

# Fact Sheets on Sweden

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## The Health Care System in Sweden

*Good health and equal access to health services for everyone are the goals of the Swedish health care system. A fundamental principle is that the provision and financing of health services for the entire population is a public sector responsibility. This responsibility rests primarily with the county councils. These operate almost all services and levy taxes to finance them. As a consequence, health services in Sweden rest largely in the hands of local politicians in 21 geographical areas.*

### Health in Sweden

By international standards, health in Sweden is relatively good. Infant mortality is low, at 3.4 deaths per 1,000 in the first year of life. Cardiovascular conditions account for half of all deaths. However, deaths attributable to these diseases fell substantially during the 1980s, which has contributed to a higher average life expectancy of 77.1 years for men and 81.9 years for women. Deaths from injuries, alcohol-related diseases and suicide have also been on the decline for many years. The proportion of the population with allergic conditions doubled during the 1980s, with more than one third of people living in Sweden saying that they suffer from some form of allergy or over-sensitivity. Another public health problem is the growing proportion of overweight children, young and middle-aged people. Mental health and psychosomatic problems are on the increase among children and young people.

The number of elderly people has risen substantially—with the greatest rise in the age group 80 years and older. Sweden is seen as having the world's oldest population, with 18% aged 65 or over. In spite of the democratic principles espoused by Swedish society, there are marked differences in health between different social groups, and these differences are growing.

### The health services

The *primary level* is the level of the health care system to which people should be able to turn with any health problem. The aim of the primary care sector is to improve the general health of the population, and it treats diseases and injuries that do not require hospitalisation. This sector employs a wide variety of health professionals—physicians, nurses, auxiliary nurses, midwives and physiotherapists. Their work is organised in health centres, which facilitates teamwork. Everyone has the right to choose their own family doctor, a general practitioner.

In addition to local health centres and family doctor surgeries, primary care is also provided by private doctors, physiotherapists, at district nurse surgeries, and at clinics for child and maternity health. The child clinics provide vaccinations, health checks and consultations as well as certain types of treatment free of charge to all children under school age. Maternity clinics, staffed by midwives and doctors, are attended by expectant mothers for regular check-ups, which are free of charge during the entire pregnancy. District nurses give medical treatment as well as advice and support, both at their own surgeries and on home visits. Occupational health services and school health services are also available.

By adapting housing, using technical aids, and providing medical services and nursing in the homes of patients, it has become easier for elderly and disabled people to remain in their own homes. People in nursing homes and those living in service apartments have access to nursing services 24 hours a day.

Medical services are provided at *county level* and *regional level* for conditions that require hospital treatment. Some 65 central county hospitals and district county hospitals provide somatic care in a number of specialist fields, partly inpatient and partly at outpatient clinics. The county medical services also offer psychiatric care, increasingly in outpatient forms.

The regional medical system comprises nine regional hospitals, which have a wider range of specialist and sub-specialist fields than at county level, for example neurosurgery, thoracic surgery, plastic surgery and highly specialised laboratories.

In Sweden, hospitals have traditionally received a relatively high proportion of total medical resources. This can be seen, for example, in the low number of visits per person and year to doctors in the primary care services. The number of general

practitioners is also low in relation to the total number of doctors (approximately 20%).

The number of days of short-term inpatient care per person and year has fallen over the last few years for all age groups. Extensive changes have been made in the area of psychiatric care during the last ten years. People with mental handicaps have largely left institutional care and now tend to live in the community.

The changes that have taken place in inpatient care must be seen in relation to the deliberate emphasis given to outpatient care. More and more medical visits are now made outside the hospitals and the nature of these visits has changed. An increasing amount of treatment and operations no longer requires the patient to be taken into hospital. The introduction of day surgery and the expansion of home medical care are examples of the changes that are taking place. The deliberate emphasis on outpatient forms of care also encourages people to consult medical staff other than doctors.

### Management and planning

Three political and administrative levels operate in Sweden: central government, county council and local authority (municipality). All these play important roles in the welfare system and are represented by directly elected political bodies that have the right to finance their activities by levying taxes and fees.

One important role for *central government* is to establish basic principles for the health services through laws and ordinances. The most important of these is the Health and Medical Services Act of 1982, which lays down that people shall be offered health services of good quality on equal terms and easily accessible to all. The services provided shall respect the patient's integrity and his right to make his own decisions. They should also, as far as possible, be organised and performed in consultation with the patient. Other laws regulate the obligations and responsibility of personnel, professional confidentiality, patient records and health profession qualifications. The number of detailed regulations has diminished in recent years. Today, central government is more interested in the results and performance of the services than how they are organised.

The Ministry of Health and Social Affairs (*Socialdepartementet*) is responsible for developments in areas such as health care,

**Organisation of the Swedish health services**

State Ministry of Health and Social Affairs National Board of Health and Welfare Swedish Council of Technology Assessment in Health Care <ul style="list-style-type: none"> <li>● legislation</li> <li>● supervision</li> <li>● evaluation</li> </ul>	Federation of County Councils	20 county councils + 1 local authority	9 regional hospitals	65 county/district hospitals	1,000 health centres
	Swedish Association of Local Authorities	290 local authorities	housing and care for elderly and disabled		

- finance
- organisation
- follow-up

social insurance and social issues. The Ministry draws up terms of reference for government commissions, drafts proposals for Parliament on new legislation, and prepares other government regulations.

The National Board of Health and Welfare (*Socialstyrelsen*) is the government's central advisory and supervisory agency in the field of health services, health protection and social services. The key task of this agency is to follow up and evaluate the services provided to see whether they correspond with the goals laid down by central government. The Board is also responsible for national guidelines for good medical practice. These focus on conditions such as diabetes, strokes, and cardiovascular disease and aim to provide the basis for local care programmes.

A further government agency engaged in evaluation is the Swedish Council of Technology Assessment in Health Care (SBU). The SBU shall promote the efficient utilisation of the resources allocated to the health services by evaluating both new and established methods from medical, social and ethical standpoints. The SBU's findings are disseminated to central and local government and health service staff to provide basic data for decision-making.

Under the Health and Medical Services Act, 20 county councils and one local authority (Gotland) are responsible for providing health services and for striving to achieve a good standard of public health. County councils are also responsible for certain issues related to education, culture, public transport and regional development. The population of these 21 areas varies between 60,000 and 1.8 million people. County council elections are held every fourth year on the same day as parliamentary elections. The county councils decide on the allocation of resources to the health services and are responsible for the overall planning of these services. It is also the county councils which own and run the hospitals, health centres and other health institutions, even

if these institutions are supplemented by private providers which, in most cases, have contracts with the county councils to supply certain services.

The total domination of the county councils in the provision of health services enables them to make decisions on structural issues. During recent years considerable changes have taken place here, chiefly the reduction in the number of beds, but also, for example, cut-backs in the number of 24-hour casualty departments. The reduction in the number of beds has been achieved by increases in productivity generated by new medical technology and incentives resulting from the development of financial management systems.

One significant change introduced by the county councils in recent years is the freedom for patients to choose where and by whom they wish to be treated. Patients can choose their health centre and/or family doctor and even which hospital they wish to attend. If a patient wishes to receive medical care at a hospital outside the county council in which he or she lives, a referral may be required. A characteristic of the Swedish health care system is that the patient does not usually need a referral to obtain specialist hospital care: he/she can go directly to the hospital without going via the primary services.

For highly specialised care, and, to a certain extent, research and medical training, the county councils co-operate in six *medical care regions*. The population of these regions varies from 1 to 1.9 million and in each there is at least one university hospital. This collaboration is based on agreements between the county councils in the region, for example on the prices that shall be charged for highly specialised care. The county councils also collaborate at national level through the Federation of County Councils (*Landstingsförbundet*).

A care guarantee for patients has been in force since 1992. This is the result of an agreement concluded at national level by the Ministry of Health and Social Affairs

and the Federation of County Councils in order to reduce the waiting lists for certain forms of treatment for which there were long queues. The nature of the agreement has changed, and it is now chiefly concerned with patient accessibility. The primary care services must now offer help the same day that the patient contacts them and a medical consultation within eight days. Where necessary the patient shall be able to see a specialist within three months, or within one month if his or her medical condition has not been clearly diagnosed. The issue of whether patients should be given a guarantee that they will receive all treatment within three months has been much discussed, especially with regard to setting priorities. The government and the Federation of County Councils are preparing for an extended care guarantee of this kind to be introduced in 2004 at the earliest.

The Swedish parliament has approved a national plan for the development of the health services during the period 2001–2004. The aim of this plan is to achieve a coordinated approach to patient access and a rational division of input between the different elements of the health services for each individual patient and each patient group. Chief priorities are better medical care for the elderly, measures to reduce mental health problems, especially among children and the elderly, and that the primary care sector should be an efficient and reliable basis for the health services.

One category of health care, namely the domestic care of elderly and disabled people, is the responsibility of the *local authorities* (municipalities) rather than the county councils. Local authorities are also obliged to pay for patients whose hospital treatment had been concluded but who have to remain in hospital because the local authority cannot offer them a place in, for example, a nursing home. Local authorities are, similarly, responsible for the living arrangements, employment and support services for people suffering from long-term mental illness.

### County council health service staff. Selected professional categories, 2001

Doctors	25,000
Nurses	78,000
Auxiliary nurses	64,000
Physiotherapists	6,000
Occupational therapists	4,000

The umbrella organisation of the Swedish local authorities is the Swedish Association of Local Authorities (*Svenska Kommunförbundet*).

### Finance

Sweden's costs for its health services amounted to SEK 178 billion in 2000, a figure which includes pharmaceutical preparations and dental care. This corresponded to 8.5% of GNP. Services provided or financed by the county councils accounted for some 80% of this figure.

The health services account for some 89% of the operations of the county councils. 71% (2001) of these operations are financed from tax revenues. The county councils are entitled to levy a proportional tax on the incomes of their residents, the average tax rate being 10%. Other important revenue sources are grants and payments for certain services received from central government, in total 19%. Patient fees amount to 4% of county council revenue.

County council revenues, and thus the funding of the health services, have diminished in recent years due to reductions in the tax base. To counteract this, the county councils reduced their expenditure in real terms by 1.5% per year during the 1990s. Patients spend less time in hospital and receive more outpatient care. The number of beds in short-term somatic care fell from 4.4 per 1,000 inhabitants in 1985 to 2.4 per 1,000 inhabitants in 2002. The corresponding figures for psychiatric care were 2.5 in 1985 and 0.6 in 2001. It is possible that patients will become more aware of the reductions in the future, when the potential for further streamlining of the health services has been exhausted.

In the early 1990s, most county councils introduced some form of purchaser-provider model, whereby the traditional system of fixed annual allocations to hospitals and primary care services was to some extent abandoned. Instead, payment is made according to results or performance. Special purchasing units, normally headed by an elected committee of local politicians, have been formed with the task of formulating the requirements which should be made of the hospitals by the county councils and of evaluating quality and prices. The hospitals, for their part, have become more

independent in relation to political bodies and have in some cases been made into county council owned limited companies. In the late 1990s it became increasingly common for county councils to put care services out to tender. The amount of care supplied by private providers rose from a very small percentage in 1990 to 9% of total county council expenditure in 2000. The fact that 29% of all visits to a doctor take place at private medical establishments is a reflection of this development.

### Patient fees

Those entitled to use the Swedish health services at subsidised prices are all residents of Sweden regardless of nationality, as well as patients seeking emergency attention from EU/EEA countries and some other countries with which Sweden has a special agreement.

The fee charged for a stay in hospital is SEK 80 per day.

Each county council sets its own fees for outpatient care. The fee for consulting a doctor in the primary health services varies from SEK 100 to SEK 150. The fee for consulting a hospital consultant or a doctor in private practice ranges from SEK 180 to SEK 300.

The county councils also set patient fees for medical treatment provided by other health professionals such as physiotherapists, occupational therapists and nurses, both in the public health services and, where appropriate, in private care. The fees vary from SEK 50 to SEK 100 per visit, depending on the county council.

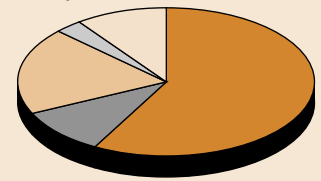
To limit personal expense there is a high-cost ceiling. A patient who has paid a total of SEK 900 in patient fees is entitled to free medical care for the rest of the twelve-month period, calculated from the date of the first consultation. All medical treatment for children and young people under 20 is free of charge.

Sweden has an extensive system of benefits for the sick. The main component of this system is sickness benefit, but it also includes compensation for participation in labour market rehabilitation schemes and benefits payable to expectant mothers who are unable to work during pregnancy.

### Pharmaceutical preparations

Before a medicine may be sold in Sweden, it must be registered at the Medical Products Agency (*Läkemedelsverket*), which is a government authority responsible for the control of pharmaceutical preparations. The activities of this authority are regulated in a new law governing medical products that has been adapted to EU regulations. There are approximately 6,000 registered pharma-

### Distribution of public health care costs, 2001



ceutical preparations. A new authority, the Pharmaceutical Benefits Board (*Läkemedelsförmånsnämnden*) was established in 2002. Its role is to decide which pharmaceutical preparations should be subsidised and then, through negotiations with the manufacturers, how much they should cost. According to a new directive, a prescribed drug which qualifies for subsidy shall be exchanged for the cheapest comparable generic alternative available at the pharmacy.

Pharmaceutical subsidies are today a matter for the county councils; they are settled annually after negotiations between the Federation of County Councils and central government. The costs for pharmaceutical preparations as a proportion of total health care expenditure have risen from just over 8% in 1990 to over 15% in 2000.

Under the terms of the social insurance scheme, the patient pays the entire cost of prescribed pharmaceutical preparations up to SEK 900. Above this a rising scale of subsidy operates, with a high-cost ceiling, which means that the patient never has to pay more than SEK 1,800 in any twelve-month period.

The state-owned National Corporation of Swedish Pharmacies (*Apoteket AB*) has the sole and exclusive right to retail medicines, both to the general public and to hospitals. This is done via 900 pharmacies nationwide.

The pharmaceutical companies have insurance coverage that provides compensation for patients whose health is damaged by a medical drug.

### Dental care

The county councils are responsible for providing free dental care for children and young people up to the age of 19, with the emphasis on preventive care. The dental health of this group has improved considerably since the 1970s. Adults receive an

economic subsidy from the national dental insurance system for basic dental care. The pricing of dental care has been deregulated, which means that providers set their own fees for each form of treatment. There is also an option to sign two-year agreements on the provision of basic dental care at a fixed price. For certain more extensive dental procedures, there is a special high-cost protection system for those aged 65 or over, aimed at limiting the cost for the individual. Approximately half of all dentists work in the national dental service run by the county councils; the others are private dentists.

#### Health service staff

Just over 230,000 people are employed in the county council health services, or some 7% of the entire Swedish workforce. This number has fallen in recent years, due in part to the financial squeeze and to changes in the work done by the services. There is a tendency for the numbers of doctors and nurses to increase at the expense of less qualified staff. There is a certain shortage of nurses, especially specialists. It is also difficult to recruit doctors to certain geographic areas and specialist fields. In Sweden there is one physician (under the age of 65 years) per 320 inhabitants.

The average salary of a hospital doctor with a specialist qualification is SEK 46,000 per month. The salary of a nurse is approximately SEK 22,000 per month.

The head of a department is, almost without exception, a medical doctor with overall responsibility for medical care as well as administration, finance and staff.

#### Training and research

Doctors are trained at the universities of Lund, Gothenburg, Linköping, Stockholm (Karolinska Institute), Uppsala and Umeå. The training is integrated with the operations of the university hospitals and other relevant parts of the health services, for example the primary health service. To become a registered doctor, a student must successfully complete a five and a half year training course and an 18-month pre-registration period as a house officer. Almost all doctors go on to qualify as a specialist after five years' service in one of the 62 recognised

specialist fields. Every year some 1,100 students start medical training. The training programme for nurses lasts three years and is available at some 30 centres, which admit around 5,500 new students each year.

Swedish medical research has a prominent international position in many fields. It is characterised by strong links between basic and clinical research and by the integration of research and development into the health services, particularly at the university hospitals. Medical research is mostly financed by government funds, but the county councils also provide resources for clinical research that is closely connected to patient care.

#### Quality and safety

During the 1990s, quality-oriented development work became more important. The aim is to generate value added for the people these services are intended for—patients, their relatives and the public in general—and to improve the health care system's ability to meet their needs. Important target areas are the availability and client focus of health services and the degree to which they are knowledge-based.

In 1994, the National Board of Health and Welfare issued a set of regulations on quality issues, which it reworked in 1997. These regulations state that all health services in Sweden shall include a system for continuous quality improvement. The new regulations embody a new approach to quality assurance work—from an emphasis on monitoring and quality-improvement measures focusing on technical quality to covering the full range of health services in a continuous, target-oriented development process focusing on the people for whom health services are intended.

Systematic improvement measures have become increasingly important in recent years and the principles of Total Quality Management (TQM) are applied by means of a variety of methods. Longterm efforts to raise awareness of patient safety are under way, especially to create a better safety climate. The aim is to develop preventive safety attitudes which will relegate scapegoat thinking to the past and increase acceptance of the fact that it is often failures

of the system as a whole which lie behind patient injuries.

The Swedish health services also benefit from another invaluable asset: the ongoing efforts to improve clinical performance and outcomes represented by some 40 national health care quality registers, each containing data on health care outcomes and treatment for a large number of categories of illness. These registers serve as a knowledge base for continuous improvement.

If a patient suffers serious injury or illness in connection with medical care or treatment, or is exposed to the risk of injury or illness, the institution providing the care or treatment is obliged to report this to the National Board of Health and Welfare. Where faults or negligence are attributable to members of staff, the matter can be referred to the National Medical Disciplinary Board (*Hälso- och sjukvårdens ansvarsmyndighet*), a government authority whose organisation is somewhat similar to that of a court. A patient or the relative of a patient can approach the Board if he considers that health service staff members have acted incorrectly. The Board can decide on disciplinary measures (warning or admonition) or remove the person from the professional register.

The Board does not deal with the matter of financial compensation for a patient who has suffered an injury; a patient insurance scheme covers such claims. The issue of holding staff responsible for their actions and deciding on sanctions is therefore kept separate from the issue of financial compensation for the patient.

Since the mid-1970s, the county councils and other institutions providing health care services have voluntarily assumed responsibility for awarding financial compensation to patients who have suffered injuries during treatment. A patient who has been injured, infected or has met with an accident in connection with an examination or treatment can be compensated, regardless of whether it is the responsibility of the medical services or not. Since 1997, every provider of health care has been legally obliged to provide, via insurance cover, compensation for injuries that occur in the course of these services.

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