The Swedish Health Care System

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Who is covered?

Coverage is universal. All residents are entitled to publicly-financed health care.

What is covered?

Services: The publicly-financed health system covers: public health and preventive services; inpatient and outpatient hospital care; primary health care; inpatient and outpatient prescription drugs; mental health care; dental care for children and young people; rehabilitation services; disability support services; patient transport support services; home care; and nursing home care. Possibilities for residents to choose primary care provider and hospital vary by county council.

Cost-sharing: Cost-sharing arrangements exist for most publicly-financed services. Patients pay SEK 100-150 (about $15-23) per visit to a primary care doctor, SEK 200-300 ($30-46) for a visit to a specialist or to access emergency care and up to SEK 80 ($12) per day in hospital (MISSOC 2007). For outpatient pharmaceuticals, patients pay the entire cost up to SEK 900 per year ($137), while costs above this are subsidized at different rates (50%, 75%, 90% and 100%) depending on the level of out of pocket expenditure. Out-of-pocket payments accounted for 13.9% of total health expenditure in 2005 (World Health Organization 2007).

Safety nets: The maximum amount to be paid out-of-pocket for publicly-financed care in a 12-month period is SEK 900 ($137) for health services and SEK 1,800 ($274) for outpatient pharmaceuticals. Children are exempt from cost-sharing for health services. An annual maximum of SEK 1,800 ($274) for pharmaceuticals applies to children belonging to the same family. Limited subsidies are available for adult dental care.

How is the health system financed?

The publicly-financed system: Public funding for health care mainly comes from central and local taxation. County councils and municipalities have the right to levy proportional income taxes on their residents. The central government provides funding for prescription drug subsidies. It also provides financial support to county councils and municipalities through grants allocated using a risk-adjusted capitation formula. One-off central government grants focus on specific problem areas such as geographical inequalities in access to health care. County councils provide funding for mental health care, primary care and specialist services in hospitals. Municipalities provide funding for home care, home services and nursing home care. Local income taxes account for 70% of county council and municipality budgets; the remainder comes from central government grants and user charges. Overall, public funding accounted for 85% of total health expenditure in 2005 (World Health Organization 2007).

Private health insurance: About 2.5% of the population is covered by supplemental private health insurance, which provides faster access to care and access to care in the private sector. In 2005 private health insurance accounted for less than 1% of total expenditure on health (World Health Organization 2007).

How is the delivery system organized?

Government: The three levels of government (central government, county councils and municipalities) are all involved in health care. The central government determines the health system's overall objectives and regulation, while local governments determine how services are to be delivered based on local conditions and priorities. As a result, the organization of the delivery system varies at the local level.

Primary care: Organization of primary care varies across county councils. Most health centers are owned and operated by county councils, and general practitioners and other staff are salaried employees. Traditionally, health centers have been responsible for providing primary care to residents within a geographical area. This model is being replaced, with increased possibilities for residents to choose their provider and physician. Primary care has no formal gatekeeping function. Residents may choose to go directly to hospitals or to private specialists contracted by county councils. Increasingly, residents are encouraged to visit their primary care provider first. Higher co-payments for specialist visits are used to support such behavior. Payment of public primary care providers is largely based on capitation, topped up with fee-for-service and/or target payments. The number of private primary care providers and ambulatory specialists working under a public contract is increasing; in some county councils about half of primary care physicians are private. Fee-for-service arrangements with cost and volume contracts is more common for payment of private providers, in particular for ambulatory specialists.

Hospitals: Almost all hospitals are owned and operated by the county councils. There are no private wings in public hospitals. Hospitals have traditionally had large outpatient departments, reflecting low levels of investment in primary care. For tertiary care the county councils collaborate in the six regions with at least one university hospital. Private hospitals mainly specialize in elective surgery and work under contract with county councils. Physicians and other hospital staff are salaried employees. Payment of hospitals is usually based on DRGs (diagnosis-related groups) combined with global budgets.

What is being done to ensure quality of care?

At the national level, the Swedish Council on Technology Assessment in Health Care (SBU) and the National Board of Health and Social Welfare support local governments by preparing systematic reviews of evidence and guidance for priority setting respectively.

At the local and clinical level, medical quality registers managed by specialist organizations play an increasingly important role in assessing new treatment options and providing a basis for comparison across providers. Transparency has increased and some registers are now at least partly available to the public. Since 2006, performance indicators applied to county councils and, to some extent, providers are systematically applied by the county councils in collaboration with the National Board of Health and Welfare. Further improvements in the transparency of national quality assessment include setting up a register of drug use.

Concern for patient safety has been growing. The five most important areas with potential for improvement are: unsafe drug use, particularly among older people; hospital hygiene; falls; routines to control for fully avoidable patient risks; and communication between health care staff and between staff and patients.

What is being done to improve efficiency?

Several initiatives are being implemented to improve general access to health services and to treatment. According to an agreement between the county councils and the central government, all non-acute patients should be able to see a primary care physician within seven days, visit a specialist within 90 days of referral by a GP and obtain treatment within 90 days of the prescription of treatment by a specialist. Most county councils struggle with longer waiting times for at least some patients and services (particularly for elective surgery). If patients are required to wait more than 90 days, they can choose an alternative provider with assistance from their county council.

In primary care, residents in several counties are encouraged to choose a provider based on their own assessment of access and quality, with money following the patient. A parallel policy is to increase the number of private primary care providers and encourage general competition for registration by residents. At the same time, however, there is a call for closer collaboration between primary care providers, hospitals and nursing home care, particularly where care of older people is concerned. There are similar calls for increased integration of health and social services for mental health patients.

How are costs controlled?

County councils and municipalities are required by law to set annual budgets for their activities and to balance these budgets. In the past, the central government has introduced temporary financial penalties (by lowering its grant) for local governments that raised their local income tax

rate above a specified level. For prescription drugs, the county councils and the central government agree on subsidies to the county councils for a period of five years. The national Pharmaceutical Benefits Board (Läkemedelsförmånsnämnden; LFN) engages in value-based pricing of prescription drugs, determining reimbursement based on an assessment of health needs and cost-effectiveness.

At the local level, costs are controlled by the fact that most health care providers are owned and operated by the county councils and municipalities. Most private providers work under contract with county councils. Financing of health services through global budgets and contracts and paying staff a salary also contributes to cost control. Although several hospitals are paid on a DRG basis, payments usually fall once a specified volume of activity has been reached, which limits hospitals' incentives to increase activity. Primary care services are mainly paid for via capitation or global budgets, with minimal use of fee-for-service arrangements. In several county councils, primary care providers are financially responsible for prescribing costs, which creates incentives to control pharmaceutical expenditure.

References

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