

# Health Care

Status Report 2003

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# *Swedish Health Care System*

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Good health and equal access to health services for everyone are the goals of the Swedish health care system. A fundamental principle is that the provision and financing of health services rests primarily with the county councils. These operate almost all services and levy taxes to finance them. As a consequence, health services in Sweden are largely in the hands of local politicians in 21 geographical areas. The population of these areas varies between 60,000 and 1.8 million people. By international standards, health in Sweden is relatively good. Infant mortality is low, at 3.4 deaths per 1,000 in the first year of life. Average life expectancy for men was 77.1 years and 81.9 years for women in 2002. Sweden is seen as having one of the world's oldest populations, with more than 17% aged 65 or over.

Three political and administrative levels operate in Sweden: central government, county councils and local authorities (municipalities). All these play important roles in the welfare system and are represented by directly elected political bodies that have the right to finance their activities by levying taxes and fees.

Sweden's health care costs amounted to SEK 213 billion in 2002, including the care given by municipalities. This corresponded to 9.1% of GDP, of which municipal care amounted to 0.7%. The cost per inhabitant is SEK 24,000 (USD 3,100). Of the total health care expenditure, public financing constitutes 83% and private 17%. The patient fee is low in hospital (SEK 80 per night) in comparison to consulting a doctor (SEK 100–300). Patients pay 60% of the cost of dental care and 25% of the cost of medication. To limit personal expense there is a high-cost ceiling. A patient who has paid a total of SEK 900 in patient fees

is entitled to free medical care for the rest of the twelve-month period. The patient pays the entire cost of prescribed pharmaceutical preparations up to SEK 900. Above this, a rising scale of subsidy applies, with a high-cost ceiling, which means that the patient never has to pay more than SEK 1,800 in any twelve-month period.

When the general public expresses its views on health care systems, Sweden is ranked in the middle of the 15 EU member states: 1996: at number 6, 1998: number 10, and 2002: number 7.

## **Systematic follow-up requires model and method development**

The 2003 issue of the Health Care Status Report [1] is the second in the series published by the Swedish National Board of Health and Welfare. The report has the same aim as that of the previous year, i.e. to describe the situation in and development of health care and dental care. The focus is on quality, which includes availability [2]. This report also constitutes an attempt to develop further the national follow-up model for health care – the Performance Assessment Framework, PAF – which started to emerge during the work on the first status report and the previously published Health Care Report 2001 [3]. This means that conscious choices and prioritisations have been made regarding the dimensions of health care to be included in the reports, and the measurements and indicators to be used to describe them.

Internationally, there are several groups working on the development of models and methods for following up health care quality. The Nordic Council of Minis-

ters has a working group for health care quality issues which published its final report [4] in the spring of 2003. The report includes a proposal for 13 overall quality indicators in seven areas of activity. This status report features reviews drawn up using 11 of the recommended indicators.

The work on the report has been inspired by a collaborative effort that has been taking place within the framework of the OECD Health Project. In January 2003 a sub-project was initiated to develop international health care quality indicators, mainly in order to compare quality of care in the OECD countries [5]. The work has been conducted rapidly by an expert committee and five sub-committees, representing inter-disciplinary scientific expertise from more than 20 countries. By autumn 2003 the groups had produced several working documents containing proposals for overall quality indicators, partly for the entire health care sector (known as the A list), and partly for five selected areas where the need to develop indicators was judged to be considerable: primary health care including health promotion (wellness) and preventive work, cardiac health care, diabetes care, psychiatric care and patient safety. The work on the indicators is continuing in 2004.

In Sweden the preconditions for being able to report on the quality and availability of health care have increasingly improved, since several of the national quality registers have decided to be more open with their quality comparisons. This broadened openness applies to both comparisons between counties and regions and between hospitals and care units. Open reports at the level of responsible authorities can be regarded as a necessity to enable the decision-makers in the authority to make reasonable decisions on levels

of resources and prioritisations. Consequently, this status report has concentrated more clearly than before on comparing responsible authorities, partly by reviewing a large number of indicators per county or region (in a data appendix). The indicators should, however, be interpreted with a degree of caution and in the light of known facts about the quality of reported register data. In some cases, factors such as geographical variations in the coverage of the quality registers may affect the comparisons.

Despite the generally good conditions for following up health care status, many problems remain in describing and following up how well health care works as a whole. The national quality registers mainly cover highly specialised care provided at hospitals, whilst primary health care largely lacks joint follow-up systems. Building up quality registers in psychiatry has proved to be a tough challenge. Development of indicators for health promotion and preventive work has only just started.

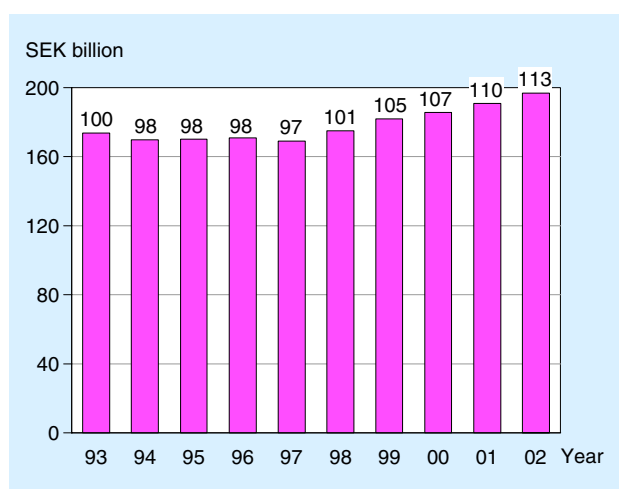
There is a tangible risk of broad and “soft” activities – in which it is difficult to use simple, quantitative measurements of quality and results – being overshadowed by activities that are easy to describe using such measurements. This can create a distorted picture of the situation in health care. It is therefore particularly important to develop methods and strategies in order to follow up activities that affect large and at-risk patient groups, and where the opportunities for quality follow-up are still limited. Such activities include care of patients with mental illnesses and substance abusers, care and rehabilitation of patients with various types of pain, as well as hearing care and paediatric care.

# General conditions for Swedish health care

## Financial development

Health care costs increased by about SEK 23 billion or 13 percent in fixed prices during the period 1993–2002 [6]. In 2002 the costs amounted to about SEK 197 billion, which constitutes 8.4 percent of the GDP (Figure 1). If municipal health care is included, the figures climb to SEK 213 billion, or 9.1 percent of the GDP.

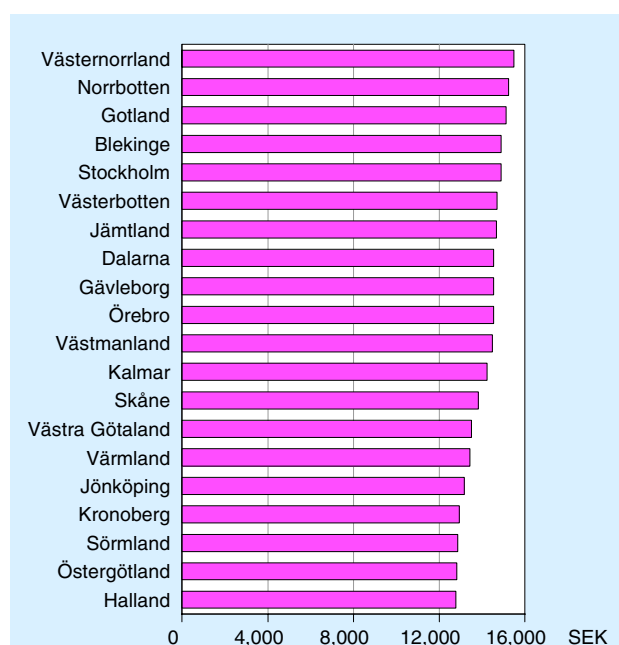
A decline in economic growth is a problem that Sweden shares with many other countries. It is worrying, because there are very strong links between economic growth and allocation of resources to health care. For example, if Sweden had managed to keep pace with OECD during the 1970–2000 period, we would probably have had SEK 30 billion more to spend on health care.



**Figure 1.** Health care costs 1993–2002. SEK billion at the price level for 2002. Index: 1993=100.

Source: SCB, Nationalräkenskaperna [Statistics Sweden, the National Accounts].

There are major cost variations between the responsible authorities (Figure 2) [7]. In 2002 the costs per inhabitant varied for all county-council health care from SEK 12,782 in the county of Halland to SEK 15,494 in Västernorrland (the county of Uppsala is not included in the comparison due to late reporting). The costs for primary care showed even greater differences: from SEK 1,871 per inhabitant in Kronoberg to SEK 3,810 in Västernorrland. Part of the variation is explainable due to differences in the responsibility for care in patients' own homes. Costs for psychiatric care varied from SEK 1,058 in Halland up to SEK 1,827 in Stockholm.



**Figure 2.** Health care costs per inhabitant 2002.

Source: The Swedish Federation of County Councils.

The proportion of health care costs paid for by households increased from 11.5 percent in 1993 to 14.9 percent in 2002. In the same period, the proportion of all health care costs accounted for by pharmaceutical preparations rose from 11.5 percent to 14.3 percent.

In 2003 Apoteket's sales totalled SEK 27.9 billion, excluding VAT (Apoteket is the sole Swedish retailing chain of pharmaceuticals). Sales of prescription medicines comprised more than 80 percent of the total. In 2003 the responsible authorities' costs for subsidised medication in the pharmaceutical benefit scheme and patients' own fees for prescription medicines was more than 20 percent higher in the county of Västernorrland (SEK 2,857) than in Örebro (the lowest, at SEK 2,362).

The rate of cost increase for the pharmaceutical benefit scheme tailed off in 2003, when we saw an increase of just 2 percent, compared to the 1990s during which society's costs for pharmaceuticals rose by about 10 percent annually. This was to some extent as a result of the generic drugs reform (substituting brands of pharmaceuticals for cheaper ones), and because the patents of some best-selling drugs expired. The development towards lower costs appears to be taking place in several countries. It is too early to say whether this is merely a short-term trend break. The National Board of Health and Welfare estimates an average cost increase of 5 percent per year for 2003–2007 [8]. This forecast is based on historical trends and the knowledge of when certain patents expire.

In the years 1993–2002 costs for dental care increased from SEK 11.3 to 17.1 billion, but their proportion of the overall health care costs decreased from 9.1 percent in 1993 to 8.6 percent in 2002 [9]. A dramatic increase has taken place in patient fees: In 1993 they constituted 39 percent and in 2002 they totalled 61 percent of the costs. In the same period, the government's proportion fell from 32 to 13 percent, and the county councils' proportion also decreased, from 29 to 26 percent.

The major deficits in county councils and municipalities are seen as very worrying. The 2003 deficit was SEK 8 billion for county councils. Despite tax increases, the deficit is estimated to rocket to SEK 15 billion in 2007 for municipalities and county councils (together) [10]. At the start of the period, the county councils/regions account for the main part of the defi-

cit, whilst the municipalities have the most problematic years towards the end of the period.

As yet, no effective remedies have been produced for the escalating costs of long-term sick leave and early retirement. In 2002 these costs were equal to those of all health care [11]. The number of people on the labour market must increase to generate enough financing for health care and nursing. This can be achieved by reducing sick leave and early retirement figures and by encouraging more people to stay on the labour market after turning 60.

### **Changes in the structure and organisation of health care**

Inpatient care at hospitals continues to decrease in terms of numbers of patients, care episodes and bed days. The number of care episodes per inhabitant fell by three percent between 1999 and 2002. One explanation for this is that more treatment is given in non-institutional forms, such as day surgery. The number of doctors' visits is on a par with the 1999 figures, with a slight shift from specialised care towards primary care [12, 13].

More than half of Sweden's county councils and regions are planning to change the structure of their health care organisation [14]. The decisive reason is the will to remove the financial imbalance. The main elements of the changes involve a combination of extended primary care and specialised hospital care, which is to be concentrated and centralised. Primary care is often the hub of extended primary care – together with sections of specialised services – at the same time as working in close co-operation with municipal health care and nursing. Technological developments, competence requirements and cost efficiency are steering the development, so that hospitals and clinics focus on certain specialties or operations. There is a tendency to keep emergency and planned care separate, to prevent emergency care from pushing planned care aside.

In 2002 a total of 7.5 million visits to private doctors were registered – doctors who are financed through public funding (health care agreements and remuneration according to a national fee). This comprises 27 percent of all primary health care visits, and 31 percent in specialised care. The relatively sharp increase in visits to private care providers between 1999 and 2001



did not continue at the same rate between 2001 and 2002 in primary care, and it came to a standstill in specialised care [13].

There are major regional variations in the proportion of visits made to private care providers. In Stockholm County Council half of the visits to doctors in 2002 were made to private practitioners in primary

and specialised care. Stockholm is followed by Skåne (34 percent) and Uppsala and Västmanland (29 percent). The lowest proportion of visits to private doctors – between five and seven percent – was recorded in Västernorrland, Dalarna, Västerbotten and on the island of Gotland.

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# *International comparisons of the quality of the health care system*

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This report contains up-to-date comparisons, using overall indicators, of the health care systems used in different countries. Most of these indicators do not only measure the quality of health care, but also reflect the quality of broader activities, of which the primary aim is to promote the wellness of the population. The comparisons may, however, be relevant to health care planning and co-ordination of health promotion and preventive measures.

## **Mortality amenable to health care in OECD countries**

The term, “amenable mortality” (or mortality amenable to health care) was introduced by an American research group at the end of the 1970s. The method drawn up has been further developed by researchers from several countries, and in a Swedish thesis published in 1993 the method was adapted to Swedish conditions. The term refers to certain illnesses or conditions that are thought can be influenced through general health policy measures – health policy indicators, or through various medical interventions – health care indicators.

An article recently published in the British Medical Journal describes two British researchers’ analysis of amenable mortality in 19 OECD countries in 1998 [15]. The background to the study is the discussion held on the WHO’s World Health Report 2000, and the comparisons it presents of the health care systems in different countries [16]. The WHO compared the efficiency of health care systems by studying disability-adjusted life expectancy, but the British researchers chose to study mortality amenable to health care.

The two researchers used a newer modification of

the term, amenable mortality, including a somewhat larger number of illnesses in the analysis and adjusting certain age limits compared to the method used in Sweden. The researchers have also conducted an extra variant of the analysis, in which 50 percent of deaths due to ischemic heart disease in people aged 1–74 are included in amenable mortality.

The results of the study illustrate how the 19 countries’ health care systems are ranked depending on which measurements are used (Table 1). Sweden and the other Nordic countries move upwards in the list when the ranking is based on amenable mortality instead of disability-adjusted life expectancy. Most Mediterranean countries move down the list instead.

When 50 percent of deaths due to ischemic heart disease are included in amenable mortality, the Nordic countries end up a few places lower down in the rankings. Sweden slips from first to second place. The move down the list is furthest for Finland, which has the highest mortality rate due to cardiovascular diseases.

To summarise, the findings of the study present the Swedish health care system in a more positive light than the criticised WHO report. It is possible that the ranking according to amenable mortality gives a more accurate view of the efficiency of the health care systems than the ranking according to disability-adjusted life expectancy, because there are greater opportunities of influencing amenable mortality through health care measures. The current study does not, however, provide any precise answer to the question of how Sweden’s total ranking among the WHO countries (23 according to the WHO report) would change if the various health measurements were combined with measurements of health care system costs, “customer sensitivity” and with various allocation aspects.

**Table 1.** Ranking of 19 OECD countries, based on comparisons of a) disability-adjusted life expectancy (1999), b) amenable mortality (1998), and c) amenable mortality including 50 percent of deaths due to ischemic heart disease (1998).

Ranking	Disability-adjusted life expectancy (1999)	Amenable mortality (1998)	Amenable mortality including 50 percent of deaths due to ischemic heart disease (1998)
1	Japan	<b>Sweden</b>	France
2	Australia	Norway	<b>Sweden</b>
3	Frankrike	Australia	Japan
4	<b>Sweden</b>	Canada	Spain
5	Spain	France	Norway
6	Italy		Italy
7	Greece	Spain	Australia
8	Netherlands	Finland	Canada
9	Canada	Italy	Germany
10	United Kingdom	Denmark	Denmark
11	Norge	Netherlands	Netherlands
12	Austria	Greece	Greece
13	Finland	Japan	Austria
14	Germany	Australia	New Zealand
15	USA	New Zealand	Finland
16	Ireland	USA	USA
17	Denmark	Ireland	Ireland
18	Portugal	United Kingdom	Portugal
19	New Zealand	Portugal	United Kingdom

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# *Satisfaction with health care*

## *– Eurobarometer*

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Statistics from Sweden are featured in the recurrent joint European surveys of Europeans' experiences of and attitudes to health care, known as the Eurobarometer. In the survey conducted in 1999 Sweden ended up in the middle, as country number eight of the 15 EU countries. 59 percent of inhabitants in Sweden were very or quite satisfied with health care. The proportion of very dissatisfied people was more than 9 percent [3].

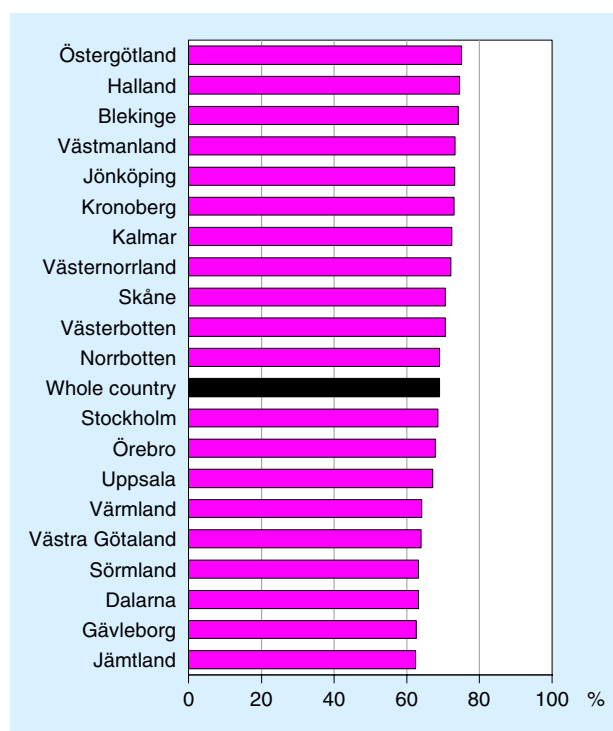
New data from a comparable survey in 2002 shows that 48 percent of the population are very or quite satisfied with health care, whilst the proportion of very dissatisfied amounts to 11 percent [17]. This places Sweden at number seven – again in the middle – of the rankings. The difference compared to Germany (in eighth place), the Netherlands (ninth) and Spain (tenth) is, however, statistically unreliable.

### **Availability and the general public's view of health care**

Seven out of ten people in Sweden state that they have access to the health care that they need. One in ten disagree [18]. This information has been obtained from "Vårdbarometern" [Health Care Barometer], an annual project in which about 0.5 percent of the adult population in Sweden are interviewed by telephone about their experiences of and attitudes to the health care system. All authorities responsible for health care, except the municipality of Gotland, participate in the survey.

The results for 2003 were about the same as for 2002. However, the opinions of inhabitants vary between counties. Those most satisfied in the survey are the inhabitants of Östergötland, Halland and Blekinge, and the least satisfied live in Jämtland, Gävleborg and Dalarna (Figure 3).

According to the Health Care Barometer, the public regard shorter waiting times and shorter waiting lists as the most important points to improve on in health care in their own county. The proportion who are of this opinion increased from 18 percent in 2002 to 23 percent in 2003. The second most important point was to recruit additional staff and reduce the workload for staff. The third point raised was more contact and time with doctors. The ranking is virtually identical among



**Figure 3.** "I have access to the health care that I need". Answers 4+5 on the scale 1–5.

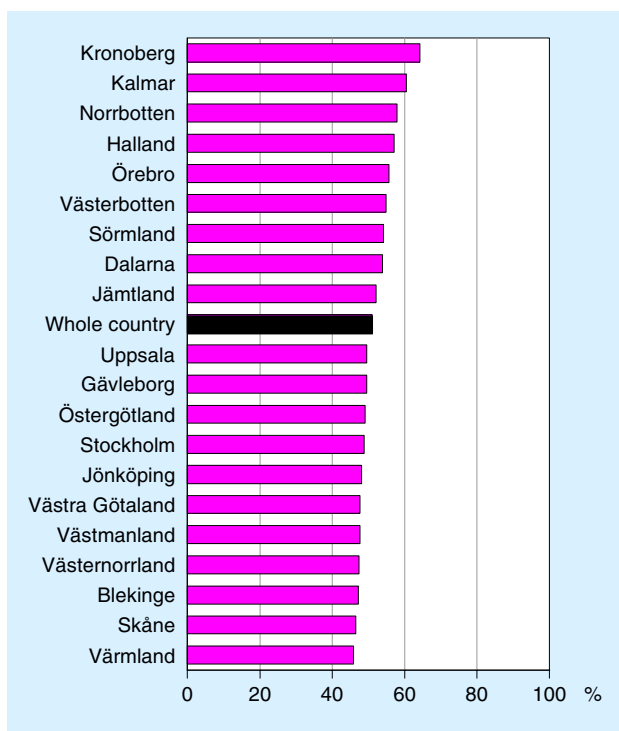
Source: Vårdbarometern [the Health Care Barometer].

all groups in the population – irrespective of gender and age.

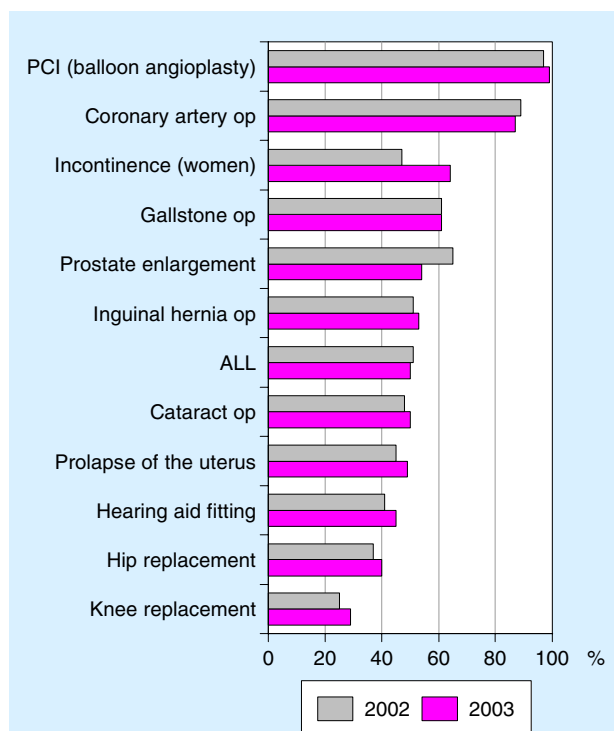
The major problem of availability in primary care continues to be the difficulty in getting through to health care centres by telephone. Only half the population thought that it was easy to get through (Figure 4). Of those who wanted to make an appointment with a doctor at a health care centre, just over half could visit the doctor the same day, and eight out of ten within a week. The waiting times remained unchanged from 2002.

Of the patients who received a referral to a hospital

clinic, more than seven out of ten received an appointment within three months. An equal number were operated on or treated within three months of receiving notification of their operation or treatment. An analysis of certain individual treatments and operations illustrated that the proportion of patients who received treatment within three months was the same in 2002 as in 2003 [19]. The shortest waiting times were seen in cardiac care and applied to balloon angioplasty and coronary artery operations (Figure 5). The longest waiting times were for knee and hip operations as well as for fitting and testing hearing aids.



**Figure 4.** “How easy or difficult was it to get through to the health centre by telephone?” Proportion who thought that it was easy. Answers 4+5 on the scale 1–5. Source: Vårdbarometern [the Health Care Barometer].



**Figure 5.** The proportion of patients who received treatment within three months. 1<sup>st</sup> four-month period of 2002 and 2003.

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# *Medical quality constantly improving, but unevenly distributed*

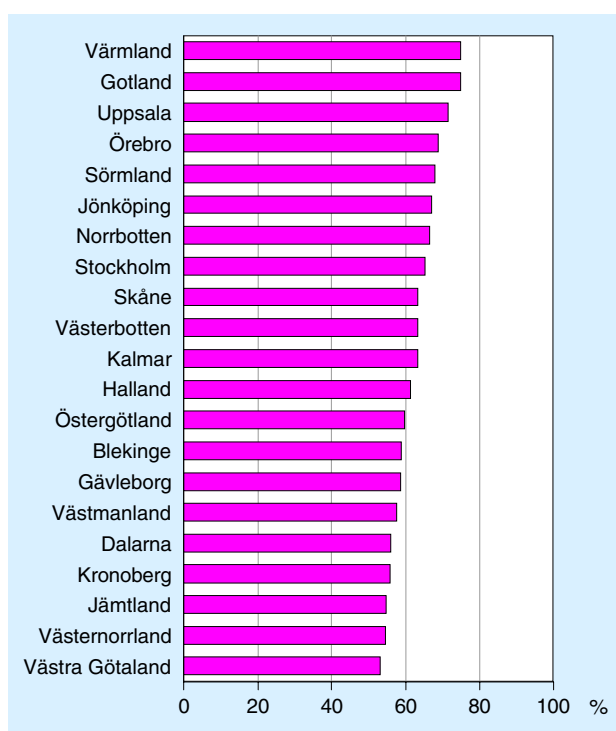
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Despite the relatively gloomy economic situation, analyses of data from national quality registers and health data registers demonstrate continued positive trends for access to evidence-based health care and treatment of major endemic diseases, such as heart attacks, strokes, diabetes and cataracts. Similarly, many of the analysed areas show steady improvements regarding health care's medical results, but no area displays deterioration in the quality of results. Examples of positive development in the quality of results in health care include less 28-day mortality after heart attacks [20]; improved five-year survival rate after common cancers such as breast cancer, prostate cancer and malignant melanoma [21]; constantly improving metabolic control in diabetics [22]; and higher implant survival after hip operations [23].

## **Regional variations**

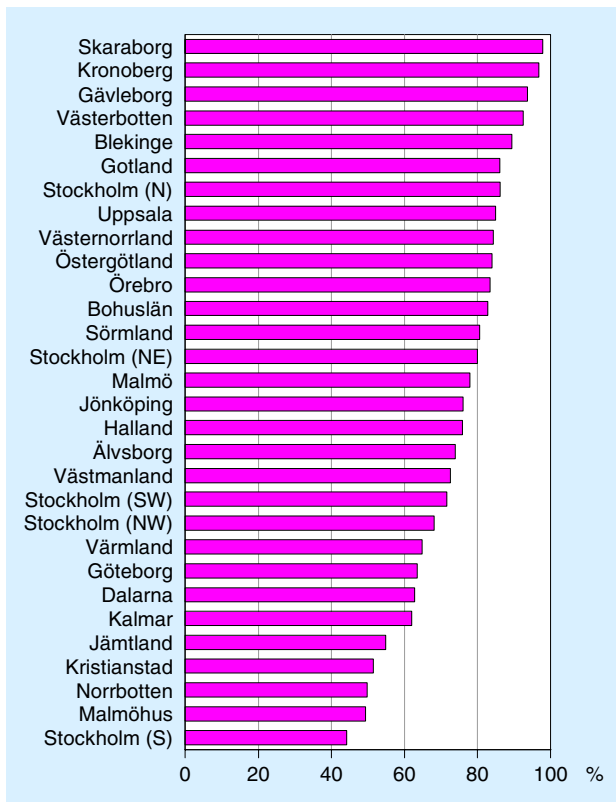
A major joint problem remains in health care: considerable regional variations in availability of and use of scientifically established treatment methods. The variations are considerable in, for example, reperfusion

treatment of heart attack patients (Figure 6) [24], access to care at stroke units following a stroke (Figure 7) [25] or eye operations to treat cataracts (Figure 8) [26]. The variations in use of medication are also large, for instance in treatment of rheumatoid arthritis with new biological drugs (Figure 9) [27]. These pharmaceuticals are also expensive, which means that even small variations in treatment praxis have major cost consequences.



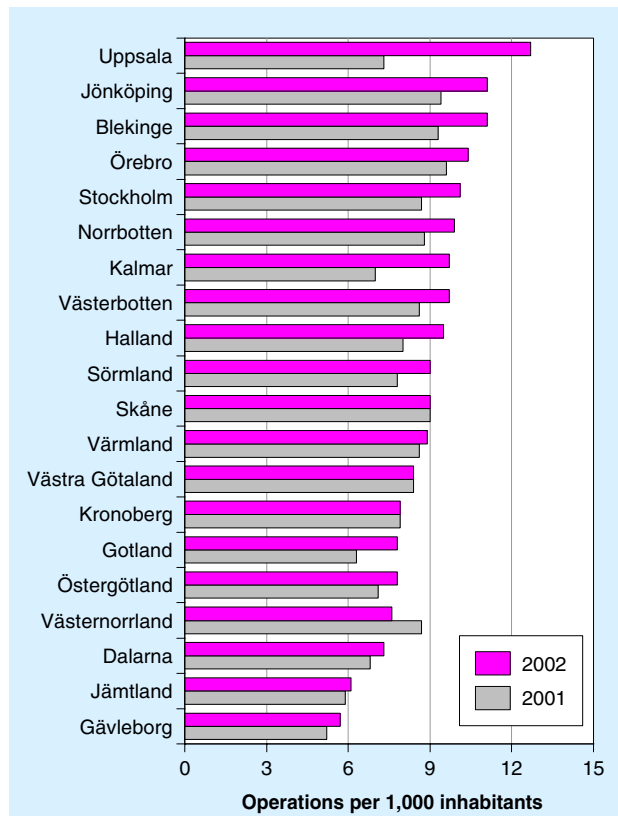
**Figure 6.** The proportion of patients <80 years old who received emergency reperfusion treatment for a heart attack with ST elevation or left bundle branch block. Per county council health care area. 2002.

Source: RIKS-HIA [Register of Information and Knowledge about Swedish Heart Intensive Care Admissions].



**Figure 7.** The proportion of patients who received treatment at a stroke unit. Per county council health care area. 2001–2002.

Source: Riks-Stroke [The National Stroke Register in Sweden].



**Figure 8.** Number of cataract operations per 1,000 inhabitants. Per county council health care area. 2001–2002.

\* Västmanland is not shown, because Västerås ögonklinik [eye clinic] does not participate in the registration.

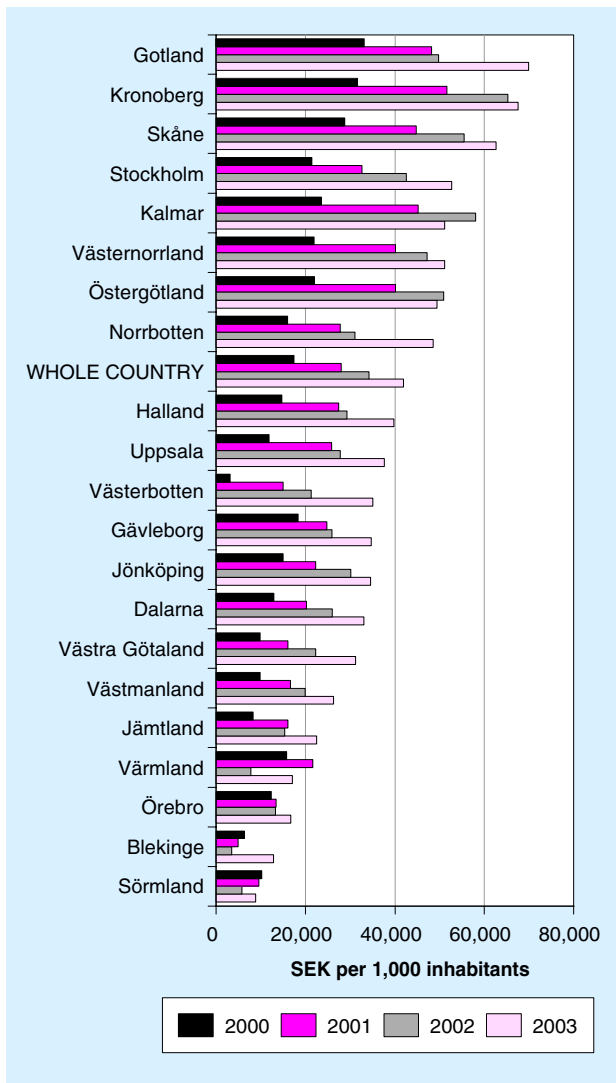
Source: Nationella Kataraktregistret and Sveriges Ögonläkarförening [National Cataract Register and the Swedish Ophthalmological Society].

The regional differences are in most cases only partially due to variations in the health and health care needs of the population. Apparently unmotivated differences in praxis also occur in many other countries. Extensive research into health systems has concentrated on the reasons for such discrepancies. Differences in local resources and prioritisations may comprise one explanation. Contrasts in knowledge, attitudes and perceptions of care providers – especially “key figures”, i.e. strong representatives of the medical profession – may also have major significance. In some cases, such as that of biological drugs to treat rheumatoid arthritis, the variations can be explained by differences in the rate of distribution of new medical technology. This may be linked to the fact that the knowledge base for use of the technology is still uncertain.

The differences call for more thorough analyses and follow-ups in future of regional and local health care results. There is a risk of uneven health care praxis leading to uneven results in health care. Compilations

of data from the national quality register for intensive cardiac care, Riks-HIA, point to regional differences in mortality rates among patients who have received intensive cardiac care following a heart attack [24]. Information from the Medical Birth Register reveals major differences in the proportion of women who have suffered a serious perineal tear in vaginal birth [28]. County councils and care providers, who in such compilations show poor results, should naturally be interested in finding out what this is due to.

Systematic quality follow-up, connected to open reporting and comparisons of care providers, can be expected to reduce the variations. Involving patients more actively as interested parties in health care, for example by publishing consumer-friendly quality information containing medical comparisons, is being tested in numerous countries. However, to make quality comparisons so reliable so that even patients/con-



**Figure 9.** Sale of etanercept and infliximab (total) per county council health care area. Note that infliximab is also used to treat Crohn's disease. 2000–2003.

Source: Apoteket AB.

sumers can use them when selecting health care, analysis and reporting models are required that take into account differences between hospitals and regions regarding various factors of significance to the disease prognosis.

Developing models for fair quality comparisons should not be a major problem, bearing in mind the wealth of information on patients and treatments in the national Swedish quality registers as well as the clinical epidemiological expertise available at, for example, the recently established competence centres for national quality registers.

## Differences in gender and age

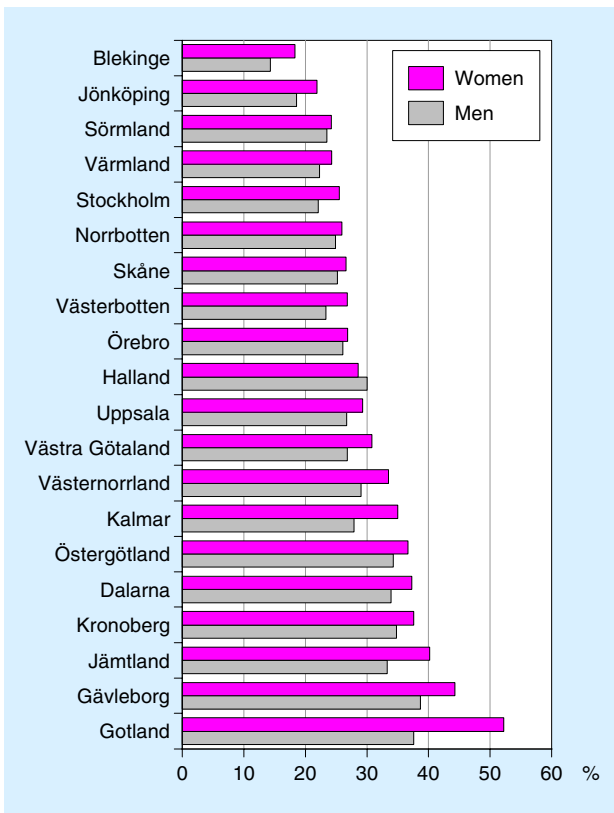
Besides regional differences, the status report discusses age and gender differences in the access to advanced care and treatment. Analyses of intensive cardiac care show a number of discrepancies in the treatment frequency of men and women in comparable age groups [24]. For instance, an early PCI (percutaneous coronary intervention) or coronary artery operation is performed after a serious heart attack somewhat more often on young men than on women. In addition there are clear differences between the age groups: old patients receive treatment more rarely than young ones. As the average age of having a heart attack is higher for women than for men (76 compared to 70 years old), this restrictiveness in the treatment of old patients affects a much greater proportion of women than men.

An important question of principle raised is whether it is medically motivated to have major differences in treatment policy between young and old patients. The answer may vary depending on the treatment – older patients may be at greater risk than younger ones, at least in certain treatments. If restrictiveness in treatment policy is interpreted as age discrimination, it affects women more than men.

Analyses in eye care indicate that women have somewhat poorer access to cataract operations, which may partly be explainable due to the fact that women constitute the vast majority of the oldest patients. In most county council health care areas, a larger proportion of women than men wait more than six months for their cataract operations. A larger proportion of women also have a best preoperative visual acuity of  $\leq 0.5$  when they are eventually operated on (Figure 10).

Gender differences appear to be largest in the county council health care areas that have relatively low operation frequencies in relation to the population. It may be a good idea to follow up the consequences of various reforms and prioritisation decisions which involve cut-backs and/or redistribution of available health care resources. The investigation into how women and men are received, i.e. attitudes to patients, in health care analysed the reforms and changes implemented in the 1990s in the health care system's macro structure, from an equality perspective. It was noted that the issue of attitudes – how women and men are received





**Figure 10.** The proportion of patients with a preoperative visual acuity under 0.5 on their best eye. Per county council health care area and gender. 2002. Source: Nationella Kataraktregistret [the National Cataract Register].

in health care – was not discussed in the reforms, and that there were no follow-ups of how women and men were affected by the changes [29]. A gender consequence analysis of reforms recently implemented, which was conducted within the framework of the National Board of Health and Welfare’s new equality investigation [30] came to the same conclusion.

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# *Shortcomings and problems in health care*

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Shortcomings in psychiatric care were highlighted in an investigation that the National Board of Health and Welfare conducted in autumn 2003 due to two acts of violence committed in Stockholm [31]. From investigations and supervision the Board saw that the statutory health care planning does not work satisfactorily for people with psychosis or the combination of substance abuse and personality disorders. The current health care organisation is rarely suitable for these groups. The people affected – those with psychotic disorders and substance abusers with personality disorders – have often received various types of health care, to which substantial resources have been allocated. However, it is likely that more co-ordinated and clearly evidence-based measures would lead to better results.

Compilations of data on complaints and criticisms reported to various bodies (such as HSAN, the Medical Responsibility Board; Patientförsäkringen, the patient insurance body; the National Board of Health and Welfare; and the patients' committees of the county councils and local authorities) provide some informa-

tion on current shortcomings and problems in health care. An update of statistics showing the number of reports to the patient insurance body and the patients' committees continues to display an upward trend, whilst complaints sent to HSAN, the Medical Responsibility Board, appear to be levelling off. Complaints filed with the National Board of Health and Welfare according to Lex Maria (the Swedish system for reporting medical errors) were slightly more common in the 1990s than today.

In the patient insurance body, specialties with considerable volumes of operations, i.e. general surgery and orthopaedics, have the highest number of cases. Health care for women, especially obstetrics, leads to relatively numerous patient injuries. As regards complaints filed with the Medical Responsibility Board and the National Board of Health and Welfare according to Lex Maria, the most complaints per specialty are seen in the statistics for family medicine. Statistics from patients' committees in Sweden demonstrate an upward trend in complaints about primary health care [32].

**Table 2.** The number of reports to HSAN, the Medical Responsibility Board; Patientförsäkringen, the patient insurance body; the patients' committees and to the National Board of Health and Welfare according to Lex Maria (the Swedish system for reporting medical errors). 1997–2002.

	1997	1998	1999	2000	2001	2002
HSAN	2,860	3,119	3,064	3,070	3,250	3,227
Patientförsäkringen	8,174	8,552	8,129	8,871	9,003	9,395
Patientnämnderna	u.s.	u.s.	16,239	18,546	19,995	22,572
Lex Maria	1,199	1,130	995	904	922	1,000

The majority of all complaints and criticisms reported in health care, about 60 percent, concern care and treatment of female patients. This applies irrespective of whether the body receiving the complaints is the Medical Responsibility Board, the patient insurance body, the National Board of Health and Welfare or the patients' committees of the responsible authority. Patient committee material shows that the proportion of cases that concern general attitudes (how a person is received) is higher for women than men [33].

Gender contrasts have already been illuminated in the report, "Jämställd vård. Olika vård på lika villkor" [Equal health care. Different health care on equal

terms] [29]. The uneven gender distribution and the higher proportion of cases concerning reception of/attitudes to female patients are therefore not simply temporary or random phenomena. The factors that explain these differences have not, however, been studied in more detail.

The differences observed in gender emphasise the importance of applying gender-specific strategies in follow-up and in development of the quality of care. A number of proposals for how to strengthen health care from a gender perspective have recently been submitted in the National Board of Health and Welfare's report on equality [30].

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