The Swedish health care system
Skåne University Hospital Cancer Centre
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Sweden had in 2019 a population of about 10,319,473 inhabitants with >80% of the population in urban areas. In Region Skåne lived 1,376,659 inhabitants in 2019. Life expectancy in Sweden is among the highest in the world at 81 years for men and 85 years for women. Diseases of the circulatory system are the leading cause of death with cancer as the second leading cause\(^1\). Cancer affects one out of three Swedes with an annual incidence of just over 63,000 cancer diagnoses and just over 23,000 deaths from cancer. The most common age for developing cancer is just over 70 years. For women, breast cancer is the most common type of cancer, and for men this is prostate cancer\(^2\).

1.1 GUIDING PRINCIPLES

According to Swedish Law equality and equity are key priorities. The Swedish health care system is a socially responsible system with an explicit public commitment to ensure well-being and health for all citizens, and abides by the three basic principles of human dignity (equal entitlement to dignity, and should have the same rights, regardless of their status in the community), need and solidarity (those in greatest need take precedence in medical care), and cost–effectiveness (when a choice has to be made between different health care options, there should be a reasonable relationship between the costs and the effects, measured in terms of improved health and improved quality of life)\(^3\).

Private healthcare is a rarity in Sweden, and even the private institutions work under the mandated city councils. The city councils regulates the rules and the establishment of potential private practices\(^4\).

1.2 ORGANIZATION AND RESPONSIBILITIES

At the national level, the National Board of Health and Welfare (Socialstyrelsen) is the central government’s key supervisory authority and sets budgets for governmental agencies and grants to regions, working in concert with eight national government agencies.

Healthcare is managed at three independent governmental levels – the national government, the 21 county councils within the 6 regions and the 290 municipalities (Figure 1). The main responsibility for the provision of health care services lies with the county councils and regions. The municipalities are responsible for care of older and disabled people. The healthcare system is administered by 21 councils, of which 18 are at the county level and three are regional and with populations ranging from 60,000 to 2,300,000.

The local and regional authorities are guided by local priorities and national regulation in their decisions. Nationally, they are represented by the Swedish Association of Local Authorities and Regions (SALAR)\(^5\).

Eight independent governmental agencies are directly involved in medical care and public health:

- The National Board of Health and Welfare supervises and licenses all health care personnel, disseminates information, develops norms and standards for medical care (e.g., national guidelines for specific therapeutic areas) and, through data collection and analysis, ensures that those norms and standards are met. The agency also maintains health data registries and official statistics.
- The Swedish eHealth Agency promotes information sharing among health and social care professionals and decision makers. It stores and transfers electronic prescriptions issued
in Sweden and is responsible for transferring electronic prescriptions abroad. The agency is also responsible for statistics on drugs and pharmaceutical sales.

- The Health and Social Care Inspectorate is responsible for supervising health care, social services, and activities concerning support and services for people with disabilities. It is also responsible for issuing permits in those areas.

- The Swedish Agency for Health and Care Services Analysis analyzes and evaluates health policy and the availability of health care information to citizens and patients.

- The Public Health Agency provides the national government, government agencies, municipalities, and regions with evidence-based knowledge regarding infectious disease control and public health.

- The Swedish Council on Technology Assessment in Health Care promotes the use of cost-effective health care technologies. The council reviews and evaluates new treatments from medical, economic, ethical, and social points of view.

- The Dental and Pharmaceutical Benefits Agency is the principal agency for assessing pharmaceuticals. Since 2002, it has had a mandate to decide whether particular drugs and medical devices should be included in the National Drug Benefit Scheme; prescription drugs and medical devices are priced, in part, on the basis of their value. The agency’s mandate also includes dental care.

- The Medical Products Agency is the Swedish national authority responsible for the regulation and surveillance of the development, manufacture, and sale of drugs and other medicinal products.

The councils are responsible for the funding and provision of care services to their population. Counties are grouped into six medical care regions to strengthen collaboration, which should be seen also in the light of an ongoing initiative to coordinate councils into regions.

One such example is the establishment of six Regional Cancer Centers (RCC), established in 2009 and were formed in 2011. In collaboration with county councils and regions, the government has focused longitudinal efforts on establishing regional cancer centers. Its basis was the challenges faced by society as cancer morbidity increases and as improved treatments mean that those affected by cancer are able to live longer. Great demands are placed on cooperation between regions, equal access to advanced cancer care, effective use of resources in health/medical care and preventative measures.

Sweden has a good access to physicians, 4.1 per 1,000 inhabitants, but overall a limited primary health care sector and a relatively large fraction of physicians within specialized care.

Medical education, highly specialized care and research are centralized to the University Hospitals. In Sweden there are 7 university hospitals of which one, Skåne University Hospital, is located in the Southern Sweden healthcare region.

Hospitals are run at the county councils, with exception for a very small number of private hospitals (none of which are located in the southern healthcare region yet). Medical treatment is provided at both hospitals and outpatient clinics. There is a small presence of private (but publicly-financed) healthcare in Sweden and the number of cancer patients treated within the private sector is negligible.
In 2018, 13.5 per cent of healthcare was financed by regional councils but carried out by private care providers. An agreement guarantees that patients are covered by the same regulations and fees that apply to municipal care facilities (The National Board of Health and Welfare).

The municipalities are responsible for the care and housing needs of the elderly and the disabled. There is a mix of publicly and privately owned, publically funded, health care facilities. Primary care forms the foundation of the health care system. Services for conditions requiring hospital treatment are provided at county and regional hospitals.

The Social Services Act specifies that adults at all later stages of life have the right to receive public services and assistance, such as home care aids, home care, and meal deliveries. Eligibility for services and assistance is based on need, which is determined by care managers from the municipality together with the client and often a relative.

End-of-life care is also included, either in the individual’s home or in a nursing home or hospice. The Health and Medical Services Act and the Social Services Act regulate how the regions and the municipalities manage palliative care. The organization and quality of palliative care varies both between and within regions. Palliative care units are located in hospitals and hospices. An alternative to palliative care in a hospital or hospice is advanced palliative home care.

In general, Sweden aims to have individuals stay in ordinary housing rather than in nursing homes. National policy promotes home assistance and home care over institutionalized care, with older people entitled to live in their homes for as long as possible 4.

Under Swedish law, health service staff must work in accordance with scientific knowledge and accepted standards of practice. Research results and comprehensive clinical experience should guide the delivery of health care. The National Board of Health and Welfare is commissioned by the government to provide evidence-based guidelines for the care and treatment of patients with serious chronic illness.

The guidelines are overall aimed to constitute a basis for priorities and national guidelines have been established for 36 cancer types but even national guidelines exist for acute oncology, alarm symptoms in standardized cancer care, severe non-specific symptoms, cancer rehabilitation, cervical cancer prevention, palliative care and long-term follow-up after childhood cancer. With this work Swedish cancer care has moved from regional to national standards of care 3.

### 1.2 FUNDING AND INSURANCE

In the Nordic countries, healthcare expenses are taxation based with co-payment from patients for care as well as medication. The taxation system finances the bulk (about 84%) of health care costs with the patient paying a small fee for examination and daily hospital charges. The proportion of the gross national product allocated to health care sector was 11% in 2018 8.

The remaining health care expenditure (15%) is paid for the most part directly by households. Only about 1% of health care expenditure is financed by voluntary health insurance 8.

The county councils and the municipalities levy proportional income taxes on the population to cover the services that they provide. The county councils and the municipalities also
generate income through state grants and user charges. Governmental grants have been important for the establishment of the Regional Cancer Centers and for specific tasks during a specified period, for instance reducing waiting lists for elective surgery.

A mix of global budgets, DRGs, and/or performance-based methods are used to reimburse hospitals. The use of global budgets, set by regions, is most common. When DRGs are used, they constitute less than half of total payments. Performance-based payments related to meeting quality targets constitute less than 5 percent of total payments. Payments are traditionally based on historical (full) costs.

In almost all county councils, patients under 20 years of age are exempt from user charges. The government regulates high-cost protection schemes that cover health care outpatient visits. There is a national ceiling for out-of-pocket (OOP) payments, above which an individual will never pay for health care visits within a period of 12 months.

Co-payments for prescribed drugs are uniform throughout the country and fully regulated by the government. The patient pays the full cost for prescribed drugs up to a threshold, after which the subsidy gradually increases to 100%, thus limiting co-payment for prescribed drugs to a maximum amount within each 12-month period. For over-the-counter (OTC) drugs and prescription drugs that are not subject to reimbursement, patients pay the full price. In 2016, about 16 percent of all health expenditures were private; of these, 92 percent were out of pocket. Most out-of-pocket spending is for drugs and dental care.

The number of people with private health insurance has increased rapidly over the past 15 years. An estimated 10% of the population aged 16–64 now have supplementary health insurance with very varying coverage and benefits. It is mainly purchased by employers and primarily used to ensure quick access to an ambulatory care specialist, general health checks and to avoid waiting lists for elective treatment.

Fig 1. The 21 Swedish counties and the 6 healthcare regions.

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2 Reference


6 A national cancer strategy for the future, “En nationell cancerstrategi för framtiden” SOU 2009:11


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