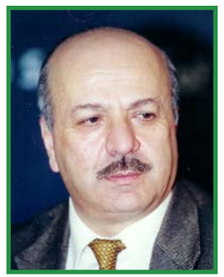
Swedish Health System: Highlights



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Providing comprehensive universal healthcare for just under 9.5 million people, the Swedish national healthcare system is regularly ranked as one of the best in the world and continues to improve through innovative solutions and investment in the latest technology.

Health in Sweden

Sweden boasts high life expectancy rates – 79 years for men and 83 years for women, high cancer survival rates, as well as one of the lowest infant mortality rates in Europe, with an average of 3 deaths per 100, 000 children born (2008). It has the European Union's (EU) highest rate of physicians per capita, at 3.3 per 1,000, which allows patients to have quick and easy access to healthcare professionals and a well-established and efficient preventative healthcare service. Compared to many other EU member states, Sweden also has a very high rate of efficiency in healthcare service delivery, despite restrictions in state funding and investment. However, like many other industrialized countries, Sweden also has a low fertility rate, which has resulted in negative natural population growth since the late 1990s, although real population growth is on the rise due to positive net migration into Sweden. 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. Although mortality due to diseases of the circulatory system has been significantly reduced during the last 30 years, this remains the leading cause of mortality, accounting for over a third of all deaths. Chronic diseases that require monitoring and treatment and often life-long medication also place great demands on the healthcare system. One positive fact is that Sweden has relatively few smokers – almost 85 percent of Swedes are non-smokers, which is reflected in the low rates of certain smoking related cancers. Many countries consider it as an excellent model to follow.

Managing National Healthcare

In Sweden there are three independent governmental levels, which are elected every four years – the national government (Riksdag), the county councils (Landsting) and the municipalities (Kommuner) – and all three are involved in healthcare. Health policy in Sweden is a national-level responsibility, however, it is a highly decentralized system.

All three levels of Swedish government are involved in the health care system. At the national level, the Ministry of Health and Social Affairs is responsible for overall health and health care policy, working in concert with eight national government agencies. At the regional level, 12 county councils and nine regional bodies are responsible for financing and delivering health services to citizens. At the local level, 290 municipalities are responsible for care of the elderly and the disabled. The local and regional authorities are represented by the Swedish Association of Local Authorities and Regions (SALAR).

Three basic principles apply to all health care in Sweden:
1. ***Human dignity:*** All human beings have an equal entitlement to dignity and have the same rights regardless of their status in the community.
2. ***Need and solidarity:*** Those in greatest need take precedence in being treated.
3. ***Cost-effectiveness:*** When a choice has to be made, there should be a reasonable balance between costs and benefits, with cost measured in relation to improvement in health and quality of life.

Who is covered and how is insurance financed?

• **Publicly financed health care:** Health expenditures represented 11 percent of GDP in 2014. About 83 percent of this spending was publicly financed, with county councils' expenditures amounting to almost 57 percent, municipalities' to 25 percent, and the central government's to almost 2 percent. The county councils and the municipalities levy proportional income taxes on their populations to help cover health care services.
• **Coverage is universal and automatic.** The 1982 Health and Medical Services Act states that the health system must cover all legal residents. Emergency coverage is provided to all patients from European Union/European Economic Area countries and to patients from nine other countries with which Sweden has bilateral agreements. Asylum-seeking and undocumented children have the right to health care services, as do children who are permanent residents. Adult asylum seekers and undocumented adults have the right to receive care that cannot be deferred (e.g., maternity care).
• **Private health insurance:** Private health insurance, in the form of supplementary coverage, accounts for less than 1 percent of expenditures. Associated mainly with occupational health services, it is purchased primarily to ensure quick access to an ambulatory care specialist and to avoid waiting lists for elective treatment. Insurers are for-profit. In 2016, 635,000 individuals had private insurance, representing roughly 10 percent of all employed individuals aged 15 to 74 years.

What is covered?

• **Services:** There is no defined benefit package. The publicly financed health system covers public health and

preventive services; primary care; inpatient and outpatient specialized care; emergency care; inpatient and outpatient prescription drugs; mental health care; rehabilitation services; disability support services; patient transport support services; home care and long-term care, including nursing home care and hospice care; dental care and optometry for children and young people; and, with limited subsidies, adult dental care. As the responsibility for organizing and financing health care rests with the county councils and municipalities, services vary throughout the country.
• **Cost-sharing and out-of-pocket spending:** In 2014, about 16 percent of all health expenditures were private; of these, 97 percent were out of pocket. Most out-of-pocket spending is for drugs. The county councils set copayment rates, leading to variation across the country. Providers cannot charge above the scheduled fee. Nationally, annual out-of-pocket payments for health care visits are capped at USD120 per individual. In all county councils, people under age 18—and in most county councils, people under 20—are exempt from user charges for visits.
• **Safety net:** In general, all social groups are entitled to the same benefits. The ceilings on out-of-pocket spending apply to everyone, and the overall cap on user charges is not adjusted for income. Some targeted groups, such as children, adolescents, pregnant women, and the elderly, are exempt from user charges or receive subsidies for certain services, like maternity care or vaccinations.

How is the delivery system organized and financed?

Primary care: Primary care accounts for about 20 percent of all expenditures on health, and about 16 percent of all physicians work in this setting. There is no formal gatekeeping function. Team-based primary care, comprising general practitioners (GPs), nurses, midwives, physiotherapists, psychologists, and gynecologists, is the main form of practice.

Outpatient specialist care: Outpatient specialist care is provided at university and county council hospitals and in private clinics. Patients have a choice of specialist. Public and private providers are paid through the same fixed, prospective, per-case payments (based on diagnosis-related groups [DRGs]), complemented by price or volume ceilings and quality components.

Administrative mechanisms for direct patient payments to providers: Patients normally pay the provider fee up front for primary care and other outpatient visits. In most cases, it is also possible for patients to pay later.

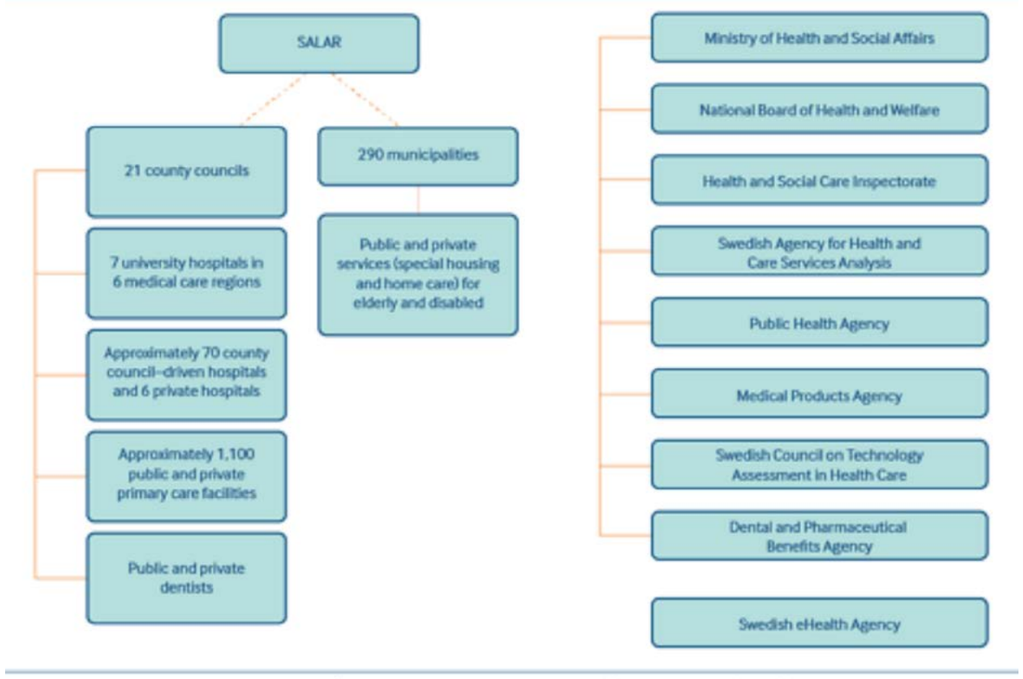
After-hours care: Primary care providers are required to provide after-hours care. Practices in proximity to each other (normally three to five practices) collaborate on after-hours arrangements.

Hospitals: There are seven university hospitals and about 70 hospitals at the county council level. Six of them are private, and three of those are not-for-profit. The rest are public. Counties are grouped into six health care regions to facilitate cooperation and to maintain a high level of advanced medical care. Highly specialized care, often requiring the most advanced technical equipment, is concentrated in university hospitals to achieve higher quality and greater efficiency and to create opportunities for development and research. Acute-care hospitals (seven university hospitals and two-thirds of the 70 county council hospitals) provide full emergency services.

Mental health care: Mental health care is an integrated part of the health care system.

Long-term care and social supports: Responsibility for the financing and organization of long-term care for the elderly and for the support of people with disabilities lies with the municipalities, but the county councils are responsible for those patients' routine health care subject to the same legislation and user fees as other health care services.

Organization of the Health System in Sweden



Source: Adapted by the author from A. Anell, A. H. Glenngård, and S. Merkur, "Sweden: Health System Review," *Health Systems in Transition*, vol. 14, no. 5, 2012, p. 19.

What are the key entities for health system governance?

The county councils are responsible for the funding and organization of health care, while the municipalities are responsible for meeting the routine care and housing needs of the elderly and people with disabilities.

More than 100 national quality registries are used for monitoring and evaluating quality among providers and for assessing treatment options and clinical practice. Registries store individualized data on diagnosis, treatment, and treatment outcomes. They are funded by the central government and by county councils, managed by specialist organizations, and monitored annually by an executive committee.

What is the status of electronic health records?

Both the quality of information technology (IT) systems and their level of use are high in hospitals and in primary care, although the type of systems used vary by care setting and by county council. Nearly all Swedish prescriptions are e-prescriptions. Patients increasingly can access their electronic medical records to schedule appointments or view personal health data, although this access varies among county councils.

County councils and municipalities are required by law to set and balance annual budgets for their activities. For prescription drugs, the central government and the county councils form agreements, lasting a period of years, on the levels of subsidy paid by the government to the councils. Because county councils and municipalities own or finance most health care providers, they can undertake a variety of cost-control measures.

Conclusion

Finally, in 2016, the government set out a vision of Sweden as world leader in e-health by 2025. The strategy involves: 1) coordination and communication among health care stakeholders; 2) development of common concepts in the field; 3) implementation of standards for health information exchange; and 4) creation of national drug lists that assist health care professionals in efforts to improve patient safety. Reforms are being undertaken to fulfil the vision.