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The Swedish National Healthcare System - Public vs. Private:The Debate Continues

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The Swedish healthcare system is a regionally based, publicly operated national health service. It is organised on three levels: national, regional and local. The county councils, on the regional level, together with the central government, are the basis of the healthcare system. Overall responsibility for the healthcare sector lies at the national level, with the Ministry of Health and Social Affairs. It is the state's obligation to provide good health and other social services to all residents of Sweden.

There are 24 county councils in Sweden. These have the authority to tax their citizens and are therefore responsible for the provision of healthcare in their territory. The state, on the other hand, holds responsibility for regulating the quality of the care provided, through the National Board of Health and Welfare and the Department of Social Health and Welfare. Although they do not fund the provision of healthcare, they are responsible for regulating and reporting on the national state of the population's health. 8% of the GNP goes directly into healthcare in this country.

Background

During the 1980s, in accordance with the constitutional reform of 1974, responsibility for all healthcare was decentralised to the county councils. Both university hospitals (the Karolinska Hospital of Stockholm and the Academic Hospital of Uppsala) also passed from state to county council ownership in the early 1980s. The overall objective of the public health services was stated, in the 1982 Healthcare Act, to be the provision of "good healthcare on equal terms for the entire population". The Act gave the county councils full responsibility for health delivery related matters.

The 1982 Healthcare Act formalised a needs-based approach to healthcare planning and made county councils responsible for preventive care and health promotion and constituted the framework for health planning and health activities. The Act requires county the situation. They will increase the percentage of priThe Swedish healthcare system is a offer equal access to healthcare.

Through the Dagmar Reform of 1985 the county councils were made cost liable; they had the authority to approve which private practices should be reimbursed by national insurance, as well as the number of patients the practices could see per year. The payments were in practice still made from the national insurance to the private practices. However, payments were balanced according to a fixed budget for each county council. If the national insurance payments exceeded the fixed capitation budget, the county councils had to balance the expenditures. County council planning capacity was thereby strengthened, as they could now plan annual budgets for primary care services (publicly and privately provided), using demographic criteria.

Public vs. Private

Sweden mostly operates on a purchasing/selling system. Most 'sellers' of healthcare services are, as already stated, public. The previous government, the Social Democrats, allowed a certain level of private healthcare to flourish, due to the rather large waiting lists caused by the Social Security system, which funds areas such as sick leave and retirement, draining the government's resources. Since three months ago, the new government, who is a conservative, right-wing alliance, has been promoting private healthcare as the solution to the situation. They will increase the percentage of private healthcare sellers, despite the fact that most service providers want purchasers (e.g. the county councils), to be public. Also, the general consensus of the population is that free healthcare provision should be funded by tax and should be democratically provided.

In my view, any healthcare system can never totally live up to the expectations of the population because it is financially unfeasible. Since areas of the social security system such as sick leave are draining the amount available for healthcare then clearly the emphasis for the future of the system should be preventative rather than curative. Debate is ongoing here, as to whether the rules for sick leave for example are too liberal, as its costs are ruining the government and increasing costs in the healthcare system. For example, if an individual has back pain, they can be on sick leave for up to six weeks here, waiting for an MRI scan, which costs a mere EUR 500 compared to the EUR 10,000 cost associated with their sick leave.

Quality Control

In Sweden, every individual has a digitalised ten-digit personal social security number, and national records are kept of every individual's healthcare history and demands. Quality registers have been introduced to follow the state of the healthcare system, particularly in surgical specialties, e.g. cardiac infarction. There is also a National Cancer Register to follow survival rates and give information on patients. These initiatives lead to good general controls of healthcare in Sweden. They are certainly factors in the fact that Sweden is second to Japan in the world, for longevity rates and the lowest infant mortality rate, amongst others.

In terms of radiology, the Swedish Society of Medical Radiology monitors the number of working radiologists as well as the level of investigations (e.g. in CT, MRI). This way we can really see the productivity level of the entire system in this area. However, we don't use ISO standards or certifications in departments of radiology or in hospitals here, only perhaps for certain machines. The correctness of diagnosis and the appropriateness of recommended exams is a more important area than productivity: it is easy to say productivity has increased if one does not monitor how it is happening and whether this is in a quality fashion.

Financing Radiology

Another area of importance to radiology in Sweden is the conflict in getting financing. Here, the largest county councils have their own special radiology purchasing/selling boards. But in smaller county councils in smaller cities they only have an integrated and fixed budget with a fixed price list. The problem, therefore, arises in the purchase of new radiological equipment in developing areas like PET/CT, which restricts development. Here, the department itself is never allowed to make a purchasing decision of over EUR 100,000 regardless of whether the money is available in the budget or not. The decision is taken unilaterally by the hospital board who have to put in requests for new equipment.

Brain Drain in Swedish Radiology

In Sweden, radiology is second only to pathology in its unmet demand for qualified staff. We are trying to address this need by educating more radiologists, but due to the restrictions of the public system, the price of educating a radiologist is so high that the university hospitals are generally the ones taking on the financial burden of training radiologists. Education in radiology is certainly a high cost here. There is also an outflux of trained radiologists to, in particular, Norway, Denmark and the UK where they are generally better paid. However, we have an influx of radiology workers from Germany, Poland and Hungary since we joined the EU, who tend to be well trained, though perhaps experience difficulties in adapting to the Swedish working culture.

Conclusion

There is no doubt that the healthcare system is in need of significant and continuous monitoring and reform. In Sweden, access to healthcare is equal, but demand outstrips the availability of public sellers to take care of everyone within the fixed budget allocated them by the county council. The resultant large waiting lists are an ongoing pressure. However, it remains to be seen whether private providers are the real solution.

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