

# Good quality, local health care

A joint effort (SOU 2019:29)

## 2 The emergence of the Swedish health care system

### 2.1 Introduction

This section outlines the development of the Swedish health care system from 1928 to 2010. The purpose of this section is to provide background information, an understanding of why the current system looks the way it does. It primarily offers an overview, focusing on how the health care system has been shaped by various pieces of legislation. As this is a brief summary, it mainly refers to inquiries and legislation which have had significant effects or are often cited. There are also other pieces of legislation and government inquiries that have had an impact in addition to those referred to here.

It is important to emphasise that because the overview predominantly describes the development of the health care system based on changes in legislation, it lacks the patient-oriented perspective which would also be required for a comprehensive depiction of the history of health care in Sweden. This reflects the text of the historic legislation on which this section is based, as this often lacks a clear patient-based viewpoint. The focus on legislation and a system-oriented approach also means that the breadth of different professions in Swedish health care and their history is not clearly highlighted. Historically, and for a long period of time, doctors were the main medical profession made visible in the legislation. Like the lack of a patient-oriented perspective, the lack of attention paid to the wide range of professions involved is historically a problem in the health system.

## 2.2 The dawn of modern health care

There has been public health care in Sweden in various forms as far back as the seventeenth century. However, it was not until the 1930s that modern health care<sup>1</sup> with clinics nationwide, specialisation, and outpatient care [*sw: öppen vård*] started to take shape. In the early twentieth century, health care was scattered and relatively disorganised. The majority of health care was provided by what were known as provincial doctors. They worked very independently, often from their own surgeries or clinics and were financed by fees from patients, while also receiving a salary from the State, which was responsible for providing these doctors in local communities. Provincial doctors were trained and were licensed by the state-run Medicinalstyrelsen (the forerunner of today's National Board of Health and Welfare).<sup>2</sup>

At that time there were also a few hospitals in Sweden, known as *lasarett*. It was up to the county councils whether or not they ran a hospital. In 1924 there were 92 such hospitals in Sweden providing 13,307 beds in total.<sup>3</sup> These were run and funded by the county councils but with quality control centralised under Medicinalstyrelsen. The majority of these were what was known as “*odelade lasarett*”, literally “undivided”, meaning that there was no division into different medical specialties. Only a few hospitals specialised in fields such as surgery or obstetrics.

The first time that county councils were obliged to provide health care by law was in the 1928 Hospitals Act [*sw: sjukhuslagen*] This made it the duty of county councils to provide “institutional care for illness, injury or physical deformity” for everyone permanently or temporarily resident in the county “where no such care is provided by any other body”. In other words, under this Act, inpatient care was to be provided by all county councils where space was available in health care institutions. The county councils were also to provide maternity care. However, the Act made exceptions for care in epidemics and “institutional care for the mentally ill, mentally

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<sup>1</sup> The Swedish term used in the legislation at the time was “*sjukvård*”, literally care of the sick, whereas today the Swedish term would be “*hälso- och sjukvård*”, adding a focus on health. In the English translation, the term “health care” has been used throughout.

<sup>2</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, pp. 79–80.

<sup>3</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, p. 70.

defective, epileptics, the chronically physically ill and convalescents”.<sup>4</sup> This means that health care for mental illnesses, epilepsy, chronic illness or for patients in a stage of recovery was not covered by the Hospitals Act.

In order to meet the increasing demands for access to institutional care, under the Hospitals Act, each county council was obliged to provide at least two hospitals. Municipalities also had the opportunity to run hospitals if they wished to; however, they were not obliged to do so. County councils and municipalities could also run hospitals jointly. Running a hospital meant that the municipality or the county council met the operating costs of the hospital in part or in full. This legislation became the start of a major expansion in the health system. However, it was to take until after the end of the Second World War before the expansion truly took off. Until 1940 still only a third of doctors worked at hospitals, the majority being provincial doctors.<sup>5</sup>

### 2.2.1 Sickness insurance

When health care expanded, the State increasingly took on the cost of the care. A large proportion, however, remained funded by patient fees. For many people in gainful employment in Sweden in this period, the greatest financial problem caused by illness was not the doctor’s fees but the loss of earnings. Many workers took out sickness insurance policies to meet these costs. In the early twentieth century, sickness insurance comprised voluntary private insurance funds. The funds were organised either by a union or by the employer. Part of the pay packet was paid into the sickness insurance system each month. The sickness insurance funds were state regulated and partly funded by government grants. Their main task was to pay out compensation in the event of illness, but they could also be used to pay some of the costs of health care. In 1925 only 13 percent of Swedes were covered by sickness insurance.<sup>6</sup> To ensure that all citizens gained access to health care, in the 1930s the

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<sup>4</sup> *Government Bill 1928:101 proposing an act on certain hospitals run by county councils or municipalities*, pp. 2–3.

<sup>5</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, p. 70.

<sup>6</sup> Swedish Association of Local Authorities and Regions (SALAR), *Hälso- och sjukvårdens reformer: En internationell jämförelse*, (Health care reforms: An international comparison), 2006 p. 10.

Government introduced a number of reforms of the sickness insurance system, which involved increasing state subsidies to the sickness insurance funds.

In 1947 the Government decided to introduce national sickness insurance.<sup>7</sup> This meant that it was compulsory for all adults to be members of a sickness insurance fund. For financial reasons and due to a certain amount of political opposition, it was not until 1955 that this actually entered into force. In the reform adopted, the sickness insurance funds were financed by a mixture of individual contributions, employer contributions and government contributions.<sup>8</sup> This system meant the cost of health care for individual citizens was partly covered by insurance.

## 2.3 Expansion of health care

The 1950s was a time in which great strides were made in medicine and medical technology. This saw specialised health care become increasingly widespread across Sweden. The existing non-specialised hospitals [sw: *odelade lasarett*] were replaced with hospitals with medical and surgical clinics, and later also X-ray and anaesthesiology departments. These new hospitals were termed *normallasarett*. Hospitals with more than the above specialisms were termed *centrallasarett*. Usually each county council had one *centrallasarett*. In addition to these, there were also specialised hospitals for more specific needs, e.g. epidemics, tuberculosis and maternity care. During the same period, a number of reforms were carried out which meant that more forms of care could be provided in hospitals. Several of the areas that had been exempt in the 1928 legislation thus became covered by the hospitals legislation. They were then included in the county councils' general responsibility for providing health care and were no longer regulated by separate legislation. Care of the elderly was reformed in 1952, and care of the chronically ill was placed on an equal footing with other physical health care. In 1960 only care of the "mentally defective" was regulated by separate provisions.<sup>9</sup>

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<sup>7</sup> Government Bill 1946:312 proposing a National Insurance Act, etc.

<sup>8</sup> Government Bill 1953:178 proposing amendments to the National Insurance Act.

<sup>9</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, p. 78

In this period there was a political desire to create a wide-ranging general welfare system capable of meeting the needs of the entire population. Expanded, accessible health care was part of this vision. For this reason, many health care reforms were carried out and several inquiries were appointed. One of the most thorough inquiries was the ÖHS inquiry, as it was known, *kommittén för översyn av hälso- och sjukvården i riket* (the Committee for oversight of health and medical care in the realm), appointed in 1954. ÖHS submitted its first and most significant report in 1958 (SOU 1958:15) ÖHS emphasised that the development that the Swedish health system had undergone had led to a very hospital-heavy system which prioritised inpatient care.<sup>10</sup> ÖHS produced several proposals to remedy this situation, some of the most important being expanding the training of doctors and other health care personnel, supporting preventive activities such as corporate health care, and the county councils taking over the running of the provincial doctor service. These proposals became a reality over the years that followed.

### 2.3.1 Regional hospitals

At the end of the 1950s, inpatient treatment was thus extensive and widespread. There was a lack of consistent organisation of specialised health care. Specialisation was mainly found in specific clinics in different parts of the country. At the same time, new findings were being made, leading to increasingly specialised training and more advanced methods that demanded specialised wards. The regional health care inquiry was set up to make specialised health care more centralised and equally accessible across the whole country. It submitted its final report (SOU 1958:26) in 1958. The view reached by the inquiry was that a number of specialisations, including anaesthesiology, paediatrics and internal medicine, could be provided at hospitals at county level. A number of more advanced specialisations, such as dermatology, cardiology and rheumatology, however, could not be provided in every county and should instead be provided at highly specialised hospitals responsible for larger geographical areas.

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<sup>10</sup> SOU 1958:15 *Health care and outpatient health care in county council areas*, pp. 17–18.

These assessments resulted in a new Hospitals Act [sw: *sjukhuslagen*] in 1960.<sup>11</sup> Sweden was thus divided into seven regions for highly specialised medicine, with regional hospitals in Stockholm, Uppsala, Linköping, Lund-Malmö, Gothenburg, Örebro and Umeå. The running of the regional hospitals was not regulated under the hospitals legislation. Instead it was regulated in agreements between the county councils in question. The clinics for the different specialities in the regional hospitals were primarily to be set up and dimensioned in line with local needs and with views on the organisation of hospitals that it was up to the bodies responsible for providing health care to decide. For this reason no detailed proposals were drawn up which were binding on the planning process.

## **2.4 Expanded outpatient provision and care in the home**

The rapid developments that took place in health care in the 1940s and 1950s almost only concerned hospitals. Outpatient treatment continued to mainly be provided by provincial doctors. As previously stated, these doctors were responsible for providing all forms of outpatient medical treatment within a predetermined geographical area. The work of the provincial doctors was based at specific surgeries or clinics but they also made home visits and in sparsely populated municipalities could have several smaller subordinate surgeries. Some provincial doctors were assisted by care assistants or registered nurses. A large number ran their surgeries entirely on their own. Some towns employed and paid their own doctors to provide health care to the population. However, they had no obligation to do so.

Outpatient health care was also provided by hospitals to a limited extent. This was mainly specialised treatment which did not require a hospital stay. It was provided by doctors who worked at the hospitals but independently, separately from inpatient health care, which was provided by the county councils. These doctors were able to access the hospital's resources and staff in return for paying a fee to the county council. Much of outpatient health care was also

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<sup>11</sup> *Government Bill 1960:159 proposing guidelines for the expansion of regional hospitals.*

provided by private doctors whose main income came from patient fees, but also from a certain national tariff.<sup>12</sup>

The system in both inpatient and outpatient care was not only focused on hospitals, it was also focused on doctors. During this period, the role of other professions was described as assisting the health care performed by doctors. In addition to the outpatient care provided by doctors, there was also what was termed “district care” provided by district nurses and district midwives. This care was also defined geographically and provided in specific areas. The provincial doctors in the area were the line managers of the district nurses and midwives. There was no officially accepted definition of what the duties of district health care involved. Tasks were often a mixture of health care and social-medical duties.<sup>13</sup>

The county councils’ obligation to provide outpatient care was not laid down in law until 1959. At this point, this only referred to outpatient care at hospitals. The county councils were only obliged to provide such outpatient care that could not be appropriately provided elsewhere. In addition, the Act stated that outpatient care was not allowed to “have a detrimental effect on inpatient care”.<sup>14</sup> Expansion of outpatient care began in 1963 when the county councils took over responsibility for the provincial doctors from the State, the thinking behind this being to link inpatient and outpatient care. This made the county councils responsible for the majority of health care in Sweden. It also revitalised outpatient care as it brought more staff and technical resources to the non-hospital-based clinics. Surgeries changed from having one doctor to having two or three. These became the first true health centres. This expansion also went hand in hand with a desire to co-locate health care resources outside the hospitals with the municipalities’ social functions.<sup>15</sup>

Due to the lack of long-term hospital beds, home care was introduced in the 1950s. Initially home care was mainly provided by the patient’s relatives. These relatives were either paid by the county council or received a home care grant amounting to a certain monthly

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<sup>12</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act* pp. 79–82.

<sup>13</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act* pp. 83–84.

<sup>14</sup> *Government Bill 1959:19 proposing a Hospitals Act, etc.*

<sup>15</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act* pp. 79–81.

sum. In the 1960s, health care in the home was mainly provided by staff of the home help service. Such “home Samaritans” had limited medical training.<sup>16</sup> To a certain extent home health care staff comprised assistant nurses and care assistants employed by the county council. At this time, health care in the home was linked to long-term health care provided by the county councils. Work in the field was mainly supervised and led by district nurses.

## 2.5 The seven-kronor reform

The sickness insurance system was reformed in the 1960s. In 1963, a new insurance act was introduced under which people were automatically signed up to several social insurance schemes, including sickness insurance. Sickness insurance was switched from local funds, mainly privately run, to a central State-run fund.

The sickness insurance system was mainly more focused on inpatient care than outpatient care. The main compensation paid out by the system was for loss of income while in hospital. As far as the costs of outpatient health care were concerned, the patient paid the doctor’s fee and could then claim it back from the sickness insurance fund. The fact that the patient paid the entire fee up front made it hard for individuals to predict how much a visit to the doctor would cost, as this varied. The design of the insurance system at the time meant it was more expensive for the person needing treatment to use outpatient treatment than inpatient treatment, even though the latter was more resource-intensive.<sup>17</sup> This was considered to be one of the causes of the remaining problem that demand for health care still relied far too much on inpatient care.

To tackle this, what was termed the “seven-kronor reform” was introduced in 1969. The Government Bill describes the Act as a “radical simplification” of the health care system to make outpatient care cheap and easily accessible to all citizens and to make the costs predictable. The Act meant the introduction of a system with, in principle, a uniform fee for public outpatient health care on 1 January 1970. The patients paid a fee of 7 kronor for each visit to the doctor and 15 kronor for home visits. The health care providers

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<sup>16</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act* pp. 84–85.

<sup>17</sup> *Government Bill 1969:125 amending the National Insurance Act, etc*, p. 11.

were compensated from the insurance system with a fee of 31 kronor per visit. The fee was not only intended to cover the visit to the doctor from whom advice was sought, but also certain specialised treatment in the form of X-rays and laboratory tests for which the patient was referred.<sup>18</sup> Compensation from the sickness insurance system was gradually increased in the 1970s.<sup>19</sup>

The seven-kronor reform involved major organisational changes for the health service. To enable a uniform cost for outpatient care, a total salary was introduced for all state-employed doctors, including provincial doctors who were no longer paid on a patient-by-patient basis. One important result of the reform was affording inpatient and outpatient care the same weight in the health system. This reform thus eradicated the differences that had previously existed between the types of care in terms of pay and the compensation system. Although the reform reinforced the role of sickness insurance in financing health care, the health care was still mainly funded by municipal and county council taxes. Sickness insurance only accounted for 7 per cent of the county council's income, while county council tax made up 60 per cent.<sup>20</sup> The main economic impact was on private households, which gained lower and more predictable medical costs.

## 2.6 Further reforms in the 1970s

As part of the expansion of the health system, pharmacies were nationalised in 1971. Up until then, pharmacies had been privately run by state-licensed pharmacists. With the aim of being able to meet the need for drugs in a large and expanding health service, it was judged that pharmacies needed to be integrated with the rest of the health system.<sup>21</sup> In 1971, therefore, the company Apoteket AB was formed, which took over the running of all pharmacies. Apoteket AB was two-thirds owned by the State and a third by Apotekarsocieteten (a nationwide organisation for pharmacists).

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<sup>18</sup> *Government Bill 1969:125 amending the National Insurance Act, etc.*, pp. 1–2.

<sup>19</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act* pp. 76

<sup>20</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act* pp. 131

<sup>21</sup> *Government Bill 1970:74 proposing a new organisation for the supply of medicinal products, etc.*

In 1973 another extensive reform of health care legislation took place. This increased the coordination of outpatient care in the form of care from district doctors. To enable collaboration between different professions such as district doctors, district nurses and district midwives, outpatient care was to increasingly be provided at health centres instead of at individual clinics or surgeries. Specialised outpatient care was decentralised from the hospitals and sited in well-equipped units for general and specialised outpatient care. As part of this reform, provincial doctors were renamed district doctors. The district doctors were no longer compulsory line managers for the district nurses and the health board was to appoint special doctors to fill that role. One aim of the reform was to create a working environment that made outpatient care as attractive as inpatient care.<sup>22</sup>

The higher education reform of 1977 made several tertiary-level courses that had previously been vocational courses university degrees, including nursing degrees.<sup>23</sup> Nursing becoming a university subject also increased the profession's links to research. This also saw nursing develop into a specific research area of its own.<sup>24</sup>

Health care increased in scale and in costs in the 1960s and 1970s. Between 1960 and 1975 costs increased tenfold from SEK 2 billion to SEK 19 billion. Two thirds of the increase in costs were due to changes in prices and wages, and the remaining third is attributable to expansion. In 1967 health care accounted for 6.6 per cent of GDP; in 1976 it accounted for 8.8 per cent of GDP.<sup>25</sup> Outpatient care was extensively developed but was still relatively minimal. The number of district doctors went from approximately 1 000 in the late 1960s to approximately 1 700 in the mid-1970s.<sup>26</sup> Between 1970 and 1976 the proportion of health care costs accounted for by outpatient care doubled from 6 per cent to 12 per cent. The system remained very hospital-heavy. Somatic short-term health care amounted to 50 per cent of the costs and long-term care to 20 per cent of the costs.<sup>27</sup>

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<sup>22</sup> *Government Bill 1972:104 proposing amendments to health care legislation, etc.*

<sup>23</sup> *Government Bill 1975:9 reforming university education, etc.*

<sup>24</sup> SOU 2019:6 *Long-term, coordinated and dialogue-based governance of universities* pp. 56–58.

<sup>25</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, p. 126

<sup>26</sup> SOU 2016:2 *Effective care* pp. 761–763.

<sup>27</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, p. 126–127.

## 2.7 Responsibility and health

The health care system expanded considerably between 1950 and 1980. At the same time, much of the responsibility for health care was transferred to the county councils. One of the reasons for this was the greater responsibility for hospitals and specialised care in the 1950s and the transfer of provincial doctors in the 1960s referred to above. In 1977 a new Local Government Act entered into force which gave county councils and municipalities greater political freedom and reduced State control. After these changes, the county council was the provider of the majority of health care, including through responsibility for running hospitals and outpatient care.

Nevertheless, there were parts of the health care system which remained outside the county councils' remit. The State ran two training hospitals (Karolinska University Hospital in Solna and Uppsala University Hospital), certain rheumatism treatment, military health care and dental care, certain school health care, forensic and forensic psychiatric institutions and some laboratories. The municipalities' responsibilities in the health care sector itself were largely limited to provision of doctors specialising in social medicine [sw: *socialläkare*], school health care, corporate health care for their own staff and specific medical care and supervision in homes for the elderly.<sup>28</sup>

## 2.8 The first Health and Medical Services Act

Developments in Swedish health care up to the end of the 1970s were to do with expansion and building up a system. There was a shift from small hospitals and provincial doctors to large hospitals and primary care covering a number of professions. After this, health care policy changed focus from providing more care to the ability to steer and make available the care that existed. The changes that came in the 1980s and thereafter were at least as wide-ranging but instead focused on governance and organisation of the existing system and how resources and actors were to be coordinated.

A very important part of this trend was when the Health Care Act from 1962 [sw: *sjukvårdslagen*] was replaced with Sweden's first

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<sup>28</sup> SOU 1979:78 *Health care goals and means – A proposed Health and Medical Services Act*, p. 157.

Health and Medical Services Act [*sw: hälso- och sjukvårdslagen*] (HSL) in 1982. For the first time, an actual goal was established for health care in legislation: “good health and care on equal terms for the whole population”.<sup>29</sup>

Although progress in health care had led to an increasing amount of health care being available and higher quality measures, there had been no clear equivalent improvement in public health. In some groups of the population there was even a higher mortality rate and rate of sickness.<sup>30</sup> It was therefore found that there was a need for the health system to incorporate measures to improve health and active work on public health. The prevailing regulations comprised the health protection statute [*sw: hälsovårdsstadgan*] from the 1950s,<sup>31</sup> according to which, the municipalities were responsible for general public health measures. The regulated public health measures were focused on the environment, mainly eliminating sanitary shortcomings, such as dirty drinking water and ensuring that the environment in which people lived in the municipalities did not cause illness. There was no specially regulated responsibility in legislation for health care focused on individuals, such as vaccination and other preventive measures. Such care did occur, however, under voluntary undertakings through the responsibility for health care incumbent upon the county councils.

In HSL, the health care system was responsible for providing measures to promote health and prevent illness in many different ways. This was partly through purely preventive measures such as vaccination but also by using knowledge in the health care system to contribute information and education that could affect people’s lifestyles and increase their wellbeing. Health care was to contribute more actively to community planning and to people’s environments.

In addition to the new responsibility for health promotion and preventive measures, this legislation strengthened the position of patients in the health care system. The individual’s responsibility for their own health was emphasised, as was the individual’s right to influence their own care. The health care system was obliged to give patients information about their health and the different treatment options available. The patient was also to have an opportunity to

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<sup>29</sup> *Government Bill 81/82:97 on a Health and Medical Services Act, etc.* p. 3.

<sup>30</sup> *Government Bill 81/82:97 on a Health and Medical Services Act, etc.* pp. 17–18.

<sup>31</sup> *Government Bill 81/82:97 on a Health and Medical Services Act, etc.*

influence the treatment prescribed and have insight into their treatment on an ongoing basis. The opportunity for self-care was to be improved by making information and support from the health system more easily available.

This first Health and Medical Services Act took the form of a target-oriented framework act. This meant that the legislation was drafted in the form of principles, guidelines and requirements. How operations were designed in detail was up to the body responsible for providing health care, at that point mainly the county councils. This gave the county councils much greater scope to plan their health care based on local needs and conditions. In order to enable a fair allocation of resources between health care and other sectors of society, the State gained responsibility for overarching planning and coordination of health care.

## **2.9 The Ädel reform of care of the elderly and responsibility of the municipalities**

After the 1960s, the county councils in principle had overall responsibility for health care. However, in specific areas, this responsibility was shared with other actors; one such area was care of the elderly, where the municipalities were responsible for particular measures. The goal of municipal measures was felt to be unclear. There was also a conflict between values when the municipal side had a social perspective and the county council side a medical perspective on how care was to be run.<sup>32</sup> To address this, some of the responsibility for health care was transferred to the municipalities in 1992 through what was termed the Ädel reform (for a more exhaustive description of this reform, see section 5.2.2). This meant a major change for the health care system, as the municipalities took over responsibility for running parts of the health service.

In the 1990s a number of additional reforms were then carried out which transferred responsibility for providing specific services to the municipalities. In 1993 the Act (1993:387) concerning Support and Service for Persons with Certain Functional

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<sup>32</sup> National Board of Health and Welfare, *Ädelreformen sluttrapport*, 1996 (Ädel reform final report 1996), p. 7.

Impairments (LSS) was passed. This Act gave people with certain disabilities and impairments the right to support and services.<sup>33</sup> The municipalities mainly had responsibility for this support, which was to be provided for daily living, either in the person's own home or in special accommodation. The care homes and specialist hospitals for people with disabilities were abolished. Responsibility for running measures directed towards people with long-term mental illnesses was transferred from the county councils to the municipalities through the psychiatry reform of 1993.

## 2.10 New governance and freedom of choice

HSL increased decentralisation of care and self-determination on the part of the county councils. This was to be strengthened even more in the Swedish Local Government Act (*kommunallagen*) (1991:900). The purpose of this Act was to give municipalities and county councils greater freedom, and to reduce State control. Among other things, the municipalities gained greater freedom to design their own boards.<sup>34</sup>

Following economic stagnation in the early 1990s, the prevailing models for running the health service with the county councils as both the client and the provider were called into question as being ineffective and financially demanding. The county councils and the municipalities then started to introduce alternative steering models which sought to make health care more market-oriented by separating the roles of health care producer and financier. This led to private actors starting to enter the health care market through public procurement of services. Another aim of this reform was to strengthen the position of patients by offering greater choice. The effects of these new models were hard to evaluate, however, as there were no previous statistics to compare them with.<sup>35</sup>

In 1994 a family doctor [*sw: husläkare*] reform was introduced in Sweden which meant that all citizens were to be registered with a specific primary care doctor to whom they should turn when needed. However, this reform was very short-lived and the

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<sup>33</sup> *Government Bill 1992/93:159 on support and service for persons with certain functional impairments.*

<sup>34</sup> *Government Bill 1990/91:117 on a new Local Government Act.*

<sup>35</sup> SOU 1999:66 *Good health care on equal terms? State governance of health care* p. 181.

legislation was overturned on 1 January 1996 when a new majority gained power in the Riksdag. The reform was considered to run counter to the trend towards greater patient choice seen at the time. Although it was never fully implemented, the reform had some impact on the system, including introducing the right to a registered general practitioner in primary care [*sw: fast läkarkontakt i primärvården*] when the reform was abolished.<sup>36</sup> To prepare for the reform and enable the sharing of data with general practitioners at their own clinics, primary care also began to be computerised. This was to lead to primary care developing computerised systems more rapidly than other parts of the health care system.

In the 1990s a large number of new actors emerged, both through the municipalities acting as the health care authority and the increasing number of private alternatives. At the same time, there was a growing need for prioritisation, as rapid medical progress, for example, was contributing towards an ageing population and many diseases becoming survivable. In 1996 legislation was passed on a common ethical platform for priorities in the health care system. This is built on three principles: the human dignity principle, the need and solidarity principle and the cost-efficiency principle (see also section 1.3.5).<sup>37</sup>

The proportion of health care costs accounted for by drugs increased considerably in the 1980s and 1990s as new and more expensive drugs were increasingly prescribed. In 1997 it was therefore decided that the county councils would gradually take over the cost of prescribing medication in both inpatient and outpatient care to make decision-making more effective. Patients were also to be made more aware of the actual cost of medication, and care was to be made cheapest for those with the highest expenditure on medication. For this reason a high cost ceiling was introduced whereby consumers met the cost of prescriptions up to SEK 1 300 and county councils topped up the remainder.

In 1992 a care guarantee was introduced in the primary care system for certain diagnoses through an agreement between the State and the Federation of County Councils. This guarantee was criticised for being incompatible with the new ethical platform and

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<sup>36</sup> SOU 1999:66 *Good health care on equal terms? State governance of health care* p. 179.

<sup>37</sup> *Government Bill 1996/97:60 on health care priorities.*

in 1997 was replaced by a care guarantee that covered all interventions. The care guarantee was introduced into HSL in 2010.

## **2.11 The introduction of LOV and the abolition of the pharmacy monopoly**

The political shift towards more alternatives and a market-driven health sector continued in the 2000s. The Act on System of Choice in the Public Sector (2008:962) (LOV) entered into force in 2009.<sup>38</sup> The Act provided an alternative method for contracting authorities to procure private suppliers of publicly funded health care and social services (in addition to the Public Procurement Act (LOU)). Under LOV, all suppliers who meet the criteria set by the contracting authority for a care choice/system of choice must be approved. Actors in care choices may not compete on price but only on quality. This thus gave citizens an opportunity to choose for themselves who they wished to provide their care. It was the responsibility of the county council to ensure that citizens had an opportunity to make informed choices. In 2010 it became compulsory for county councils to establish systems of health care choice in the primary care they provide.<sup>39</sup> In other parts of the health service, it is up to the respective authority whether it wishes to provide care itself or procure it and, if so, apply LOV or LOU.

The introduction of health care choice meant a further increase in the number of actors providing care. People were no longer geographically bound to certain providers. Digitisation was also rapidly introduced. The Patient Data Act (2008:355) was introduced in 2008. This Act regulated the sharing of information in the health care system.

An additional element in the shift towards a greater number of actors in the health care service was the deregulation of the pharmacy market. In 1996 the State decided to buy all the shares in Apoteket AB, making it the only actor in the pharmacy market.<sup>40</sup> This changed in 2008 when the state monopoly on the sale of

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<sup>38</sup> *Government Bill 2008/09:74 Health care choice in primary care.*

<sup>39</sup> *Government Bill 2008/09:29 Act on System of Choice in the Private Sector.*

<sup>40</sup> *Government Bill 1995/96:141 Active administration of the State's ownership of companies.*

pharmaceuticals was abolished.<sup>41</sup> This made it possible for private companies to set up and sell drugs. To facilitate competition, approximately 450 of the 900 state-owned pharmacies were sold to private companies.<sup>42</sup>

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<sup>41</sup> *Government Bill 2008/09:145 Deregulation of the pharmacy market.*

<sup>42</sup> *SOU 2012:75 Price, access and service – continued development of the pharmaceuticals and pharmacy market, p. 118*