Sweden’s healthcare system is a central part of the country’s comprehensive welfare state. Although the Ministry of Health and Social Affairs provides policy guidelines, implementation is decentralised to the 21 regions or county councils. Resources come largely from local taxes, although there are some central government grants and about 15% is raised from patient fees. Current legislation emphasises equity, but health and welfare reforms over the past few years have substantially changed the system, and there is concern that health inequalities will rise.

Health system performs well
Sweden spends around 9.1% of its gross domestic product on health care, and the system compares well with that of many other countries, in terms of costs, distribution of services across the country, and health outcomes. In a study comparing countries in the Organisation for Economic Cooperation and Development (OECD), Sweden had the lowest rate of avoidable mortality, a measure sometimes used to evaluate the performance of healthcare systems. Public satisfaction in Sweden is similar to that in the United Kingdom.

Life expectancy at birth was 82.9 years for women and 78.7 years for men in 2006, and infant mortality was 2.5 per 1000 live births in 2007. The risk of dying from myocardial infarction has been almost halved (down by 44% in 2007). The number of hospital beds has fallen by about half, and care of elderly people has been shifted to municipal authorities. In 2005, Sweden had the lowest absolute death rate in Western Europe. Social differentials also exist in avoidable mortality, in avoidable episodes of inpatient care, and quality of drug treatment for people with some major public health diseases, including myocardial infarction, cardiac insufficiency, and stroke.

In 2003, the government adopted an intersectoral social determinants approach to promote health and improve equity in health. Rather than focusing on reduction in specific diseases, policies have been aimed at underlying factors that affect health such as promotion of better conditions in childhood, financial transfers to families, support of good parenthood, high quality preschools for all children, high quality schools, access to leisure activities that support healthy development, improvement in health and safety at work, and programmes to prevent disease and promote health. Since 2008 the emphasis has shifted more towards individual responsibility and health related behaviours, such as reducing smoking and excessive drinking and increasing physical activity to reduce overweight and obesity.

Access to services
The organisation of health services has changed considerably in recent decades. The number of hospital beds has fallen by about half, and care of elderly people has been shifted to municipal authorities. In 2005, Sweden had the lowest number of beds (2.2 per 1000 inhabitants) among OECD countries and one of the shortest average length of stay (6.1 days).

A recent assessment of the Swedish healthcare system concluded that health care is increasingly evidence based and that high quality care is widely available to patients of all ages. The benefits of Sweden’s strong child health services are well recognised, and the generous family policies may also contribute to low child mortality. There is concern, however, that mental and psychosomatic problems are increasing among children and adolescents.

Another concern is social differentials in the use of inpatient and outpatient care. Inequalities in access to and use of health services are partly caused by geographical differences in the supply of health care. People in rural areas make fewer visits than people in towns and cities. Higher educated groups also make more visits to the doctor than lower educated groups, in relation to their needs.

Effect of user fees
Although patients have always paid fees for both primary and secondary care, they were raised and the rates differentiated by type of care in the early 1990s (box). Patient user fees for outpatient visits vary between regions (from Kr100 to Kr150 for general practitioner consultations) and are higher for specialist visits (Kr200 to Kr300). Preventive services and services for under 18 year olds are usually free, but elderly people are not exempt from fees. Increases in user fees seem to have deterred low income groups from seeking health care and purchasing drugs despite perceived need.

Sweden is introducing large scale market reforms, patient choice, and privatisation into its healthcare system. It is unclear whether it can also maintain its good record on social equity, says Bo Burström.

Social differentials are widening
Socioeconomic differentials in quality adjusted life expectancy in Sweden increased from 1980 to 1997, largely because of a faster improvement among more educated people. Social differentials exist for most causes of death, particularly cardiovascular diseases. Although the relative social differentials are large, manual workers in Sweden have the lowest absolute death rate in Western Europe. Social differentials also exist in avoidable mortality, in avoidable episodes of inpatient care, and quality of drug treatment for people with some major public health diseases, including myocardial infarction, cardiac insufficiency, and stroke.

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**Recent developments**

The current government has made substantial changes to the welfare system and is working towards creating a market in health care. It also hopes to export its health services to other European countries, either by treating foreign patients in Swedish hospitals or by operating services abroad. Changes in legislation in 2007 enabled privatisation of hospitals and creation of for-profit companies. In 2008 almost one third (29%) of outpatient visits were to private providers, paid for by public funds. In July 2009, the state monopoly on pharmacies was abolished, opening the way for private pharmacies. Although relatively few people have private health insurance, the proportion insured increased from 2.3% in 2004 to 4.6% in 2008.

For many years Sweden has had high levels of long term illness absence, with citizens able to claim benefits for indefinite periods. In 2008 the government decided to limit claims for sickness insurance to one year and to increase efforts to get people back to work. Unemployment benefits have also been reduced. These changes were implemented before the onset of the current economic recession and the effects are not yet clear.

A few county councils are implementing extensive patient choice reforms such as choice of provider in primary care and in other specialities to improve responsiveness and access to care and strengthen patient rights. National legislation last year means that all councils will have to introduce such measures.

**Concerns about the effect of reform**

As the patient choice reforms will mean that public funds follow the patient, local county councils have protested that this will limit their ability to plan services according to need. In Stockholm, the capitulation part of the new primary care reimbursement system takes into account age but disregards socioeconomic factors, and doctors are paid according to the number of visits. Evaluations show that primary care visits increased by 6% in 2008, but the new system also meant a withdrawal of previous extra resources from primary care in disadvantaged areas. The emphasis on visits may generate many, short visits that may not always be medically required. Other county councils are taking into account experiences from Stockholm and investigating other reimbursement systems.

Doctors’ responses to the reforms have been mixed. Critics argue that the choice reforms are not evidence based and will not meet the stated health policy goals of equity and prioritisation according to need, while others see reforms as an opportunity to strengthen primary care and improve working conditions for general practitioners. The concerns are supported by a survey among doctors in counties that have tried patient choice. Most respondents said the focus on improved general access comes at the expense of opportunities for people with greater needs, complex health problems, and chronic diseases.

Do the current reforms represent a change of Swedish welfare state policy? It’s hard to tell, but the experiences in other countries suggest that the choice reforms at least will be of more benefit to better educated and healthier people and thus risk increasing inequalities.

**ANALYSIS**

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