Health Services System of Sweden

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THE SWEDISH health services system has been cited by authorities in the United States and in other countries as providing solutions to some contemporary problems in health care. It is of interest, then, to examine the administration of this system, which serves a population of 7.77 million persons, 4.17 million of whom live in cities.

National Authority

Numerous agencies cooperate to run the Swedish National Health Service. All health services available to the public are subject to control by the National Government. Many activities of the health service are run by local authorities, and in fields such as outpatient services and pharmacy some functions are performed by private persons.

In Sweden, unlike other Scandinavian countries, government activity takes place on two levels—in the ministries and in the national administrative boards. The boards, which supervise and direct government activity and State institutions according to directives of the legislature and the cabinet, are responsible to the Crown. Thus, the Minister of Social Affairs has no authority over the Director General of the National Board of Health and Social Affairs. The national boards are, therefore, largely autonomous.

The National Board of Health and Social Affairs is the most important central administrative body directing the National Health Service. The board supervises general health and pharmaceutical services, controls treatment of the ill in general and private hospitals, and supervises the work of medical personnel and the hospitals, pharmacies, and other institutions. It also has many administrative responsibilities.

Regional Authorities

The basic regions in Sweden are the 24 Provinces, with an average population of 250,000 to 300,000 each. The regional authorities responsible for planning, organizing, operating, and financing general hospitals are the county councils. The councils have handled these activities since 1864 and have acquired responsibility for additional health service tasks to such an extent that 85 percent of their total gross expenditure is related to health (fig. 1).

The area of a county usually corresponds to that of the Province. The county has local self-government under the county council regarding public health and vocational education and rehabilitation, while the Province, which is the national administrative area, is controlled by the Provincial Governor—the representative of the Crown. The Governor has no legal authority over the council.

The high standards of the Swedish health service can be attributed in part to the councils' autonomy and their unrestricted right to impose taxes. Average county taxes take about 6 percent of a taxpayer's income. The total county income is about 10 percent from State funds, 14 percent from charges and fees, and the remainder from county taxes.

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Figure 1. Organization of health services in a county

Medical Health Officer

The county or Provincial medical health officer and his staff represent the National Board of Health in the county and perform supervisory and inspectional functions for the board. The health officer is not attached to the Provincial government or to the county council, but he is responsible to and paid by the State. He is seated by law as an adviser in the administrative and executive bodies of the county council and is also medical adviser to the Provincial Governor. Involved with each of the county's power structures, he can help coordinate preventive, curative, and rehabilitative services in the region.

The medical officer also functions as a supervisor and consultant in the field of environmental hygiene. He is assisted in this role by a deputy health officer and a senior sanitary consultant.

Preventive health, school health, field epidemiology, and environmental hygiene are the responsibilities of the towns and rural districts—the local communes. Communal councils appoint local public health committees to oversee observance of general health laws and to work for improved public health. These councils are responsible to the State through the Provincial Governor.

Regional Hospitals

The population of each county is not large enough to support specialized services such as neurosurgery, neurology, thoracic surgery, cardiology, plastic surgery, pediatric surgery, urology, radiotherapy, dermatology, and specialized laboratory work. Therefore, in 1960 Parliament divided the country into seven regions for specialized care, and the counties cooperate to maintain a regional hospital in each (fig. 2). At the end of 1964, 40 such regional clinics and two laboratories had been opened within the regional hospitals.

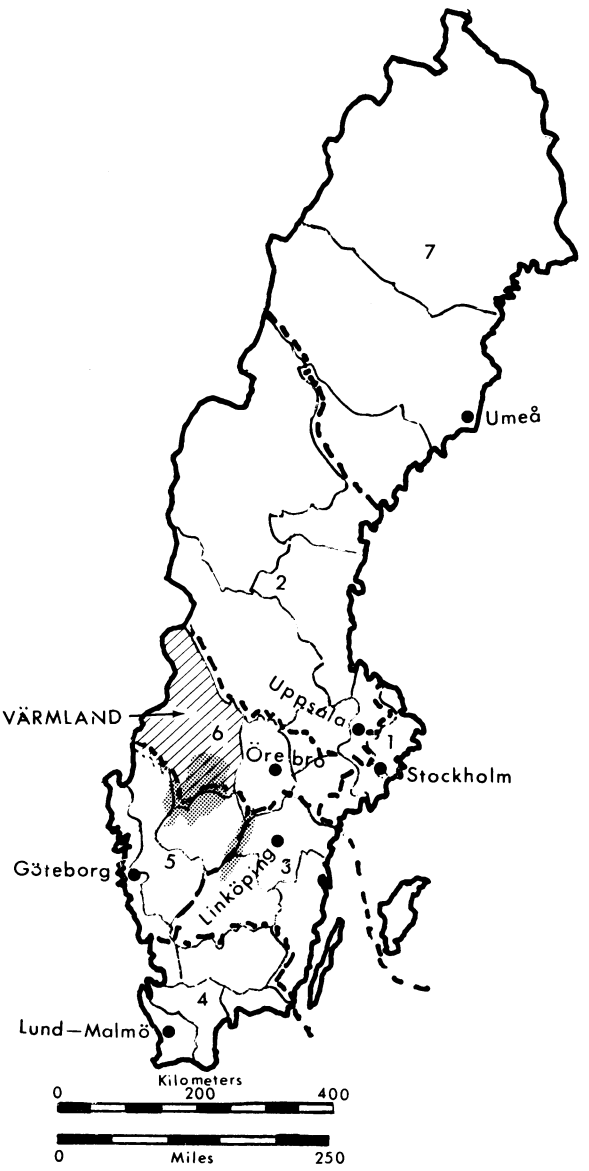
The regional hospitals retain their status as central general hospitals for a county and have been expanded to include specialized facilities. In five regions, university hospitals have become the regional hospitals. It is expected that the two remaining regional hospitals will also be used for medical education.

The populations served by the regional hospitals vary because of factors such as the sparse population in the northern districts. Theoretically, each regional hospital should serve about 1 million persons. However, three regions have smaller populations—the northernmost has a population of 700,000.

Health Insurance System

The expenses of illness to private citizens are covered to a great extent by the health insurance service, compulsory in Sweden since 1955. Each

Figure 2. Regions for specialized care, Sweden



STATISTICS ON HEALTH SERVICES OUTSIDE HOSPITALS, SWEDEN, 1965

743 rural medical officers' posts, 75 vacant
1,818 public health nurses posts, 100 vacant
376 midwifery districts, 39 vacant
1,433 maternity and child welfare units
57 central and 610 district tuberculosis units. 670,462 X-ray examinations made in the central units
198,000 visits to 27 policlinics for venereal disease; 127,000 visits made when the disease was in its contagious phase
6,095 ruled cases in 20 consultation bureaus for sexual hygiene and abortion
400,000 persons vaccinated against poliomyelitis, bringing total vaccinated to 5.2 million persons
42 child guidance clinics
50,000 epileptics treated, 95 percent in ambulatory care
29 central policlinics and 770 district policlinics in public dental service. 1,736 dental surgeons employed in service. 1,559 dental surgeons attached to the district policlinics worked 2,558,000 hours. 63 percent of time in district clinics devoted to children
134,040 medical personnel in service, including administrative and hospital domestic staffs
8,520 physicians, including 270 foreign physicians on limited license, one per 890 population
6,080 dental surgeons
23,190 nurses
1,040 nurse midwives
720 midwives

Province has a Provincial Social Insurance Fund with local branches to administer the social insurances, including health insurance. Swedish citizens living in the country are automatically registered as members of such funds at age 16, and children under age 16 are covered by their parents' insurance. The insurance service refunds payments for medical treatment, certain dental and hospital treatment, and traveling expenses connected with such treatment.

Patients are repaid three-fourths of the cost for treatment, but no more than three-fourths of the fees stated in a special scale of charges. Swedish citizens pay nothing for inpatient hospital care. Costs are shared by the county council and the Provincial Social Insurance Fund.

County of Värmland

The organization of health services in the county of Värmland are typical of those in all the counties of Sweden. Värmland, in the southwest of the country, has a population of about 290,000. Its geography and topography make it difficult to create medical units that are easily available to the population.

Hospital facilities. The county has five hospitals with 2,200 beds for somatic care and one hospital with 997 beds for psychiatric care. This sum includes 949 beds for persons requiring long term care, but excludes 350 beds for the mentally retarded. Around 3,300 persons, including 165 physicians, are employed in the hospitals. The operating cost for the system in 1968, excluding the cost of constructing new buildings, will be SKr 139 million (U.S. $27 million).

Nonhospital services. The county council employs rural medical officers to provide care outside the hospitals. Each of the 43 rural medical officers in Värmland has his practice and makes home calls in his own district. The council also employs 99 district nurses who give information and advice on child care, home hygiene, health care, and preventive health, and who provide home nursing services.

The county council is legally obliged to employ district midwives in defined geographic areas to give prenatal care, assist in deliveries, and give home postnatal care. The services of the 18 midwives are free to patients.

Since most deliveries occur in hospitals (94.1 percent in 1950; 99.7 percent in 1962), the number of district midwives has been reduced to 18 and their work has become concentrated on prenatal and postnatal care. In some areas, these responsibilities have been experimentally transferred to district nurses with supplemental training.

Maternal and child welfare care also are the concern of the county. Maternal health includes diagnosis of pregnancy, health checks, treatment of pregnancy-associated illnesses not requiring hospital care, and advice on birth control. Child health care covers children from birth to age 7 years, when the school health service begins. Treatment for mothers and children is free. In the towns, it is given at centers frequently situated at hospitals and staffed by

specially trained physicians and specially employed nurses and midwives. In rural areas, care is given at units by medical officers assisted by district nurses and midwives.

The school health service in both commune and State schools is operated by communes. It is aimed at maintaining the health of school children and teaching them good health habits. The school physician, usually the medical officer in smaller towns and rural areas, follows each child's development and supervises his health care. A child is examined when he begins school and at least four times during the course of his education. Larger communities have specially trained school nurses; in smaller communities the district nurse fills this role.

The county is responsible for providing free dental service to school children up to age 16 and for providing tuberculosis centers. There are 23 public dental clinics and two tuberculosis centers in Värmland.

Weaknesses of the System

In Sweden today, the life expectancy is 71.5 years for men and 75.5 years for women. The death rate is 10.11 per 1,000 population, the rate of live births 15.88 per 1,000 population, and the infant mortality rate is 13.3 per 1,000 live births. There are 16 hospital beds for every 1,000 inhabitants. These data place Sweden among the leading nations in health care, but the future development of the hospital organization must vary from the present trend.

There is a marked tendency toward expansion of curative medicine at the expense of preventive and social medicine and environmental hygiene. The hospital organization has been built up by the county councils, with their unrestricted right to impose rates, at the expense of the health services outside the hospitals. The weak organization of services outside hospitals has caused the majority of physicians and nurses to seek employment in the hospitals and the majority of patients to seek treatment in hospitals. Hospital costs are unreasonably high and hopelessly accelerating.

The cost per patient day in a somatic hospital currently is about SKr 150 or U.S. $25, and the costs for the total health service program have increased 100 percent in the last 5 years. The cost of the medical services system in 1968 will be about SKr 8,000 to 9,000 million, or 8 to 9 percent of the total gross national product.

Local public health committees (with responsibility for hygiene, environmental health, promotion, and preventive health) are composed only of politically elected laymen. Before 1960 a physician was always a member of the committee, but now the educated health expert is missing. In Norway the district physician of the local commune is not only a member but is the chairman of the committee.

An Ideal System

In trying to balance the total health service, we must resolve the difficulties within the traditional system of various agencies responsible (with varying economic possibilities) for the various sectors of the health and medical services.

If it were possible to create a new health organization without the burden of traditions, we would learn from the past that the most rational way is to form one organization responsible for the entire system.

Only a single, strong body can integrate the promotion of health, preventive and curative medicine, and rehabilitation, hygiene, and social medicine. Only such a body can decide how many beds per 1,000 inhabitants the country can afford (paying proper regard to the structure of the population and economy) and can keep expenses within the limits set. (In contrast, for instance, to the 16 hospital beds per 1,000 persons in Sweden, Israel has six beds per 1,000 population.)

Medical personnel should be employed, not only for a special job inside or outside a hospital, but also for the health service of the whole region. The entire medical staff in a region should be attached to a common health organization and have a collective responsibility for the service and for the individual patient. Only such a setup can result in maximum development of all fields and be flexible enough to meet the demands of urbanization and other structural changes.

Only such an organization can coordinate its activities with the engineers, architects, politicians, and others planning our future.