SUPPLEMENT

TALKING POINT

Being a doctor in Sweden

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Doctors are the highest paid professional group in Sweden and the high rate of taxation there is a powerful disincentive to work. So discussions on conditions of service tend to concentrate on a shorter basic working week and improved payment for working at night. Almost all doctors choose to take their on-call compensation as extra holidays instead of extra money with the result that many are absent from their work for three months each year. If the taxation rates were lower many would willingly sacrifice several weeks' annual holiday, with subsequent benefit to the service. These are not the only differences between working as a doctor in Britain and in Sweden, where I spent two years.

With an established comprehensive welfare state Sweden organises her health service in a completely different way from us. All public medical services are subject to state control. The county councils have the main responsibility for providing the services, and every county has a central general hospital. To avoid costly duplication Sweden, which has a population of eight and a quarter million, is divided into seven medical care regions, each formed from the amalgamation of several neighbouring counties. Regional hospitals provide the complete range of specialist services and their running costs are shared according to usage by the counties they serve.

All Swedes are covered by the state sickness insurance scheme, which provides compensation for medical care costs, including travelling expenses, and sickness benefit during illness. Patients can choose where to be treated and primary care is hospital-oriented, with over half of outpatient visits to hospital clinics, about a third to health centres, and less than a quarter to private practitioners. The number of health centres has more than doubled in the past decade and the number of specialists working in health centres is increasing. All pharmacies are state-owned and prescriptions are expected to be for appropriate amounts that can be dispensed without opening packets or bottles. There is a list of essential drugs that are provided free for certain chronic illnesses. Swedes have the right to read their medical records in the presence of a doctor, but this can be denied if doctors consider that the knowledge would cause distress.

About 800 of Sweden's 17 000 doctors work in full-time private practice and about two-thirds are specialists. Most private practitioners are registered with the state sickness insurance scheme. This means that the doctors' fees are regulated by a schedule and the patients pay only a portion, the remainder being paid by the state sickness insurance. So most private practice in Sweden is state-subsidised.

Doctors employed by the county councils can practise

privately in their free time and they can be registered with the State sickness insurance scheme as private practitioners. Private practice is not permitted in public hospitals or health centres; there are a few private hospitals in the larger cities.

Finance

County councils raise most of the funds required for medical care by local income tax. Each time a patient visits a health centre or hospital the county council receives payment from the patient as well as from the state insurance. Money for building is borrowed from banks. The state sickness insurance scheme is funded by contributions from employers and the self-employed (85%) and a state grant (15%). Costs and charges increase over the years and the patients now pay 20kr (about £2.25) for each consultation at a health centre or hospital and 10kr for each treatment session in certain departments—for example, physiotherapy and speech therapy. Visits to certain clinics are free. If a patient attends a hospital or health centre more than eight times in any 12-month period, the charges for the ninth and subsequent visits are refunded on producing the receipts to the local insurance office. Inpatients pay up to 30kr per day in hospital, which the insurance office deducts from their sickness benefit and credits to the county council.

Outpatients pay a portion of prescription costs with a ceiling of 25kr per prescription. A consultation with a private practitioner registered with the state insurance scheme costs 25kr. Travelling expenses in excess of 10kr are refunded; costs are reckoned according to the cheapest mode of travel compatible with the patient's condition.

Medical training

The medical undergraduate course lasts five and a half years and, until recently, only applicants with the best academic record were selected to study medicine. Now, however, mature students with several years' professional work in any vocation are also being accepted. Furthermore, a special curriculum of four and a half years' study for nursing sisters wishing to become doctors started in 1977. To become fully licenced, the newly qualified doctor must undergo 21 months' general service training, all or most of this in hospital. After the period of general service there is specialist training or training in general practice. Specialist competence or competence in general practice is necessary for appointment to a permanent post. Appointments are made on the basis of a candidate's experience and without an interview.

Trainee specialists have to work a minimum time in their specialty and in stipulated related specialties. They attend six courses, each of five days' duration, on relevant subjects and

take examinations at the end of each course. Training in most specialties lasts four and a half years. That for general practice, however, lasts for three and a half years, at least six months of which must be spent in a health centre. Trainee general practitioners also attend six five-day courses with examinations. General service and subsequent training are usually provided by rotation schemes, frequently in the same hospital. Doctors with academic interests can acquire a Doctor of Medicine degree by undertaking a university study course and a research project, which has to be published and successfully defended in public as a thesis.

Non-Scandinavian doctors who wish to acquire a Swedish medical licence have to sit a day-long examination in the Swedish language and pass an examination at the end of a three weeks' course in social and legal medicine. In some instances service in hospitals abroad is reckoned as equivalent to service in Swedish hospitals for the purpose of training or establishing competence.

Terms of service

Doctors in hospitals and health centres have a closed contract based on the number of hours worked per week—frequently between 40 and 45 hours. Consultants are paid slightly more than GPs. On-call rates are one-tenth the basic working rate, with one-fifth the basic working rate for standby at weekends and public holidays. (Higher rates are paid if the doctor is required to sleep in hospital.) On-call working rates are slightly higher than the basic working rate and travelling time is included in working time. A doctor is recompensed only if a hospital or health centre requests his attendance, not if his visit is voluntary. Doctors can take their on-call compensation in part or whole as extra holidays instead of money. These are estimated by adding the number of standby hours and dividing as appropriate by 10 or five to convert them to equivalent working hours and adding this to the on-call working hours. This total is divided by 40 and the resulting figure gives the number of weeks' extra holiday that the doctor is entitled to.

The basic holiday entitlement varies according to the doctor's age—those under 30 have roughly five weeks per annum and those over 50 have over six weeks in addition to the many public holidays—and according to specialty; radiologists with over five years' service have longer holidays. Study leave with salary and expenses is generous.

The active building programmes throughout the country have produced hospitals which are well equipped and luxuriously appointed—impressive monuments to the benevolent welfare state. The costs, of course, come ultimately from income tax and the stage has been reached when many Swedes would probably be quite satisfied to receive treatment in more humble surroundings if this meant lowering of a tax rate which they consider to be the highest in the world.

There seems to be no rationalisation in patients' transport arrangements. Almost every day I saw patients from the same place arriving in individual taxis at the taxpayers' expense. Presumably they think they are highly taxed and must get something back. It would not be difficult to arrange for the collective transport of patients. Perhaps there would be more stimulus to economise if the county councils and not the state insurance scheme had to foot the bill.

The most costly and uneconomical feature of the Swedish medical system is the hospital-oriented primary care. This leads to overinvestigation and unnecessary admissions to hospital, especially if patients attend casualty departments outside office hours, when only inexperienced junior doctors may be on duty. Most health centres work office hours, whereas there are always casualty departments open 24 hours per day. Unfortunately, only 11% of active doctors in Sweden are general practitioners—the lowest percentage in Western Europe. The development of a training course similar to those for hospital specialists will, it is hoped, stimulate interest and increase the number of GPs. The

problem is aggravated because the private sector of occupational health care is competing with the public services for GPs and there are no regulations to limit the number of doctors in the private sector. (Companies with over a 1000 employees have their own industrial medical officers; smaller companies share doctors.) Perhaps most of the mature medical students intend to become GPs and it will be interesting to see how many last the undergraduate course.

Well-trained GPs may be frustrated when they join health centres which already have paediatricians, otolaryngologists, physicians, etc., on the staff. Primary care requires attention and Sweden can learn much from the systems in Britain and Denmark.

The prescription of appropriate quantities that can be dispensed without opening containers streamlines work in the pharmacy. Doctors receive regular information on all pharmaceutical preparations, including packaging and costs. There is no restriction on the number of prescriptions that may be issued for an illness.

The fees charged by private practitioners attached to the state insurance scheme are only slightly higher than those charged at health centres and hospitals, presumably to encourage patients to use the private sector to take as much weight as possible off the hospitals. It is a pity that there has not been a more positive and imaginative approach to private practice in Britain. When a free-at-source medical service is available to all and is underfinanced those who suffer most are the poor and the handicapped. They are a prime concern of a humane welfare state and when resources are limited they alone should be given free facilities and others should be given the opportunity to make their own arrangements towards payment for medical care.

The care and attention given to the handicapped in Sweden are impressive. Every attempt is made to integrate them in the community—where possible in their own homes—instead of isolating them in closed communities. Grants are available for installing special equipment in the home and there is generous financial aid (means-tested) in connection with aptitude testing, rehabilitation training, and setting up or continuing a private business.

Allowing patients access to their medical reports does not seem to cause problems—the Swedes are stoical, are relatively well educated in medical matters, and are accustomed to detailed presentations of medical topics in the lay media. Furthermore, there are no taboos.

Preventive medicine

The importance of preventive medicine and environmental health are appreciated and "self-care"—positive measures to improve health—is encouraged. By and large, the Swedes are participants and not spectators; this ensures an active National Committee for Health Education, which concentrates on diet and exercise, tobacco, alcohol, and drugs. Parents and school-children are lectured on the dangers of smoking. At the school my children attended all parents are asked whether they permit their children to smoke. A smoke room is provided where children must go if they wish to smoke in school. If any non-smokers are seen in this room their parents are told. There is much anti-alcohol propaganda; drink is expensive, and all state liquor stores have impressive posters of various sporting personalities advocating abstinence. The Health Education Committee perhaps exceeded itself when it launched a large advertising campaign to promote the consumption of "six to eight slices of bread per day." This shocked many people, who thought it was too much of a command and that it might lead to obesity. There was much subsequent debate on how far society can force an individual through information to modify his habits. The incident, however, probably led to hilarity more than anything else, for spoken quickly in Swedish, the slogan sounds like "Eat 68 slices of bread per day."

(concluded on page 154)

That this meeting deplores the fact that widows of doctors who retired before 25 March 1972 receive only one-third of their husband's pension, and urges Council to press for this pension to be raised to one-half in line with pension rights subsequent to 1972. (East Dorset)

That this meeting regrets the failure of the Superannuation Committee to obtain equal benefits for the dependants including widowers of all doctors. (Liverpool)

HCSA

That in the interests of unity within the profession, the BMA would welcome a reconciliation with HCSA. (Blackburn, as amended)

Private practice

That the fee for the examination of elderly drivers should be paid by the driver's insurance company. (Agenda Committee) *Priority motion*

That this meeting instructs Council to circulate to members an up-to-date list of all recommended fees for part-time medical services at least annually. (East Hertfordshire)

That general practitioners should be entitled to charge their own patients for certain services not attracting category D fees at present. (South Bedfordshire)

That this meeting considers that all fees paid from public funds outside of general medical services should be increased substantially to a level comparable with those paid by insurance companies and private employers. (Hertfordshire LMC)

That this meeting feels that a substantially higher retaining fee for police surgeons should be negotiated. (Oldham)

That this meeting believes that the present fee payable for attendance at a road traffic accident is unrealistically low, and calls on the Association to press the Government to alter present legislation to allow payment of a proper amount for this service. (Grampian)

Finances of the Association

That notes to the accounts should give detailed reports of the expenditure in each region. (Liverpool)

WMA and CMA

That this meeting firmly believes that the BMA should continue membership of the WMA. (South Bedfordshire)

That this meeting firmly believes that the BMA should continue membership of the CMA. (South Bedfordshire)

Civil liability and compensation for personal injury

That in view of the interpretation being put on the McIvor decision by some members of the legal profession the BMA Council should make available to all members advice on the correct procedure in dealing with demands for confidential documents. (Portsmouth and South-east Hampshire)

Liability for vaccine damage

That this meeting insists that medical practitioners should not be liable to damages allegedly consequent upon the administration of vaccine which has been recommended by the DHSS in interests of the community, beyond the liability for negligence in its administration. (Cambridge)

Being a doctor in Sweden—continued

There are many safety regulations in Sweden. The most obvious is the compulsory wearing of front-seat safety belts. All moving motor vehicles must have their front lights switched on, even in midsummer. For the past few years all new cars have been required to have rear-seat safety belts and their use will perhaps become compulsory.

Specialists

The pathway to specialist competence seems to be an easier journey in Sweden than in Britain. The rotation schemes in hospital enable practical training to be undertaken with minimum disruption of professional and personal life, while the various training courses provide the opportunity to acquire a sound theoretical knowledge. It is quite unusual for doctors to fail the tests at the end of each course—a different story from the fellowship and membership examinations in Britain.

Appointing doctors to posts on the basis of experience and without interview works well. The names of all candidates for a particular post are published in *Läkartidningen* (Swedish doctors' journal) and in the local press and each candidate's curriculum vitae is open for inspection. The head of the department concerned is responsible for selecting a candidate and his choice is endorsed by a local lay health committee. The committee is not obliged to support the choice automatically but disagreement

is unusual. If a candidate contests a decision there is machinery for appeal, and should a departmental head wish to interview candidates he is at liberty to do so.

No doctors I met complained about their contract, which is generally recognised as including a fair system of remuneration, rewarding those who are required to give more of their time to their employer and at the same time favouring those who must work when on call.

Unlike Britain, where there are remarkable variations in the hours of work performed by different doctors receiving the same pay, doctors in Sweden are expected to be in the hospital or health centre for the number of hours they contract to work. When not occupied in immediate patient care they have time to read journals and attend to administrative matters. In the hospital where I worked there is a clinical meeting for an hour and a half each week when different departments present topics of interest. The wide divisions which often exist in the British medical profession on medicopolitical matters do not seem to exist among Swedish doctors—perhaps because they all have similar work-sensitive contracts. Certainly no open-ended contract would ever be tolerated by Swedish doctors. Indeed, I understand that negotiations are now complete for a scheme whereby hours worked between midnight and 7 am will be compensated at twice the basic rate. It will be no surprise when the 35-hour working week becomes the standard for all doctors.

(Accepted 15 May 1979)