The health care system in Sweden operates in a single-payer, decentralized, publicly owned model, providing health insurance to every individual. At the national level, the Ministry of Health and Social Affairs monitors and supervises the system. The authority is highly decentralized, as the 20 county councils are responsible for the bulk of funding and operations. Over 90% of county revenue goes to health care, which is funded primarily from tax levies (70%), federal contributions and user fees. Some 290 smaller municipalities are responsible for the funding and delivery of long-term care. Total health care expenditure equates to 9.1% of the GDP. Overall, 85% of health care expenditure comes from public funding.

The county councils own and govern almost all hospitals and employ the majority of physicians and other health care workers. The workers are paid either through a salary or on a capitated rate. All personnel are under the supervision of The Board of Health and Welfare. All pharmacies and pharmaceutical distribution are also controlled and regulated. Providers and facilities operate on annually adjusted global operating budgets, which utilize diagnosis related groups (DRGs). The Swedish Council on Technology Assessment in Health Care reviews and evaluates the impact of new and existing technology, determining coverage and promoting the use of cost-effective methods. There are a small number of private hospitals and providers, but even these are still contracted by the county governments.

The Swedish Social Insurance agency is a part of the Ministry of Health and Social Affairs that oversees the local health insurance system. Individuals enjoy universal health insurance and comprehensive benefits, though they are still subject to small co-payments and fees for hospital and office visits. The maximum annual contributions are capped at $150 for doctor visits and $300 for prescription drugs. Dental care is also subsidized, and no fee is charged for patients under 20 years old. There is no referral system, and patients are generally free to go to the provider of their choice. Private insurance is very limited, and only 2.3% of individuals choose to purchase supplementary plans.
Health care delivery is based on equity and need. Rising costs have forced the action of rationing care and as a result Sweden experiences some of the longest wait times in Europe. Recent market oriented reforms at both the national and county levels have been implemented to control rising costs and shorten wait times. Counties are experimenting with splitting the purchaser and provider functions and allowing privatization of some primary care physicians. These changes, though, have not shown significant gains in efficiency. Another initiative includes a 90-day guarantee from initial visit to treatment, though many elective surgeries still cannot meet this deadline.

Quality incentives have also become topics of discussion, as there has been public demand for transparency across the system. In 2006, a set of performance indicators was established for the county councils and a national database was created to compare and evaluate council goals and results in order to hold them accountable. Sweden has continually been ranked in the top tier regarding physician ratios, health outcomes, and survival rates. Though wait times are still an issue, the cost-containment strategies appear to have been able to control costs without sacrificing general health. In the search for higher efficiency, Sweden hopes to develop better collaborations between primary care, specialists, and hospitals. Increased integration of care may help to alleviate some of the inefficiencies in the system.

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References:

