Consumer Assessment of Health Plans Survey (CAHPS) approach in the United States. The centre also generates publicly available information for consumer choice.

What is being done to improve efficiency?

The main approach to improving efficiency in the Dutch health system rests on regulated competition between insurers, combined with central steering on performance and transparency about outcomes via the use of performance indicators. This is complemented by provider payment reforms involving a general shift from a budget-oriented reimbursement system to a performance-related approach (for example, the introduction of DTCs). In addition, various local and national programmes aim to improve health care logistics and/or initiate 'business process re-engineering'. At a national level, health technology assessment is used to enhance value for money by informing decision-making about reimbursement and encouraging appropriate use of health technologies. At the local level, several mechanisms are used, including those to ensure appropriate prescribing.

How are costs controlled?

The new Health Insurance Act aims to increase competition between private health insurers and to encourage providers to control costs and increase quality, but it is still too early to say whether these aims have been achieved. Increasingly, costs are expected to be controlled by the new DTC system in which hospitals must compete on price for specific treatments.

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The health system in Sweden

Anders Anell

Who is covered?

Coverage is universal. All residents are entitled to publicly-financed health care.

What is covered?

Services: the publicly-financed health system covers public health and preventive services; inpatient and outpatient hospital care; primary health care; inpatient and outpatient prescription drugs; mental health care; dental care for children and young people; rehabilitation services; disability support services; patient transport support services; home care; and nursing home care. Possibilities for residents to choose primary care provider and hospital vary by county council.

Cost-sharing: cost sharing arrangements exist for most publicly-financed services. Patients pay SEK 100–150 per visit to a primary care doctor, SEK 200–300 for a visit to a specialist or to access emergency care and up to SEK 80 per day in hospital.[1] For outpatient pharmaceuticals, patients pay the whole cost up to SEK 900 per year, while costs above this are subsidised at different rates (50%, 75%, 90% and 100%) depending on the level of out-of-pocket expenditure. Out-of-pocket payments accounted for 13.9% of total health expenditure in 2005.[2]

Safety nets: the maximum amount to be paid out-of-pocket for publicly-financed care in a twelve month period is SEK 900 for health services and SEK 1,800 for outpatient pharmaceuticals. Children are exempt from cost sharing for health services. An annual maximum of SEK 1,800 for pharmaceuticals applies to children belonging to the same family. Limited subsidies are available for adult dental care.

How are revenues generated?

The publicly-financed system: public funding for health care mainly comes from central and local taxation. County councils and municipalities have the right to levy proportional income taxes on their residents. The central government provides funding for prescription drug subsidies. It also provides financial support to county councils and municipalities through grants allocated using a risk-adjusted capitation formula.

One-off central government grants focus on specific problem areas such as geographical inequalities in access to health care. County councils provide funding for mental health care, primary care and specialist services in hospitals. Municipalities provide funding for home care, home services and nursing home care. Local income taxes account for 70% of county council and municipality budgets; the remainder comes from central government grants and user charges. Overall, public funding accounted for 85% of total health expenditure in 2005.[2]

Private health insurance: about 2.5% of the population is covered by supplementary private health insurance, which provides faster access to care and access to care in the private sector. In 2005 private health insurance accounted for less than 1% of total expenditure on health.[2]

How is the delivery system organised?

Government: the three levels of government (central government, county councils and municipalities) are all involved in health care. The central government determines the health system's overall objectives and regulation, while

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local governments determine how services are to be delivered based on local conditions and priorities. As a result, the organisation of the delivery system varies at the local level.

Primary care: organisation of primary care varies across county councils. Most health centres are owned and operated by county councils and general practitioners and other staff are salaried employees. Traditionally, health centres have been responsible for providing primary care to residents within a geographical area. This model is being replaced, with increased possibilities for residents to choose their provider and physician. Primary care has no formal gate-keeping function. Residents may choose to go directly to hospitals or to private specialists contracted by county councils. Increasingly, residents are encouraged to visit their primary care provider first. Higher co-payments for specialist visits are used to support such behaviour. Payment of public primary care providers is largely based on capitation, topped up with fee-for service and/or target payments. The number of private primary care providers and ambulatory specialists working under a public contract is increasing; in some county councils about half of primary care physicians are private. Fee-for-service arrangements with cost and volume contracts are more common for payment of private providers, in particular for ambulatory specialists.

Hospitals: almost all hospitals are owned and operated by the county councils. There are no private wings in public hospitals. Hospitals have traditionally had large outpatient departments, reflecting low levels of investment in primary care. For tertiary care the county councils collaborate in the six regions with at least one university hospital. Private hospitals mainly specialise in elective surgery and work under contract with county councils. Physicians and other hospital staff are salaried employees. Payment of hospitals is usually based on DRGs (diagnosis-related groups) combined with global budgets.

What is being done to ensure quality of care?

At the national level, the Swedish Council on Technology Assessment in Health Care (SBU) and the National Board of Health and Social Welfare support local government by preparing systematic reviews of evidence and guidance for priority setting respectively.

At the local and clinical level, medical quality registers managed by specialist organisations play an increasingly important role in assessing new treatment options and providing a basis for comparison across providers. Transparency has increased and some registers are now at least partly available to the public. Since 2006, performance indicators applied to county councils and, to some extent, providers are systematically applied by the county councils in collaboration with the National Board of Health and Welfare. Further improvements in the transparency of national quality assessment include setting up a register of drug use.

Concern for patient safety has been growing. The five most important areas with potential for improvement are: unsafe drug use, particularly among older people; hospital hygiene; falls; routines to control for fully avoidable patient risks; and communication between health care staff and patients.

What is being done to improve efficiency?

Several initiatives are being implemented to improve general access to health services and to treatment. According to an agreement between the county councils and the central government, all non-acute patients should be able to see a primary care physician within seven days, visit a specialist within ninety days of referral by a GP and obtain treatment within ninety days of the prescription of treatment by a specialist. Most county councils struggle with longer waiting times for some patients and services (particularly for elective surgery). If patients are required to wait more than ninety days they can choose an alternative provider with assistance from their county council.

In primary care, residents in several counties are encouraged to choose a provider based on their own assessment of access and quality, with money following the patient. A parallel policy is to increase the number of private primary care providers and encourage general competition for registration by residents. At the same time, however, there is a call for closer collaboration between primary care providers, hospitals and nursing home care, particularly where care of older people is concerned. There are similar calls for increased integration of health and social services for mental health patients.

How are costs controlled?

County councils and municipalities are required by law to set annual budgets for their activities and to balance these budgets. In the past the central government has introduced temporary financial penalties (by lowering its grant) for local governments that raised their local income tax rate above a specified level. For prescription drugs, the county councils and the central government agree on subsidies to the county councils for a period of five years. The national Pharmaceutical Benefits Board (Läkemedelsförmånsnämnden) engages in value-based pricing of prescription drugs, determining reimbursement based on an assessment of health needs and cost-effectiveness.

At the local level, costs are controlled by the fact that most health care providers are owned and operated by the county councils and municipalities. Most private providers work under contract with county councils. Financing of health services through global budgets and contracts and paying staff a salary also contributes to cost control. Although several hospitals are paid on a DRG basis, payments usually fall once a specified volume of activity has been reached, which limits hospitals' incentives to increase activity. Primary care services are mainly paid for via capitation or global budgets, with minimal use of fee for service arrangements. In several county councils, primary care providers are financially responsible for prescribing costs, which creates incentives to control pharmaceutical expenditure.

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