were not in the hands of county councils yet. Second, responsibility for residential care of the elderly and the disabled were transferred to municipalities in 1992, under the Ädel reforms.

As for the internal market reforms, half the county councils have introduced some form of purchaser-providing split, as well as some other support mechanism such as new management and organization schemes or new contractual arrangements based on prospective per case payments. Competition has been further enhanced through increased contracting-out of services and expanded opportunities for choosing health care providers. By the end of the 1990s, however, awareness of some of the disadvantages of this reform model led to partial re-orientation of reforms, through initiatives aimed at increasing cooperation among purchasers and providers, and re-centralizing some of the delegated powers to higher management levels.

During the 1990s, other reforms have been passed, aimed at improving accessibility (e.g. reducing waiting times through the 1992 *National Guarantee of Treatment*), quality, and patients' rights; and at containing pharmaceutical expenditure (through the introduction of a reference price system in 1993). In 1994 two laws came

**Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2000 or latest available year**

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Denmark	3.3 <sup>a</sup>	19.2 <sup>a</sup>	5.5	79.9 <sup>a</sup>
Finland	2.4	19.3 <sup>a</sup>	4.3	74.0 <sup>a</sup>
Norway	3.1	14.5 <sup>d</sup>	6.0	85.2
Sweden	2.5	15.9 <sup>d</sup>	5.5 <sup>a</sup>	77.5 <sup>d</sup>
EU average	4.2 <sup>a</sup>	17.1 <sup>a</sup>	8.2 <sup>b</sup>	77.0 <sup>b</sup>

Source: WHO Regional Office for Europe health for all database.  
Note: <sup>a</sup> 1999, <sup>b</sup> 1998, <sup>c</sup> 1997, <sup>d</sup> 1996, <sup>e</sup> 1995, <sup>f</sup> 1994, <sup>g</sup> 1993.

into effect (the *Family Doctor Act* and the *Act on Freedom to Establish Private Practices*) that aimed to encourage private PHC provision. In June 1995 the newly-elected social democratic government withdrew both laws; however, a few countries had already started to implement them. They were replaced by a new act on PHC organization in June 1995, which precluded further extension of private contracted out providers in the field, and extended county councils' responsibilities over the regulation of private provision.

## Conclusions

The Swedish health care system has undergone several major structural changes, particularly during the 1990s. Responsibilities were gradually

transferred to local governments and providers, and new management and organizational schemes were introduced. This continued the devolution process initiated in the 1970s. Internal market reforms were launched in the late 1980s, against a background of tightened cost-containment policies. As a result, there is evidence of productivity gains in regional and county health services and Sweden continually reduced health care expenditure as a percentage of GDP during the 1990s. However, a coordinated reform strategy has been difficult to achieve, due to changes in government, increasing fragmentation of governance and provision, problems of coordination among different administrative levels, and lack of a global perspective whereby all policy goals are considered as part of an overall reform process.

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The Health Care 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 Care Systems.

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