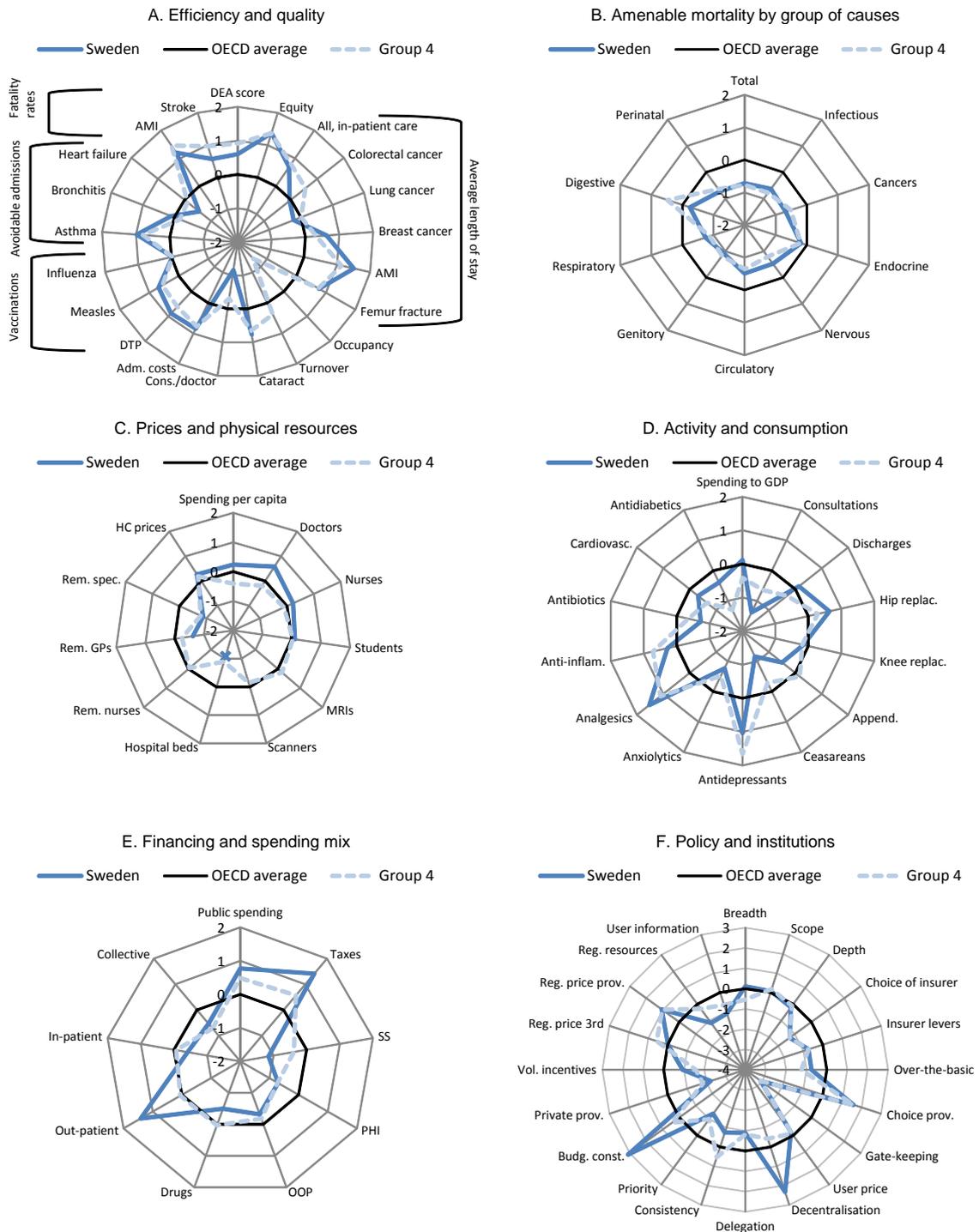


Sweden: health care indicators

Group 4: Iceland, Sweden, Turkey



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country). In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area). In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations. In Panel F, data shown are simple deviations from the OECD average.

Source: OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

SWEDEN

GROUP 4: Mostly public insurance. Users are given ample choice of providers but private supply is limited and prices tightly regulated. Gate-keeping is virtually inexistent.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
High DEA score compared to the OECD average, low amenable mortality rate and low inequalities in health status		Above average spending <i>per capita</i>	Large public share, mostly tax-financed, and very limited role of out-of-pocket payments and private health insurance	Basic insurance coverage is slightly less generous (physiotherapies and eyeglasses are not covered; large co-payments apply to dental care)	
Rather high output efficiency in the in-patient care sector	More doctors and nurses <i>per capita</i> , less acute care beds			Ample user choice of providers and no gate-keeping	The high number of health professionals and low number of consultations per doctor is striking. Achieving the same quality of health care services with fewer human resources could be an objective. Incorporating an activity-based component to the existing salary system for health professionals could be considered
Rather high quality of out-patient and preventive care but low number of consultations per doctor	Low relative income level of (salaried) GPs and specialists	Less consultations <i>per capita</i>	High share of out-patient care	Very little private provision, low volume incentives and little information on the quality of services. Heavy regulation of prices	Improving information on the quality of services could reinforce pressures on providers to increase the quality of care
Low administrative costs				Tight budget constraint. High degree of decentralisation but low degree of consistency in responsibility assignment	Efforts to increase consistency in the allocation of resources across government levels could contribute to raise spending efficiency