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ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
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ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE

Document :	AEMH 12-037
Title:	National Report Sweden
Author :	Swedish Association of Senior Hospital Physicians
Purpose :	Information
Distribution :	AEMH Member Delegations
Date :	9 May 2012

National report Sweden 2012

1. Hospital structure, finance and management

In Sweden, hospitals are financed by county councils with own taxation rights, a situation leading to uneven conditions between the regions. Compensatory state subsidies only equalize the differences to some extent. The Stockholm region is expanding fast and has a strong economy, whereas other regions face weak economy and in some cases also a decreasing population. Even though Sweden as a whole has not been heavily affected by the financial crisis, many hospitals are struggling economically and several cutbacks have been made.

The number of hospital beds per 1000 inhabitants has continued to decrease in spite of general population growth, reaching an all time low every year. The quota is the lowest in Europe according to OECD¹. Today, Sweden has approximately 2.6 hospital beds per 1000 inhabitants, compared to the OECD average of 4.9. A vast majority of Swedish acute-care hospitals have more than 100% bed occupancy on a daily or weekly basis. A large proportion of satellite patients endangers patient safety and leads to a stressful work environment for hospital staff.

The trend towards hospital mergers has been strong in Sweden. There is an ongoing merger process in southern Sweden between Lund and Malmö university hospitals, to the new Skåne university hospital, with approximately 12 500 employees.

The opposite trend is observed in Stockholm, where the county council plans to move a large proportion of inpatient and outpatient care from the Karolinska University hospital to new specialists' centers and local hospitals in the Stockholm area, strengthening the focus on highly specialized care in the university hospital.

2. A free choice system for specialized medical care

There has been a recent reform in Swedish primary health care aiming to provide better opportunities for patients to choose between public and private health care providers. The free choice system has opened new possibilities for general practitioners to establish private practices and health centers providing publicly financed health care.

The government now encourages the county councils to extend the free choice system to specialized medical care. Stockholm is leading the way with an expanding free choice system, adding new specialties every year. The free choice system has potential to change both the health sector and the labor market for hospital doctors in Sweden, offering a broader variety of employers and providing better opportunities to start their own clinics.

A key factor for the future is to accomplish a well balanced compensation system, covering costs for continuing professional development and allowing for research, education and development to be carried out in private clinics.

3. Medical education and continuing professional development

¹ OECD (2011), *Health at a Glance 2011: OECD Indicators*, OECD Publishing.

The medical education in Sweden is 5.5 years, followed by a requirement for doctors to work as interns after the basic training in order to receive authorisation/license to practice medicine. The minimum internship period is currently 18 months. Completed internship is also a prerequisite for specialist medical training in Sweden.

The internship system is appreciated by younger doctors as it offers a tutored introduction to different aspects of medical work. The employers and more experienced colleagues also value the system, since it gives an assurance that newly licensed doctors not only have theoretical knowledge but also clinical experience. In addition, many young doctors who did their basic training in other European countries welcome the possibility of paid positions as interns as an introduction to the Swedish health care system.

The Directive 2005/36/EC on the recognition of professional qualifications declares that each member state must recognize formal qualifications as defined in the Directive. The consequence for Sweden is that the internship requirement is invalidated. Also, the Directive in its present form has been interpreted as to stipulate that the minimum length of basic medical training should be 6 years.

In the process of implementing the Bologna process and the professional qualifications directive, the Swedish government has initiated a revision of the medical education. The committee directive stipulates that the medical training in Sweden should be lengthened to six years and the internship period should be transformed to an introductory year within the specialist education.

The European Commission's position in November 2011 to shorten the required minimum length of the medical education to 5 years seems to have taken the Swedish revision committee by surprise, but it is yet unsure if changes in a new Directive will alter the current government position to lengthen the training period.

The Swedish Medical Association publishes yearly surveys of doctors' continuing professional development (CPD). The results are not encouraging as they show a slow decline every year with less hours spent on CPD. As a result of an initiative taken by the Swedish Senior Hospital Physician Association, the current strategy is to find models for incorporating CPD in an existing system of education and training inspections for the specialists' education. That would allow for the hospitals' CPD plans to be revised regularly.

4. Implementation of the directive on cross-border healthcare

The Swedish government has been a driving force for the directive on cross-border healthcare that was adopted in the European Council on February 28th 2011.

March 2012, the Swedish government presented a bill to implement the directive in Swedish law. According to the proposal, the National Social Insurance Board will be the decision-making body on reimbursement to patients. The costs will be covered by the patients' county councils. There is no requirement for prior authorisation.

The directive on cross-border healthcare is based on European law (e. g. TFEU, the Treaty on the functioning of the European Union) and decisions in the EU Court of Justice. One of these court decisions is the Jelinek case (2004), in which a Swedish patient won against the Swedish National Social Insurance Board and was reimbursed for medical costs for SLE treatment in Germany.

In the Jelinek case, the National Social Insurance Board had argued that the specific SLE treatment in Germany was “not a recognised method in Sweden” and therefore should not be reimbursed. The EU Court decision made it clear that the Insurance Board was wrong; the treatment was recognised in another EU country which is a sufficient condition for the costs to be covered.

In 2010, 1.780 Swedish patients applied for reimbursements of medical costs in other EU countries, 770 of those for dental care. In total, 1.384 patients were reimbursed. A review made by the Swedish magazine *The Hospital Physician* showed that the National Social Insurance Board kept using “not a recognised method in Sweden” as a reason to deny reimbursement in several cases. In 2011, after much criticism, the Insurance Board decided to withdraw and reassess earlier decisions, finally accepting the legal interpretation of the EU Court.

According to the recent law proposal in Sweden, medical treatment in EU according to “international medical science and generally recognised good medical practices” should be reimbursed. This statement is open for interpretations, and will most likely be subject of court decisions the coming years.