Swedish Healthcare Solution or Problem Tax or Insurance

At the national level, the Swedish people are represented by the Government, which has legislative powers. It has 349 seats, of which 31 0 are directly elected; the remaining seats are divided among the political parties on the basis of votes received nationally. The Riksdag appoints the Prime Minister, who is requested to form a government. The Government is assisted in its work by the government offices, comprising a number of ministries and some 300 central government agencies and public administrative bodies. The Social Democratic Party has governed Sweden, supported by a left-wing majority in Parliament, since the 1930s, except for the periods 1976–1982 and 1991–1994.

The Swedish health care system is primarily funded through taxation. Both county councils and municipalities have the right to levy proportional income taxes on their respective populations. In addition to taxation revenue, financing of health care services is supplemented by state grants and user charges. The social insurance system, managed by the Swedish Social Insurance Agency, provides financial security in case of sickness and disability. No basic or essential health care or drug package is defined within.

Resource allocation principles vary among the county councils. Most county councils have decentralized a great deal of the financial responsibility to health care districts through budgets. A small group of about five county councils continues to develop per-case payment with expenditure ceilings for some services (primarily hospitals) and capitation models for primary care. The majority of health care providers are publicly owned, and therefore physicians, dentists, pharmacists and other professional groups are mainly salaried employees.

Swedish health care.

To understand the Swedish Social Security and Healthcare System, the historical perspective is important. A traditional strong state bureaucracy and citizens' natural acceptance of state planning in their lives explain a lot about the structure of the Swedish health care system.

Between 1958 and 1963, a government commission investigated health care in Sweden's county regions. In its report, the commission held that expenditures on education and health care would greatly increase, as would expenditures in other areas of the economy, and that these increases could produce problems in the manufacturing sector. Total health care costs were 1.8 percent of GDP in 1946: by 1960 the figure had increased to 3.5 percent of GDP, and the commission expected it to grow to 4 percent or 5 percent by 1970. This growth in health care expenditures had to be accepted, according to the commission. It pointed out one major benefit of increased expenditures-less loss of production due to illness.

The commission estimated the benefits of providing health care at about 5 billion crowns

a year, somewhat less than US$1 billion. However, it also pointed out that the expansion of the health sector would create financial problems. In times of low economic activity, incomes would shrink and the costs of health care would remain high. In the commission's opinion, though, investments in the health sector should be used to create work: "If rising total costs for the health care sector were to be accepted, it was necessary . . . to maintain economic efficiency." Planning and rationalization were looked on as important factors, along with medical innovation and research. It was recommended that economic expertise be secured for the health care sector: the commission also wanted resources put into the collection and analysis of health care statistics.

Increased educational requirements for nurses, doctors, and health economists formed a major element of the commission's report: so did different models of organization. For example, which level of the public sector should be responsible for the health care system: the central state, county regions, or local councils? What is more, should the responsibility for health care be the same for every kind of health care? The answer to the last of these questions was "Yes," even if standardization could not be implemented at once.

The consumers, the patients, and their wishes were not really a major focus of the commission's discussions. The patient was looked on as an object of the state health care system. In the whole of the commission's report, there are only two places where the patient is even discussed. First, a member of the Social Democratic Party stressed that patient fees ought to be low and the same for both in- and out-patients. The Conservative commission member remarked that it was necessary that all patients receive the same care regardless of age.

Sweden's health care sector before the reforms that began in the 1960s

The Swedish health care sector was small compared with countries like Great Britain. The costs of health services were borne partly by the state (district doctors and mental hospitals), partly by the social insurance system, partly by taxes (county and/or local council income taxes), and partly by patient fees. The organization of the health care system was not integrated. In many ways, it reflected the special circumstances of a geographically large country with a small population.

Hospitals were managed by the bigger towns and county regions. Private hospitals were rare: in 1950, they provided only 2,600 of a total 58,000 beds for somatic care. Heads of clinics in hospitals were allowed to treat private patients, and hospitals had private wards. By the end of the 1950s, the hospitals started to phase out both private wards and the senior physicians' privilege of serving private patients.

During this time, the majority of doctors were employed in the public sector: 20 percent were state-employed district doctors (general practitioners), 7 percent were district doctors employed by local councils, and about 47 percent were employed by hospitals

managed by local councils (towns) or county regions. Doctors in private practice constituted about 25 percent of the total.

In the 1950s and even more during the 1960s, physicians were well paid compared with other professionals. From the late 1940s on, the blue-collar unions and Social Democrats pursued a wage policy of solidarity with low-paid workers. The ideological goal was to gradually decrease the wage disparities between higher-paid groups like physicians and the blue-collar workers. Now this goal could be reached in different ways; raising the educational requirement for physicians, abolishing the fee-for-service system in the public sector, trimming rewards to doctors in private practice by limiting the fees they could charge, and so forth. The commission proposed all of these measures.

The county regions and the Swedish health care model

The purpose of many of the political decisions made in Sweden during the 1960s was to create larger government administrative units. The local councils were examples of this. In the 1950s, Sweden had 2,500 local councils: twenty years later they had been merged, leaving only a couple of hundred. Whereas, the old local councils were managed by laymen and administrative staffs were small, the reform created a new type of bureaucracy and also a new type of career politician.

The new local councils were to implement a new building and housing policy and also create a new comprehensive school system. In order not to overload the local councils, it was thought necessary to have the county regions manage the integrated health care system.

Changes in various laws and regulations created a health care model, which was founded on the following principles:

After the Second World War, the first important step towards universal coverage for physician consultations, prescription drugs and sickness compensation was taken, when a National Health Insurance Act was voted in by the Parliament in 1946. The plan was for expenditures on physician consultations and prescribed drugs to be reimbursed but, because of financial constraints, the Act was not implemented until 1955.

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In the post-war era, a considerable expansion of the Swedish health sector began, particularly in the hospital sector. New therapeutic and diagnostic procedures created new subspecialties both among physicians and with regard to hospital structures. As living standards and technology improved, so did the health of the Swedish population, and the eradication of some diseases, e.g. tuberculosis, began. Like for most other countries of Western Europe during this period, the Swedish health care delivery system became hospital-based: approximately 90% of health care expenditure was consumed by hospitals. In 1963–1966, the county councils assumed responsibility for general practitioners working in rural areas, and in 1966–1968 they assumed responsibility for care of the mental health patients. These two areas were previously the responsibility of central government. Thus, by the end of the 1960s, the county councils had been given responsibility, to a great extent, for the provision of health and medical services.

Reforms passed

1960 - Private beds in hospitals were abolished. Counties were made responsible for open care.

1968, the Royal Medical Board merged with the Royal Board of Welfare to form the National Board of Health and Welfare, which, today, is still responsible for the supervision of health care, acting as the Government's central advisory and supervisory agency. It is also responsible for health and social services statistics.

1970- as part of the "seven-crown reform", outpatient services in public hospitals were taken over by the county councils. Patients paid SKr 7 to their county council for each outpatient consultation, and the county council was compensated directly by the national health insurance authority for the remainder of the cost.

1970 - A single fee was decided on for public care. (Today there are different fees) Publicly employed doctors were salaried. All pharmacies were bought by the state and a state monopoly of pharmacies was founded.

1971-The National Corporation of Swedish Pharmacies (Apoteksbolaget), was founded when private retail distribution was nationalized

1975 - Private doctors were permitted to work for the social insurance system. The fees they could charge and the number of patients they could see were regulated.

1982 The Health and Medical Services Act emphasized a vision of equal healthcare for all. According to the Act, ''every county council shall offer good health and medical Services to persons living within its boundaries ... In other respects too, the county council shall endeavor to promote the health of all residents." The Act gave the county councils full responsibility for matters relating to health care delivery, i.e. they were responsible for providing not only health care, but also health promotion and disease prevention, for their residents

1983 - County councils were requested,, by law, to take responsibility for all kinds of health care (Health and Medical Services Act).

1985 - County councils were given the right to control the establishment of private practices, permitted to work for the social insurance

1985 DAGMAR reform transferred responsibility for costs of both publicly and privately owned ambulatory health care from the Swedish Social Insurance Agency to the county councils.

1992 ÄDEL reform, the most dominant structural reform of the 1990s, was the transfer of responsibility for providing long-term care to the elderly and disabled from the county councils to the local municipalities.

1992, Sweden implemented a national maximum waiting-time guarantee (MWG) through an agreement between the Swedish Government and the Federation of Swedish County Councils. The "guarantee" assured patients that the waiting time between the decision-to-treat and the treatment itself would not exceed three months.

1995 Mental Health reform, aiming at improving the quality of life for mental health patients, made the municipalities financially responsible for these patients when they no longer require hospital care, i.e. when they are fully medically treated.

1997, the National Drug Benefit Scheme, which regulates co-payments on pharmaceuticals for patients, was separated from the cost ceiling for medical treatments.

1997, county councils were given the right to buy pharmaceuticals for inpatient care directly from pharmaceutical companies.

1998- county councils took over (from the State) financial responsibility for prescription drugs.

1998 -the Swedish PM Göran Persson, a Social Democrat, suddenly implemented there would be caps in fees for childcare and elderly care, a reflection of the low flat fee-philosophy. Counties were reimbursed for the number of patients served. This led to a fixed amount that each county could spend annually on health care services.

1999 Dental Care Reform, which led to the implementation of fixed and nominal subsidies for different types of services, together with free pricing for providers.

2002, the Pharmaceutical Benefits Board was created, with the responsibility of deciding if a medicine or specific product should be subsidized. The Pharmaceutical Benefits Board (Läkemedelsförmånsnämnden or LFN, the acronym by which the Board is known internationally) was introduced. The introduction of LFN has markedly changed the principles of pricing and reimbursement of drugs in Sweden. The Board makes decisions based on cost-effectiveness data; pharmaceutical companies must submit economic

evaluations, when relevant, as part of their applications for reimbursement. LFN is an independent government agency,

2002 New Dental Care Reform, high-cost protection schemes for patients above 64 years of age were implemented.

2002, the Swedish Government authorized the National Board of Health and Welfare to review and analyze gender equity trends in health care. Data from, e.g. the national quality registers, epidemiological health data registers, population surveys, and Patient Trust Boards were compiled to identify gender disparities in the quality and accessibility of health services The National Board found that many of the gender disparities identified in the 1990s still exist, e.g. access to advanced evidence-based technologies such as coronary interventions. Previously, women account for around 60%, and men for 40%, of complaints, e.g. to the Patients' Advisory Committees. Many of the proposals of the National Committee have not been fully implemented by the national authorities or the county councils.

2004, the left-leaning Social Democratic coalition, which controlled parliament, banned the privatization of hospitals and forbad the practice of private patients buying their way past waiting lists

2005, a new maximum waiting time guarantee (MWG) was introduced in Sweden. This new guarantee should put the patient in a stronger position, improve accessibility, and make it possible for the situations in different parts of the country to become more equal. The guarantee is based on the rule, i.e. (1) instant contact (zero delay) with the health care system; (2) consultation with a general practitioner within 7 days; (3) consultation with a specialist within 90 days and; (4) a wait of no more than 90 days between diagnosis and treatment. The guarantee will be the same all over the country and cover all elective care in the county councils

Since 2003, tendencies have been emerging of a re-centralization of specialist and emergency care within geographical areas – for example, smaller county councils have started to cooperate on specialist care in larger regions. In 2003, the Parliamentary Committee on Public Sector Responsibilities was formed, with the purpose of analyzing the current separation of responsibilities between the three levels of government.
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Although the overwhelming majority of Swedes enjoy good health, according to the latest report on public health and social conditions there are some worrying tendencies, considering self-reported mental illness, alcohol related problems and overweight Reported by the (National Board of Health and Welfare 2004).

So before we go any further in this let us take a look at cause and effect.

Government control at all levels, numerous reforms, Taxation, Re-centralization, all are or have been implemented under a socialist system for the greater good of the people. So now let us take a look at the results of it all, Based on the bureaucratic attitude.

Look at the direction in Government. To cope with the rapidly growing welfare state the original 2800 municipalities were merged to form 300 in the 1970s, and in 1988 some of the 26 county councils joined together to form larger regional bodies. They didn't decentralize which was the initial plan they went the other way.

Despite the rapid increase in overall spending on welfare up to the 1980s, Swedish healthcare spending has recently been kept under very strict control. During the 1980s the national government reduced spending on health care from 9.5% to 8.8% of gross domestic product. The economic crisis of the early 1990s made things even tougher. No country in Western Europe or North America experienced such a dramatic drop in healthcare spending: between 1990 and 1996.Central government has curtailed costs by cutting its grants to the county councils and legislating against any rise in local taxation rates. High unemployment has also reduced local tax revenues. County councils have responded to these cost constraints by sacking thousands of auxiliary nurses, thereby reducing overall employment in health care by 25%. Some of this has been due to a shift of nursing homes to the municipalities, but the net effect on the workload of the remaining nurses has been dramatic. In the longer term, many county councils have implemented wide reaching reforms of the way they deliver health care, looking to the British NHS and introducing purchaser-provider splits, fee for service payments in hospitals, and capitation payments in general practice.

What about care and provision thereof.

You may be referred to a hospital by a GP, but once in the hospital, you will not see or communicate with your GP until you are discharged. Doctors work in the hospital or in primary care, not both.

There is somewhat of an assembly line mentality among physicians that most Swedes do not question, but which can be hard for Americans to accept. Americans who are used to a personal physician or pediatrician, and who are used to taking responsibility for their own health, may have some difficulties adjusting to the Swedish system. Doctors are generally just parts of the assembly line, and one doctor can easily be exchanged for another. Patients are filed into the system, treated and sent home. Doctors in Sweden need not sell themselves to patients. Medical education does not emphasize interviewing and listening skills. They are not accustomed to patients questioning their prescribed treatments. Patients are not expected to know (or want to know) much about their diseases.

In fact, the system is constantly changing. A few years ago there was an attempt to facilitate more doctor continuity through the house-doctor (husläkare) system. Each person, or an entire family, is assigned to a particular GP at the local primary care center (in some cases, vårdcentral). Unfortunately, the reform included several changes that were not popular with the physicians. Consequently, the system does not always work as

it was intended. (Taken from An Article Titled) “Welcome to the Swedish Medical System”.

Vårdcentral -- primary care center

These centers usually include general practitioners, district nurses, a lab for simple tests, and physical therapists. These centers often include pre- and postnatal clinics (mödravårdcentralen).

Mödravårdcentralen (MVC) --OB/GYN clinics

Besides maternity care, MVCs are responsible for contraception, abortion, pap smears, and some other gynecological problems. You've probably heard about the extremely low mortality rate for births in Sweden. It can be attributed to two factors. One, Sweden has not had a poor, undernourished population that falls outside the system (like in that big country "over there"). Two, because virtually every woman takes advantage of prenatal care (unlike that country "over there," where a substantial proportion of American mothers choose not to have medical care until they are about to deliver.) You can also choose to go to the MVC that is most convenient for you, so if you want to use the one that is closer to where you work than close to home, you can do this. The most serious defect in the Swedish system for maternity care is that there are essentially two systems. You go to the prenatal clinic for nine months; at most clinics you are assigned to a midwife and get to know her quite well during this time. Then, when it's time to give birth, you go to the hospital and meet a completely new set of midwives whom you have never seen before and who have never seen you. Try running that by an expectant mother in America

Barnavårdcentralen (BVC), the well-baby clinic

You will be told to visit the BVC shortly after you come home with your baby. You may even get a home visit from the nurse. In the first weeks home you take your baby in every week,ten less frequently as the baby gets older. The BVC works very well.

Akutmottagningen -- hospital emergency room

Emergency care is attached to hospitals. Expect long waits! No different then in America

Private care

Sweden does not have private medical care. (with the exception of the physicians grand-fathered in Prior to the reform of 2002. The primary providers are connected to the national system, that is, they are reimbursed for visits or paid per capita. The fee you pay is somewhat higher than the regular fee for private care, but it can be worth it to have a choice alone.

Wait times

Before I talk about wait time I should provide the doctor patient ratio which the only stats I could find were from 2002 posted by Anna H. Glenngård, Frida Hjalte, Marianne Svensson, Anders Anell, Vaida Bankauskaite Authors of Healthcare in Transition.

One doctor for every 330 patients and 1 nurse for every 100 patients

Lengthy waiting times have been a problem in Swedish health services for many years. In 1992 revised in 2005 Sweden implemented a national maximum waiting-time guarantee (MWG) through an agreement between the Swedish Government and the Federation of Swedish County Councils. The first "guarantee" assured patients that the waiting time between the decision-to-treat and the treatment itself would not exceed three months. Needless to say it must have failed since it needed revision in 2005, which further read "This new guarantee should put the patient in a stronger position, improve accessibility, and make it possible for the situations in different parts of the country to become more equal. The guarantee is based on the rule, i.e. (1) instant contact (zero delay) with the health care system; (2) consultation with a general practitioner within 7 days; (3) consultation with a specialist within 90 days and; (4) a wait of no more than 90 days between diagnosis and treatment. The guarantee will be the same all over the country and cover all elective care in the county councils. Now look at number one how does that correspond with the others if you need a referral form the GP to see a specialist. And what would it equate to if you waited 7 days to see a GP and another 90 days after the referral and an additional 90 days to start treatment. Simple math tells me I am going to wait 6.1 months to get any specialized treatment and that is not talking surgeries, which is a whole other matter.

Here is a real kicker Uncovered in Sweden YSA analysis

Görann Persson had to wait eight months during 2003 and 2004 for a hip replacement operation. Persson was not considered to be a very pleasant person to begin with, and he became even grumpier due to the pain he endured while waiting for his operation. As a result, Persson walked with a limp, reportedly used strong pain medication and had to reduce his workload.

What made Persson unique was not his wait for hip surgery. Despite the government promise that no one should have to wait more than three months for surgery, 60 percent of hip replacement patients waited longer than three months in 2003 Rather, Persson stood out because he was Prime Minister of Sweden at the time. Persson could surely have used his position in the government to gain access to essential care, jumping the waiting list. Yet Persson stated that he planned on waiting for his surgery like everyone else.

Whether Prime Minister Persson did this out of benevolent motives is an open question. His party, the Social Democrats, have used the phrase "equal access to health care" to attack the center-right parties on the issue of health care for many years. Persson would have greatly undermined the effectiveness of that attack had he jumped the waiting list. For all Swedes who needed an operation in 2003, slightly more than half waited more than three months.

Here is a statement by David Hogberg who is a senior analyst for National Center for Public Policy Research.

> "While Sweden is a first world country, its health care system - at least in regards to access - is closer to the third world. Because the health care system is heavily-funded and operated by the government, the system is plagued with waiting lists for surgery. Those waiting lists increase patients' anxiety, pain and risk of death.
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> Sweden's health care system offers two lessons for the policymakers of the United States. The first is that a single-payer system is not the answer to the problems faced as Americans. Sweden's system does not hold down costs and results in rationing of care. The second lesson is that market-oriented reforms must permit the market to work.
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> When the United States chooses to reform its health care system, reform should lead to improvement. Reforming along the lines of Sweden would only make our system worse".

Complaints as Quoted by the Stockholm County Patient Advisory board

Medical Treatment 38%

Interaction / communication Information 18%

Organizational Resources and availability 36%

Other complaints 9%

First I want you to know I prepared and researched this Cross Cost Analysis in a non-biased manner to see who was more accurate and to self educate myself. Originally I had perceived the Swedish system to be compatible to the German Health Insurance concept, I was mistaken. First Germany uses an insurance based system where all are covered such as in a UHC where as Sweden is an actual UHC system. It fell far short and was heavily influenced by government control. So we will use the appropriate numbers in percentage of the National GDP for each Country regarding healthcare 9.4% for Sweden and 15.2% for the USA

Here is something else The Government only covers 45% of the percentage of the GDP while Sweden covers 85% of the same. The difference here is our government is only covering the welfare base with 45% of the allotted percentage of our healthcare cost where as your country is covering the entire country with the 85% of the allotted healthcare cost So what would that look like in real numbers after a quick number's crunch.

The U.S. Government only covers 45% of the 15.2% making our government tax responsible for 6.84% of our healthcare cost where as the Swedish Government covers 85

% of the 9.4 % making the government tax rate for healthcare 7.99%. So in addition one has to calculate that also by tax percentage. So if the U.S. is just over 28% and Sweden is just over 50% (reflected by a tax table representing various nations on the (Angel-fire site) Again who pays more? 6.84% of a just over28% tax base or 7.99% of a just over 50% tax base I just wanted you to know my overall outlook has not changed.

Now what we didn't look at is the population numbers. For instance Sweden posts a population of 9.1 million while the USA posts a population of 300.1 million. But let us talk real numbers as I was not able to find any numbers reflecting illegal immigrants for your country, I can tell you ours is estimated at 12.5 million which equates to an additional 4.2% increase to our population not reported but covered. So to be fair you would also have to increase your own population by 4.2 percent and then recalculate that ratio to your GDP once again which would equate to an additional .34 of a percent bringing your number up to 8.325% Unemployment rates would not apply but in principal you have 1.1 percent more than the USA. Which could also equate to Sweden paying more into social programs than we do. Now let's put those numbers together and apply simple math.

Sweden 8.325% of GDP actually paid by government for healthcare
USA 6.84% of GDP actually paid by government for healthcare

Sweden 1.485% higher

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