Ensuring Equitable Access to Healthcare in Rural Sweden

Analysing Regional Healthcare Policies

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Abstract

Equal access to healthcare for all residents is a core principle of Sweden's universal and publicly funded healthcare system, yet rural areas continue to face challenges that threaten equity. Long travel distances, workforce shortages, and uneven resource allocation hinder fair access to care, particularly for elderly people, migrants, and individuals with chronic conditions. This thesis investigates how regional healthcare policies and strategies address these challenges, with a focus on Region Skåne, Region Västerbotten, and Region Stockholm.

Guided by the Health Equity Framework (HEF), the study applies a qualitative document review method. Regional development strategies, public health policies, and official reports were purposively sampled and thematically analyzed with the support of Computer Assisted Qualitative Data Analysis Software (CAQDAS). The analysis focused on five dimensions of health equity: equity, availability, accessibility, acceptability, and quality.

Despite strong policy commitments, major barriers remain. Rural residents face long distances to care, weak public transport, digital exclusion among elderly populations, and difficulties in securing long-term healthcare staff. In addition, systemic changes in Swedish healthcare—such as the centralization of specialized units in larger cities, reliance on costly medical technologies, and rising pharmaceutical expenses—have further strained rural access. These developments risk reinforcing urban advantages while leaving rural communities more vulnerable. Regional priorities also differ: Skåne emphasizes socio-economic disparities and migrant health, Västerbotten prioritizes Sámi populations and sparsely populated inland areas, while Stockholm focuses on socio-economic and multicultural inequalities in its metropolitan context.

The study concludes that while Sweden's decentralized healthcare system enables regions to adapt policies to local contexts, the absence of stronger national coordination risks leaving rural inequities unresolved. Addressing these challenges requires targeted investment in rural healthcare infrastructure, workforce development, digital inclusion, and systematic monitoring. The findings contribute to broader debates on how universal health systems can achieve not only coverage but also equity in practice.

Keywords: healthcare equity, rural healthcare, Sweden, health policy, accessibility, healthcare planning

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Abbreviations

Abbreviation	Description
AMI	Acute Myocardial Infarction
CAQDAS	Computer Assisted Qualitative Data Analysis Software
ERRIN	European Regions Research and Innovation Network
EU/EEA	European Union/European Economic Area
HEF	Health Equity Framework
MaaS	Mobility-as-a-Service
NCDs	Non-Communicable Diseases
OECD	Economic Cooperation and Development
PCC	Primary Care Centre
RUS	Regional Development Strategy(Regional Utvecklingsstrategi)
SUS	Saude(Brazil's Unified Health System)
VIP	Västerbotten Intervention Programme
WHO	World Health Organization

1. Introduction

Access to healthcare is a fundamental aspect of a well-functioning and equitable health system, ensuring that all individuals receive the necessary medical services regardless of their geographical location. Sweden traditionally ranks highly in global comparisons of healthcare outcomes, including rural healthcare, due to its strong welfare state and universal healthcare system (Public Health Agency of Sweden 2021). However, the trend in access appears to be negative, with increasing centralization and budget constraints limiting investments in rural area(*Långt bort men nära* 2021). Ensuring equitable access to healthcare in rural areas is a significant challenge faced by many countries, including Sweden(Janlöv et al. 2023).

Sweden is known for its comprehensive and publicly financed healthcare system, which aims to provide good health and care on equal terms for the entire population (Kullberg et al. 2018; Janlöv et al. 2023; Blåhed et al. 2024). The system is funded through taxation and provides automatic coverage against virtually all health risks to the whole population(Janlöv et al. 2023; Blåhed et al. 2024). As stated in the 1982 Health and Medical Services Act, legal residents, including Swedish citizens and foreign residents registered in the population registry, are entitled to publicly financed healthcare services. Asylum-seeking and undocumented children are also entitled to healthcare on the same terms as all other children living in Sweden, including preventive, dental, and specialist care. In practice, however, administrative barriers and regional variations can create differences in how these rights are realized. For adults, the framework is more restrictive: asylum seekers and undocumented migrants are entitled to urgent and essential care, including maternity services, but undocumented adults must pay the full cost for non-subsidized care, which significantly limits their access to broader services. Emergency care is available to visitors, tourists, and non-residents, including patients from EU/EEA countries and nations with bilateral agreements with Sweden, and temporary visitors can access healthcare by paying for treatment costs(Anderson 2015).

Sweden has a high life expectancy of 82.4 years and a low infant mortality rate, reflecting the overall strength of its healthcare system. The country invests around 11% of its GDP in healthcare—slightly above the OECD average of 8.8% in 2019(OECD 2023) and maintains one of the highest ratios of doctors and nurses per capita in Europe. These investments contribute to generally high standards of medical care, although significant regional and rural–urban disparities persist within the system. Access to healthcare in rural municipalities, particularly in the northern regions, is constrained by long travel distances, limited healthcare infrastructure, and shortages of skilled medical staff(Kullberg et al. 2018; Janlöv et

al. 2023). Studies show that residents in sparsely populated areas often travel over 45 minutes to reach a hospital, which can lead to delays in diagnosis and treatment for time-sensitive conditions(Janlöv et al. 2023). Research further indicates that increased travel distance to emergency hospitals significantly worsens health outcomes for acute conditions such as myocardial infarction, where survival rates decline markedly when care is delayed(Avdic 2016).

In rural areas, there are geographical differences in healthcare service delivery, resulting in less favorable regional differences in health outcomes and access to services(Kullberg et al. 2018; Janlöv et al. 2023). Residents in rural areas, particularly in the north of the country, often have to travel long distances to access healthcare facilities. For many (about 15 to 36 out of every 100 people), it takes more than 45 minutes to reach a hospital(Janlöv et al. 2023). Increased distance to emergency hospitals in rural Sweden significantly worsens healthcare outcomes, particularly for time-sensitive conditions like Acute Myocardiac Infarction (AMI). A significant increase in mortality risk is observed beyond 25km, which corresponds to the time it takes for an ambulance traveling at 100 km/h to reach the patient within 15 minutes — a critical window for survival during cardiac arrest (Avdic 2016).

In many rural municipalities, nearly one-third of the population is aged 65 years or older—significantly higher than the national average of about 20%(Blåhed et al. 2024). This demographic imbalance creates a substantial healthcare burden, as older adults typically require more frequent and complex medical care, including the management of chronic conditions and greater use of long-term and home-based services(Janlöv et al. 2023). These pressures are compounded by persistent shortages of skilled healthcare staff, particularly doctors, which undermine the continuity and quality of care(Kullberg et al. 2018; Janlöv et al. 2023). Primary care centres (PCCs), which are intended to serve as the first point of contact, are more densely located in metropolitan areas than in rural municipalities, forcing rural residents to rely on fewer facilities with limited resources(Janlöv et al. 2023). Recruitment and retention difficulties often result in dependence on temporary staff, reducing continuity in patient–provider relationships and making it difficult to uphold consistent standards of care(Kullberg et al. 2018; Janlöv et al. 2023).

The disparities in healthcare access between urban and rural areas remain a significant concern in Sweden, as they directly affect health outcomes and the quality of care received by different population groups(Janlöv et al. 2023). In this context, “significant” means that these disparities have measurable and meaningful impacts on the health and well-being of rural residents compared to their urban counterparts. Key concerns include long travel distances, which can delay access to necessary medical care and worsen outcomes in emergencies or for patients requiring frequent treatment(Janlöv et al. 2023). Primary care centres in rural

municipalities are often fewer in number and lack the resources and specialized services that are more readily available in urban areas, further deepening inequities in access(Janlöv et al. 2023).

Beyond these structural barriers, vulnerable groups often face additional disadvantages. Indigenous populations, particularly the Sámi, experience poorer health outcomes linked to cultural marginalization, discrimination, and the lack of sufficiently adapted healthcare services(Region Västerbotten 2020b). Migrants and recent arrivals in rural municipalities may also struggle with language barriers, limited trust in institutions, and the absence of culturally appropriate care, which restricts their ability to access timely services(Janlöv et al. 2023; Blåhed et al. 2024). These social and cultural inequities intersect with geographic barriers, creating overlapping disadvantages that compound the challenges of rural healthcare access.

The rural groups in Sweden that face the most significant healthcare disparities include:

- **Elderly Populations**: Elderly populations in rural areas, particularly in southern Lapland, face challenges such as long travel distances to healthcare facilities, mobility issues, and difficulties in accessing consistent care. The number of home care patients surpasses the national average, making elderly care particularly resource-demanding for these municipalities(Blåhed et al. 2024).

- **Migrants and Minorities**: Migrants in rural areas also face disparities in healthcare access, with fewer resources and services available to meet their specific needs. Rural municipalities are culturally diverse and include both long-established minority groups, such as the Sámi, and more recent migrants. These populations often encounter additional barriers such as language difficulties, limited cultural adaptation of services, and challenges related to social integration(Region Västerbotten 2020b; Janlöv et al. 2023). Together, these issues contribute to poorer health outcomes and reduced trust in healthcare institutions, underscoring the importance of culturally sensitive policies.

- **Individuals with Chronic Conditions**: Chronic conditions require ongoing management and frequent medical visits, which can be especially challenging in rural areas with limited healthcare infrastructure and long distances to specialist care(Janlöv et al. 2023).

1.1 Selection of regions

Three regions were purposively selected to capture geographic diversity, rural demographics, and the availability of strategic documentation: Region Skåne, Region Stockholm, and Region Västerbotten. These regions represent contrasting healthcare contexts: Skåne and Stockholm as larger and more urbanized regions with rural fringes, and Västerbotten as a sparsely populated northern region with significant healthcare access challenges. Rather than a strict comparison, the purpose of this selection is to reflect the diversity of rural contexts within Sweden and to illustrate how regional authorities interpret and address the principle of equity in healthcare provision under different demographic and geographic conditions. This diversity provides a broad lens through which to examine the challenges of achieving equitable healthcare access in rural Sweden.

1.2 Aim

The aim of this thesis is to analyse how regional healthcare policies in Sweden address challenges related to equitable healthcare access in rural areas, using the Health Equity Framework (HEF) as an analytical lens. Through a comparative analysis of policy documents from Skåne, Västerbotten, and Stockholm, the study examines how equity is framed, operationalized, and addressed within regional healthcare strategies.

The study focuses particularly on how regional policies seek to improve healthcare access for rural populations through strategies related to availability, accessibility, acceptability, quality of care, and governance. It also examines how vulnerable groups—including elderly populations, migrants and minorities, and individuals with chronic conditions—are represented within regional healthcare planning.

By systematically analysing regional policy documents, the thesis seeks to identify both the strengths and limitations of current approaches to rural healthcare equity in Sweden and to contribute evidence-informed recommendations for improving equitable healthcare access across rural and urban populations.

1.3 Research Questions:

To address this aim, the study is guided by the following research questions:

1. How do regional healthcare policies and strategies in Sweden frame and address equity in healthcare provision across rural and urban areas?
2. What strategies and approaches are described in regional healthcare policies to improve healthcare access for rural populations, and what challenges and limitations are identified in relation to these strategies?

1.4 Key Concepts from the Health Equity Framework

This thesis applies selected concepts from the Health Equity Framework (HEF) to analyse regional healthcare policies in Sweden. The analysis focuses particularly on the dimensions of equity, availability, accessibility, acceptability, and governance/accountability. These concepts are used to examine how healthcare services are distributed and adapted across rural and urban contexts, how vulnerable populations are addressed, and how regional strategies seek to reduce healthcare inequities. The framework also provides a basis for evaluating whether policy commitments to equity are supported by practical mechanisms for implementation, monitoring, and accountability.

2. Theoretical framework

This thesis is anchored in the Health Equity Framework (HEF), which positions equity as the central principle for assessing healthcare access and outcomes. The framework emphasizes that the goal of health systems is not merely to provide equal services, but to ensure that opportunities for health are distributed fairly and proportionately across a population according to need, while recognizing that such distribution must take place within the constraints of available resources and competing policy priorities(World Health Organization 2010).

According to Braveman, Egerter, and Williams (2011), health equity exists when every individual has the opportunity to achieve their full health potential, and no one is disadvantaged from attaining it due to social, geographic, or economic position(Braveman et al. 2011). In this view, inequities are not simply differences in health outcomes but differences that are systematic, avoidable, and unjust(Whitehead 1991).

The HEF provides a normative stance that health disparities caused by avoidable conditions — such as inadequate resource distribution, geographic isolation, discrimination, or economic deprivation — are unacceptable within just health systems. It reflects a broader ethical commitment to distributive justice, ensuring that populations facing greater structural barriers to health receive proportionately greater attention and resources(Corbridge 2002; World Health Organization 2010). Thus, the framework moves beyond a narrow biomedical definition of health to recognize the social, political, and institutional contexts that shape how health opportunities are produced, distributed, and maintained.

2.1 Health Equity as a Principle of Justice

Health equity extends beyond equal distribution of healthcare resources; it emphasizes fairness in the distribution of both opportunities and outcomes. Equality, in this sense, refers to providing the same resources or services to everyone, whereas equity recognizes that populations differ in their circumstances and therefore require proportionately greater or different forms of investment to achieve comparable outcomes(Whitehead 1991). Populations living in rural or underserved areas, for example, often face structural barriers such as distance, workforce shortages, and infrastructural limitations, which demand tailored policies and greater resource allocation to ensure fairness. The principle of equity draws upon broader theories of justice. Amartya Sen's capability approach highlights that justice is not realized through equal entitlements alone, but through ensuring that individuals have the substantive freedoms necessary to live healthy and dignified lives(Corbridge 2002). Similarly, Rawls' theory of distributive justice

argues that social and economic inequalities are only acceptable if they benefit the most disadvantaged members of societ(Rawls 1971). Applied to healthcare, this means that systems must deliberately prioritize those who are structurally disadvantaged in order to close health gaps. From this perspective, inequities in health are understood as moral and ethical failings of systems that fail to address avoidable disparities(Institute of medicine 2001). Structural disadvantage — whether shaped by geography, socioeconomic status, ethnicity, or migration status — cannot be dismissed as neutral difference; rather, it represents an injustice that calls for corrective action. The HEF therefore provides both a normative framework, grounded in fairness and justice, and a practical tool for guiding policy and governance to ensure that vulnerable groups receive proportionately greater attention.

2.2 Dimensions of the Health Equity Framework

The Health Equity Framework (HEF) identifies key dimensions that must be satisfied to achieve equitable access to healthcare. These dimensions capture the interplay between supply-side and demand-side factors that shape how populations experience health systems. Together, they allow for a comprehensive assessment of healthcare systems in both high- and low-income contexts(Braveman et al. 2011).

2.2.1 Equity

Equity emphasizes the fair distribution of resources and opportunities, based on the recognition that different groups face different starting points and barriers. It requires proportionate resource allocation to populations with greater health needs or structural disadvantages, such as rural residents, the elderly, or migrants(Whitehead 1991). Equity goes beyond service provision and requires deliberate strategies to dismantle systemic inequalities that perpetuate health gaps, including those shaped by socioeconomic position, geography, or discrimination(Braveman & Gruskin 2003).

2.2.2 Availability

Availability refers to the existence of healthcare resources in sufficient quantity and distribution to meet population needs. This includes healthcare facilities, skilled personnel, medical equipment, and essential medicines. Without adequate availability, individuals cannot realize their right to health, regardless of financial or cultural factors. In rural contexts, shortages of general practitioners, specialists, and emergency services are particularly critical barriers that undermine the principle of equity(World Health Organization 2010; Braveman et al. 2011).

Availability is therefore the foundational dimension upon which accessibility and utilization depend.

2.2.3 Accessibility

Accessibility concerns the ability of individuals to reach and use available healthcare services. It encompasses geographic accessibility (travel distance and time), financial accessibility (affordability of services, medicines, and transport), and organizational accessibility (opening hours, referral pathways, waiting times). Even when services exist, they may be effectively inaccessible if travel distances are excessive or costs unaffordable. Accessibility is therefore closely tied to the social determinants of health, as disadvantaged groups often lack the resources or capacity to overcome structural barriers(Braveman et al. 2011).

2.2.4 Acceptability

Acceptability relates to the cultural and social alignment of healthcare services with the populations they serve. Services must be respectful, responsive, and sensitive to cultural norms, languages, and expectations in order to be trusted and utilized(World Health Organization 2010). Lack of acceptability may result in populations avoiding care, even when services are available and accessible. For example, stigma, perceived discrimination, or disregard for patient preferences can deter individuals from seeking treatment. Acceptability thus underscores the importance of patient-centered care and community engagement in achieving equity.

2.2.5 Quality

Quality constitutes the final dimension, ensuring that healthcare services are not only available, accessible, and acceptable, but also effective, safe, and continuous. High-quality care requires adherence to evidence-based standards, competent health professionals, adequate infrastructure, and monitoring systems that ensure patient safety and positive health outcomes(Institute of medicine 2001). Low-quality services may reinforce inequities by providing substandard treatment to disadvantaged populations, further entrenching disparities(World Health Organization 2010). From an equity perspective, quality must be universal — it is not sufficient for rural or marginalized populations to have access to care if the services provided are consistently below the standard enjoyed by urban or advantaged populations.

2.3 Policy and Governance in the Health Equity Framework

The Health Equity Framework situates healthcare inequities not only within the domain of service delivery, but also within the broader governance and policy environments that shape how health systems function. It emphasizes that inequities are often embedded in upstream political, social, and economic structures, which determine how resources are allocated, who receives priority, and how accountability is enforced(World Health Organization 2010). This perspective underscores that healthcare inequities are rarely accidental; they are the outcomes of decisions, policies, and institutional arrangements that either mitigate or perpetuate disadvantage.

From this viewpoint, policy frameworks and governance structures act as the scaffolding of health equity. Decisions on health financing, for example, directly influence the distribution of resources between rural and urban populations, and between preventive and curative services. Likewise, workforce policies determine not only the number of healthcare professionals available, but also where they are deployed, whether rural areas are prioritized, and how staff are trained to meet the needs of diverse populations(Braveman et al. 2011).

Governance also shapes the strategic priorities of health systems — whether investments are directed towards large, specialized urban hospitals or decentralized primary care facilities. The emphasis on centralization or urban-centered infrastructure, while often economically efficient, can exacerbate inequities by leaving rural populations underserved. Conversely, policies that promote decentralization, strengthen primary care, and engage communities in planning are more consistent with the principles of health equity(Whitehead 1991; World Health Organization 2010). Moreover, governance determines the degree of inclusiveness and accountability in health policy-making. Transparent, participatory governance mechanisms ensure that the voices of marginalized groups, including rural residents, migrants, and minorities, are incorporated into decision-making. This aligns with the principle that equity requires not only technical adjustments in service provision but also structural reforms in representation and power-sharing(Corbridge 2002).

Ultimately, the HEF views governance and policy decisions as determinants of determinants — higher-order structures that shape the availability, accessibility, acceptability, and quality of care. Inadequate governance can entrench inequities by perpetuating underfunding, workforce shortages, and institutional bias. Conversely, equity-oriented governance can redistribute resources, prioritize

vulnerable populations, and embed fairness into the core functioning of the health system.

2.4 Applying the HEF to Rural Healthcare

By integrating structural, social, and governance factors, the Health Equity Framework (HEF) provides a comprehensive analytical tool for examining rural healthcare systems. Rural populations often experience multiple, overlapping disadvantages that extend beyond the simple presence or absence of services. HEF makes it possible to interrogate these complexities by asking not only whether services exist, but whether they are equitably distributed, physically and financially accessible, socially and culturally acceptable, and delivered at an adequate standard of quality(World Health Organization 2010; Braveman et al. 2011).

Rural healthcare access is shaped by structural barriers such as long travel distances, inadequate transport systems, and shortages of skilled healthcare personnel. The HEF highlights how these barriers are not merely logistical challenges but manifestations of inequity in resource allocation and governance priorities(Whitehead 1991). Through its emphasis on proportional fairness, the framework draws attention to the fact that rural populations often require greater per-capita investment in healthcare infrastructure and workforce distribution to achieve outcomes comparable to urban residents.

At the same time, rural healthcare access is influenced by social determinants, including lower average income levels, higher rates of chronic illness, and demographic patterns such as aging populations(Marmot 2013). The HEF acknowledges that access cannot be understood in isolation from these broader determinants, which shape both the demand for healthcare and the ability of individuals to utilize available services. For example, even where facilities are present, financial barriers or low trust in institutions may deter service use.

HEF also underscores the importance of governance and policy in shaping rural healthcare access. Centralized planning, budgetary constraints, or urban-centered investment models can reinforce rural disadvantage by systematically channeling resources away from less populated regions(Braveman et al. 2011). Conversely, policies that emphasize decentralization, strengthen primary care, and involve communities in decision-making align with the HEF's principles of fairness and justice(World Health Organization 2010).

The framework makes explicit that healthcare equity requires more than service provision; it demands services that are not only present but also affordable, high-quality, and appropriate to the specific needs of different population groups. Appropriateness in this context refers to the extent to which services are tailored to

the circumstances of those who use them. For instance, elderly populations may struggle with digital health technologies, requiring alternatives such as in-person consultations or support with digital literacy. Similarly, migrants and minority groups may need culturally sensitive care, including translation services and practices that acknowledge different health beliefs and traditions, in order for services to be truly accessible and effective(World Health Organization 2010; Braveman et al. 2011). In rural contexts, where cultural differences, linguistic barriers, or reliance on temporary healthcare staff may weaken continuity of care, the HEF offers a critical lens to evaluate whether policies address these subtler but equally important dimensions of access.

2.4.1 Previous Applications and Relevance of the Health Equity Framework

The Health Equity Framework (HEF) has been widely applied in public health research to examine how structural, social, and institutional factors shape inequalities in healthcare access and health outcomes. Previous studies have used the framework to analyse disparities linked to geography, socio-economic status, ethnicity, migration, and access to healthcare resources(World Health Organization 2010; Braveman et al. 2011). In rural health research, the framework has proven particularly useful because it allows researchers to move beyond narrow measures of healthcare availability and instead examine how multiple dimensions of inequity interact.

Several studies have applied equity-oriented frameworks to investigate rural healthcare challenges, including workforce shortages, long travel distances, and unequal access to specialist services(Kullberg et al. 2018; Janlöv et al. 2023). Research on digital healthcare and rural access has similarly highlighted that technological solutions may improve availability while simultaneously creating new inequities related to digital literacy, language barriers, and infrastructure limitations(Benda et al. 2020; Blåhed et al. 2024). These studies demonstrate the importance of analysing healthcare access through broader social and structural perspectives rather than focusing only on service provision.

At the same time, the Health Equity Framework has also been subject to criticism. Some scholars argue that equity frameworks can remain overly normative and difficult to operationalize in practice because concepts such as fairness, proportionality, and justice are interpreted differently across political and institutional contexts(Smith et al. 2016). Others suggest that broad equity frameworks may insufficiently address power relations and intersectionality unless these dimensions are explicitly incorporated into the analysis(Flores 2006). In decentralized healthcare systems, there is also a risk that equity principles are

interpreted unevenly across regions, producing variation in how healthcare needs are prioritized and addressed.

These debates are particularly relevant to the Swedish context. Sweden's healthcare system is internationally recognized for universal coverage and strong welfare institutions, yet significant rural–urban disparities persist in healthcare accessibility, workforce distribution, and specialist care availability(Janlöv et al. 2023; Blåhed et al. 2024)(Janlöv et al. 2023; Blåhed et al. 2024). Applying the HEF in this thesis therefore provides a useful framework for examining not only whether healthcare services are formally available, but also whether they are equitably distributed, accessible, acceptable, and responsive to the needs of different rural populations. The framework is especially valuable for analysing how regional governance structures, demographic differences, and geographic conditions shape unequal healthcare outcomes within Sweden's decentralized healthcare system.

By situating the analysis within the HEF, this thesis contributes to existing literature by applying the framework comparatively across three Swedish regions and by examining how equity is interpreted and operationalized within regional healthcare policy. In doing so, the study also highlights some of the tensions within decentralized universal healthcare systems, where regional flexibility may support local adaptation while simultaneously creating uneven equity outcomes across territories.

3. Methodology

Having introduced the selection of study regions in the previous chapter, this section provides a comprehensive account of the research methodology, including the overall design, data collection strategies, and analytical procedures employed to examine how regional healthcare policies address equitable access in rural Sweden. The methodological approach is guided by the Health Equity Framework (HEF), which offers a structured lens for analyzing how equity is articulated in policy texts and how different dimensions of access—such as availability, accessibility, acceptability, quality, and fairness—are addressed. By focusing on policy documents, the study seeks to uncover not only the explicit priorities outlined by regional authorities but also the underlying assumptions and strategies that shape healthcare delivery in rural areas. A qualitative design was chosen because it enables detailed exploration of meanings, interpretations, and policy commitments. Moreover, this approach allows for triangulation across multiple document sources, enhancing the credibility and depth of the findings. In this way, the methodology is aligned with the overall aim of the thesis: to critically assess how equity is interpreted and acted upon within Sweden's decentralized healthcare system."

3.1 The Swedish healthcare system

The Swedish healthcare system is decentralized, with responsibilities shared among national, regional, and municipal levels(Janlöv et al. 2023). At the national level, the decentralized nature of the Swedish healthcare system means that regions and municipalities have significant autonomy in how they implement and manage healthcare services(Kullberg et al. 2018). This can lead to variations in performance and access across different regions and municipalities(Kullberg et al. 2018). Regions are tasked with providing primary care, specialized care, and emergency services, while municipalities handle social services and certain health services for the elderly and disabled(Janlöv et al. 2023). National policies and frameworks aim to ensure that care is provided on equal terms for the entire population based on need and in accordance with available evidence and best practice(Blåhed et al. 2024). However, the conditions and capacity for policy development and implementation differ across the 21 regions and 290 municipalities, leading to disparities in healthcare access and quality(Janlöv et al. 2023). Despite the robust policy framework, rural areas in Sweden face challenges that hinder equitable access to healthcare. The 21 regions separately, and at times jointly, plan and fund healthcare investments based on regional needs. While Sweden lacks a single national policy specifically dedicated to rural healthcare access, national health and public health frameworks provide broader guidance on equity, accessibility, and the reduction of health inequalities. Nevertheless, differences in regional capacity and

priorities may complicate efforts to achieve equitable healthcare access across the country(Janlöv et al. 2023). Recent health reforms, such as the "Good Quality and Local Health Care" reform, aim to strengthen primary care and promote interorganizational collaboration and e-Health innovation(Blåhed et al. 2024). However, implementing these reforms in rural areas presents unique challenges related to resource constraints, workforce shortages, and geographic conditions that may limit the effectiveness of nationally formulated reforms in local rural contexts(Blåhed et al. 2024). This study examines how regional healthcare policies and strategies address challenges related to equitable healthcare access in rural areas

I am motivated to carry out this research following my experience working as a health professional in rural parts of Nigeria. During my time in Nigeria, I witnessed firsthand the challenges faced by rural communities in accessing healthcare services, including shortages of healthcare professionals, long travel distances to healthcare facilities, and financial barriers. These experiences have driven my interest in exploring the present situation of health care access in rural Sweden. I hope that the findings of this research will provide valuable insights into best practices for improving healthcare access in rural areas, not only in Sweden but also in Nigeria and other countries facing similar challenges. By sharing these insights, I aim to contribute to the development of more equitable and effective healthcare systems worldwide.

3.2 Research Design

The study is characterised as a qualitative research design, guided by the health equity framework. This theoretical lens informs the research questions, data collection, and analysis, ensuring that the focus remains on understanding how regional healthcare policies address equitable access to healthcare in rural Sweden.

3.3 Data collection

3.3.1 Document Review

Document review served as the primary method for data collection. This involved systematically analyzing existing written materials to extract relevant information. The types of documents to be reviewed included:

- Regional healthcare policies.
- Government reports and official minutes.
- Administrative records.
- Publicly available documents from healthcare agencies.
- Research articles and studies related to healthcare access in Sweden.

This approach ensured that the study was grounded in both official policy frameworks and scholarly perspectives.

3.3.2 Sampling Strategy

A purposive sampling approach was employed to select documents most relevant to the research questions. Criteria for inclusion were:

- Policies specifically addressing rural healthcare
- Documents published within a recent timeframe to capture current policy contexts
- Reports focusing on equity, equality, and access issues

Triangulation was applied by consulting multiple document sources to strengthen the comprehensiveness and validity of findings.

3.3.3 Data Procedures

All documents were systematically catalogued to ensure proper organization for analysis. Metadata such as publication date, author, and source were recorded to maintain transparency and traceability. Several of the policy documents analysed in this study were originally published in Swedish. Where official English versions were available, these were used. For documents without official translations, Google Translate was used to produce an initial English version, which was then manually reviewed and refined to ensure consistency of meaning and terminology. Particular attention was paid to healthcare and policy-related concepts to minimise potential distortions arising from translation. Details regarding the original language of each document and the translation approach used are provided in Table 1a. Following Creswell and Creswell (2018) and Robson and McCartan (2016), translation was treated as an interpretive process, and efforts were made to maintain transparency regarding translation decisions and their potential influence on the analysis.

3.4 Data Analysis

The analysis was conducted using qualitative thematic document analysis supported by MAXQDA. The purpose of the analysis was to examine how regional policy documents frame healthcare equity, identify barriers to healthcare access, and describe strategies intended to reduce inequalities between rural and urban populations. Rather than measuring the frequency of individual words or comparing financial expenditures across regions, the analysis focused on the meaning,

emphasis, and policy significance of the content contained within the selected documents.

3.4.1 Organization and Coding

All nine regional policy and strategy documents included in the study (see Table 1) were imported into MAXQDA and coded using a common coding framework derived from the Health Equity Framework (HEF). I used MAXQDA as a support tool for organizing, managing, and retrieving coded material. The software facilitated the systematic storage of documents, assignment of codes to relevant text segments, retrieval of coded passages, and comparison of themes across documents and regions. However, MAXQDA did not generate the findings automatically. All coding decisions, interpretation of meaning, comparison of themes, and analytical conclusions remained my responsibility.

The coding process combined deductive and inductive approaches. Initially, I developed a coding framework based on the Health Equity Framework (HEF). Five overarching analytical categories were established: equity, availability, accessibility, acceptability, and quality/governance. These categories were selected because they represent key dimensions through which healthcare access and health equity can be assessed and because they align directly with the theoretical framework guiding this study.

Each document was read several times and coded according to these categories. For example, references to healthcare staffing, specialist healthcare provision, recruitment, retention, and primary care capacity were coded under availability. References to travel distance, transport infrastructure, waiting times, telemedicine, and digital healthcare were coded under accessibility. Discussions of migrant health, Sámi health, language support, cultural adaptation, and patient-centred care were coded under acceptability. Statements concerning monitoring, evaluation, accountability, coordination, and policy implementation were coded under quality and governance.

As coding progressed, additional sub-themes emerged from the empirical material. These included workforce shortages, rural distance, digitalisation, transport barriers, vulnerable populations, chronic illness, preventive healthcare, and health monitoring. These sub-themes were incorporated into the coding framework and subsequently used to compare patterns across the three regions.

Table 1. Coding Framework Used in MAXQDA

Main Code (HEF Dimension)	**Sub-Codes Identified During Analysis**	**Indicators in the Policy Documents**
Equity	Socio-economic inequalities; rural–urban disparities; vulnerable populations; health inequalities	References to equal healthcare access, inclusion, proportional universalism, and equity goals
Availability	Workforce shortages; primary care capacity; specialist healthcare provision	References to staffing, recruitment, retention, healthcare facilities, and service provision
Accessibility	Distance; transport barriers; telemedicine; digital healthcare	References to travel times, rural accessibility, e-health, transport infrastructure, and waiting times
Acceptability	Migrant health; Sámi health; cultural adaptation; language support	References to culturally adapted care, translation services, patient-centred care, and inclusion
Quality/Governance	Monitoring; evaluation; accountability; coordination	References to indicators, follow-up systems, reporting, policy implementation, and inter-organisational collaboration

The main codes were derived deductively from the Health Equity Framework, while the sub-codes emerged inductively during the coding process as recurring themes within the policy documents.

3.4.2 Thematic Analysis

Following coding, I used MAXQDA to retrieve and organise coded segments for comparative analysis. The software enabled me to identify where particular themes appeared across documents and regions and to examine relationships between codes. However, the identification of themes and the interpretation of their significance were conducted by me rather than generated automatically by the software.

The analysis did not rely solely on counting the frequency of terms or keywords. Instead, themes were assessed based on their prominence within the documents, the extent to which they were linked to specific policy measures, and their relevance to the research questions and the Health Equity Framework. A region was therefore interpreted as placing strong emphasis on a particular issue when that issue

appeared consistently across multiple documents, was linked to concrete policy actions, or was presented as a strategic priority.

For example, Västerbotten was interpreted as placing strong emphasis on rural accessibility because long distances, telemedicine, sparsely populated municipalities, and local healthcare solutions appeared repeatedly throughout its policy documents. Similarly, Sámi health emerged as a major theme because it was addressed through a dedicated strategy. Skåne was interpreted as emphasizing socio-economic inequalities, migrant inclusion, and regional accessibility, while Stockholm placed greater emphasis on socio-economic and multicultural inequalities within metropolitan and suburban healthcare contexts.

The final stage involved comparing the coded material across the three regions and relating the findings to the Health Equity Framework and relevant academic literature. This process enabled the identification of similarities and differences in how equity was framed and operationalized across regional healthcare policies. While MAXQDA facilitated the organisation and retrieval of data, I remained responsible for interpreting the findings and developing the conclusions presented in this thesis.

3.5 Data Presentation

The findings of this study are presented thematically, guided by the dimensions of the Health Equity Framework (equity, availability, accessibility, acceptability, and quality). Regional policy documents are first summarized individually to show how each region frames and prioritizes healthcare access. Thereafter, comparative analysis is conducted across the three case study regions (Skåne, Västerbotten, and Stockholm) to identify patterns, similarities, and differences.

To enhance clarity, findings are organized into two levels of presentation:

1. Regional summaries, where each region's strategies are analyzed in relation to the HEF dimensions.
2. Cross-regional comparison, where themes are synthesized to highlight broader trends and contrasts.

Tables are used to condense key information (e.g., barriers to access, focus on vulnerable groups) and to facilitate comparison across the regions. Direct quotations from policy documents are included where relevant to illustrate how equity principles are articulated.

This structured presentation ensures that the analysis remains transparent and closely aligned with the theoretical framework, allowing readers to clearly follow how findings were derived from the data.

3.6 Data Sources

The study is based on publicly available documents published by regional authorities and related bodies. These documents were purposively selected because they address healthcare policies, regional development strategies, and public health planning in relation to equity and access. Table 1 summarizes the key documents reviewed for each region.

Table 2: Key Policy Documents reviewed by Region

Region	Document Title	Year	Publisher/Source	Focus/Notes	Reference
Skåne	*Det öppna Skåne 2030 – Regional utvecklingsstrategi för Skåne*	2020	Region Skåne	Regional growth, health in all policies, and equity across socio-economic groups.	(Region Skåne 2020)
Skåne	*Strategi för kultur och hälsa 2022–2030*	2022	Region Skåne	Links cultural participation with public health and well-being.	(Region Skåne 2022)
Skåne	*Mål och strategi för Framtidens hälsosystem*	2021	Region Skåne	Healthcare accessibility, digital transformation, equitable healthcare delivery, and future health system planning.	(Region Skåne 2021)
Västerbotten	*Regional utvecklingsstrategi för Västerbotten 2020–2030*	2020	Region Västerbotten	Rural sustainability, workforce supply, and healthcare access challenges.	(Region Västerbotten 2020a)
Västerbotten	*Strategi för samisk hälsa – en hälso- och sjukvård som bidrar till god och jämlik hälsa för samer 2020–2030*	2019	Region Västerbotten	Sámi cultural rights, culturally adapted healthcare, equal health access, digital care access, and indigenous health policy.	(Region Västerbotten et al., 2019)
Västerbotten	*Folkhälsostrategi och funktionsrättsstrategi 2024–2030*	2024	Region Västerbotten	Prevention, chronic disease management,	(Region Västerbotten 2024)

				accessibility, and rural health gaps.	
Stockholm	*Folkhälsopolicy – God och jämlik hälsa i Stockholms län*	2005	Stockholms läns landsting	Social determinants of health, health inequalities, socio-economic disparities, and public health governance.	(Stockholms läns landsting 2005)
Stockholm	*Årsredovisning 2024*	2024	Region Stockholm	Healthcare monitoring, governance, and service delivery.	(Region Stockholm 2024)
Stockholm	*Forsknings-, utbildnings- och utvecklingsstrategi*	2021	Region Stockholm	Research, innovation, education, and healthcare development.	(Region Stockholm 2021)

Table 3a. Language and Translation of Policy Documents

Region	**Document Title**	**Original Language**	**Translation/Version Used**
Skåne	*Det öppna Skåne 2030 – Regional utvecklingsstrategi för Skåne*	Swedish	Google Translate + manual verification
Skåne	*Strategi för kultur och hälsa 2022–2030*	Swedish	Google Translate + manual verification
Skåne	*Mål och strategi för Framtidens hälsosystem*	Swedish	Google Translate + manual verification
Västerbotten	*Regional utvecklingsstrategi för Västerbotten 2020–2030*	Swedish/English version available	Official English version consulted
Västerbotten	*Strategi för samisk hälsa – en hälso- och sjukvård som bidrar till god och jämlik hälsa för samer 2020–2030*	Swedish	Google Translate + manual verification

Västerbotten	*Folkhälsostrategi och funktionsrättsstrategi 2024–2030*	Swedish	Google Translate + manual verification
Stockholm	*Folkhälsopolicy för Stockholms läns landsting*	English version available	Official English version consulted
Stockholm	*Årsredovisning 2024*	Swedish	Google Translate + manual verification
Stockholm	*Forsknings-, utbildnings- och utvecklingsstrategi*	English version available	Official English version consulted

Several of the policy documents analysed in this study were originally published in Swedish. Where official English versions were unavailable, the documents were translated using Google Translate and then manually checked to preserve the meaning of key healthcare and policy concepts.

Although Sweden does not have a single national policy dedicated exclusively to rural healthcare equity, several national frameworks address health equity, accessibility, and the reduction of health inequalities. One important example is the Public Health Agency of Sweden's framework *Towards a Good and Equitable Health: A Framework for Implementing and Monitoring the National Public Health Policy*(Public Health Agency of Sweden 2019), which emphasizes equity, social determinants of health, and the systematic monitoring of health inequalities. However, because responsibility for healthcare planning, organisation, and service delivery in Sweden is largely decentralized to the regional level, this study focuses primarily on regional policy and strategy documents. This approach makes it possible to examine how national equity ambitions are interpreted and operationalized within different regional contexts and how regional authorities address challenges related to rural healthcare access.

3.7 Ethics and positionality

Ethical considerations are central to the credibility and trustworthiness of this study. As the research is based on document analysis rather than direct interaction with human participants, it does not involve risks related to personal data collection or issues of informed consent. All documents analyzed are publicly available policy strategies, reports, or official publications, which minimizes ethical concerns around confidentiality or privacy. Nonetheless, careful attention was paid to ensure that sources were cited accurately and that interpretations of policy texts remained transparent and faithful to the original context.

Positionality also plays an important role in shaping the research process. My professional background as a healthcare practitioner in rural Nigeria has influenced my interest in questions of equity and rural healthcare access. This experience provides valuable insights into the challenges faced by underserved communities, but it also carries the risk of shaping interpretations through a comparative lens that may emphasize similarities or differences with the Swedish context. To mitigate this, reflexivity was maintained throughout the research process by critically reflecting on how my perspectives, assumptions, and experiences might influence the coding, analysis, and interpretation of policy documents. As Creswell and Creswell (2018, p. 199) emphasize, reflexivity requires researchers to make their values, biases, and influence on the research process explicit(Creswell & Creswell 2018).

Translation of Swedish-language documents into English represents another ethical and positional challenge. While every effort was made to preserve the accuracy of meaning, nuances may be lost or altered in translation. To address this, official English versions were used wherever possible, and key terms in Swedish were retained alongside translations when their contextual meaning was significant. By acknowledging these limitations openly, the study enhances its transparency and provides readers with a clear understanding of the interpretive processes involved.

By integrating these ethical reflections and positional considerations, the study strengthens its overall trustworthiness. In qualitative research, trustworthiness is commonly evaluated through criteria such as credibility, dependability, confirmability, and transferability(Robson & McCartan 2016) (pp. 170–172). Maintaining transparency in data handling, openly acknowledging the researcher's influence, and reflecting on translation challenges ensures that the findings are both rigorous and ethically grounded. As Creswell and Creswell (2018, p. 199) note, reflexivity and transparency not only enhance the integrity of the research process but also help readers to understand how interpretations are situated(Creswell & Creswell 2018). These principles provide a strong foundation for the subsequent analysis of regional healthcare policies, where the focus shifts to identifying patterns and themes that reflect equity concerns in rural Sweden.

4. Data, Analysis and Discussion

4.1 Overview

This chapter integrates the coded findings from the document review with their interpretation through the Health Equity Framework (HEF). To address the research questions, the analysis is organized in two steps. First, I examine how each region frames equality/equity (RQ1). Second, I assess the strategies used to secure equal access—and their likely effectiveness—across the HEF dimensions of equity, availability, accessibility, acceptability, and quality (RQ2). Where claims about implementation appear, they are explicitly grounded in external empirical literature on rural Sweden(Avdic 2016; Kullberg et al. 2018; Janlöv et al. 2023; Blåhed et al. 2024). Two concise summary tables are included and accompanied by interpretive notes that clarify how entries were derived from the coded policy texts.

4.2 Regional Approaches to Equity

Region Skåne

Region Skåne explicitly links health to regional development under the principle of "health in all policies." Its *Regional utvecklingsstrategi för Skåne* emphasizes reducing inequalities across the region and highlights differences between eastern and western Skåne(Region Skåne 2020).

Equity is largely framed through socio-economic disparities and population health inequalities. Region Skåne also emphasizes accessibility, person-centered care, and health promotion through broader regional and healthcare strategies(Region Skåne 2021; 2022). Rural challenges are acknowledged, yet the measures outlined for rural municipalities are less detailed compared to broader urban and socio-economic interventions.

To improve availability and accessibility, Region Skåne promotes digital healthcare development, closer and more person-centered care, and investments in transport and regional accessibility(Region Skåne 2020; 2021).

However, shortages of healthcare professionals remain an important challenge, particularly in maintaining equitable access across different parts of the region. Specialist healthcare services continue to be concentrated in larger urban centers, meaning that distance and accessibility remain barriers for some rural municipalities.

Region Västerbotten

Västerbotten's strategy explicitly frames rural–urban inequities as one of the region's greatest healthcare challenges. Long distances to hospitals and specialists, especially in inland municipalities, are presented as structural barriers to equitable healthcare access(Region Västerbotten 2020a).

The region places strong emphasis on the Sámi population, supported by a dedicated Sámi health strategy that prioritizes culturally and linguistically adapted healthcare for indigenous populations(Region Västerbotten et al., 2019). While migrants are present in the region, they receive less explicit attention in policy compared to indigenous populations.

In terms of healthcare strategies, Västerbotten has pioneered innovations such as telemedicine, virtual health rooms, and the Västerbotten Intervention Programme (VIP) for preventive screening and rural healthcare delivery(Region Västerbotten 2024). Workforce strategies also emphasize recruitment, competence supply, digital solutions, and collaboration to address healthcare staffing challenges in sparsely populated municipalities(Region Västerbotten 2020a).

Despite these measures, the region acknowledges that maintaining equitable healthcare provision in remote inland municipalities remains difficult due to persistent workforce and accessibility challenges.

Region Stockholm

Stockholm frames equity primarily through socio-economic inequalities in metropolitan and suburban areas, with a strong focus on the social determinants of health(Stockholms läns landsting 2005). Rural and archipelago municipalities are acknowledged, but they are less systematically integrated into the broader equity discourse.

The region also emphasizes patient-centered care, multicultural accessibility, research, and healthcare development, including efforts to improve quality, digitalisation, and inclusion within the healthcare system(Region Stockholm 2021).

While this aligns with the HEF's acceptability dimension, challenges linked to the archipelago and geographically dispersed populations receive comparatively less attention in regional policy discussions.

Stockholm invests heavily in digital healthcare development, research infrastructure, and healthcare innovation(Region Stockholm 2021). It also emphasizes systematic monitoring and evaluation through annual reporting and governance systems(Region Stockholm 2024). However, although monitoring

systems are comparatively advanced, rural–urban differences are not always clearly disaggregated, which may reduce the visibility of geographic inequities.

4.3 Cross regional comparison

A comparative reading across the three regions reveals both commonalities and divergences in how equality and access are framed and pursued.

Equity:

- Skåne emphasizes socio-economic inequalities and population health disparities, including challenges linked to regional accessibility and inclusion.
- Västerbotten prioritizes Sámi health and rural–urban disparities.
- Stockholm focuses on socio-economic and multicultural inequalities, with weaker attention to rural contexts.

All three regions reflect the principle of proportional universalism(Marmot 2010), but operational strategies are unevenly distributed across groups and geographies.

Availability and workforce:

- Both Skåne and Västerbotten report persistent challenges related to healthcare accessibility, competence supply, and workforce distribution in rural areas.
- Stockholm, while better staffed overall, still highlights shortages in outer municipalities and the archipelago.

These gaps confirm research noting recruitment and retention difficulties in rural Sweden(Janlöv et al. 2023).

Accessibility:

- Digital solutions are promoted in all three regions. Skåne integrates digitalisation and closer care into healthcare transformation strategies (Region Skåne 2021); Västerbotten uses telemedicine and virtual health rooms to bridge long distances(Region Västerbotten 2024); and Stockholm emphasizes digital healthcare development and healthcare innovation(Region Stockholm 2021).
- However, digital exclusion remains a challenge, especially for elderly populations and migrants with limited language skills. Physical transport barriers persist in all regions, with Västerbotten most severely affected.

Acceptability:

- Skåne emphasizes inclusion, health promotion, and person-centered approaches; Västerbotten prioritizes Sámi cultural sensitivity and indigenous health rights; and Stockholm advances multicultural and patient-centered healthcare approaches.
- In both Västerbotten and Stockholm, migrants in rural municipalities appear less explicitly addressed in policy frameworks.

Quality and monitoring.

- Skåne emphasizes innovation, prevention, and long-term healthcare transformation, although evaluation of regional equity outcomes remains less clearly articulated.
- Västerbotten's Västerbotten Intervention Programme (VIP) is internationally recognized, although equity outcomes remain uneven across geographic areas(Region Västerbotten 2024).
- Stockholm demonstrates comparatively strong monitoring and reporting systems, but the limited disaggregation of rural–urban indicators risks masking geographic inequities.

4.4 Strategies and Effectiveness

Across the three regions, strategies such as telemedicine, preventive programmes, digital healthcare platforms, and workforce initiatives demonstrate clear attempts to address rural inequities. However, their effectiveness is limited by persistent structural barriers:

- Distance remains most severe in Västerbotten and the Stockholm archipelago.
- Workforce shortages remain significant in rural Skåne and inland Västerbotten and continue to affect outer municipalities and archipelago areas in Stockholm.
- Digitalisation helps mitigate geographic barriers but also risks creating new inequities through digital exclusion.
- Limitations in monitoring and evaluation mean that the effects of these strategies on rural populations are not always consistently assessed.

From the perspective of the HEF, regional authorities clearly identify equity as an important policy objective and have implemented innovative approaches to address

disparities. Nevertheless, structural constraints—including geographic remoteness, demographic pressures, uneven workforce distribution, and accessibility challenges—continue to limit the ability of these strategies to fully ensure equitable healthcare access.

4.5 Vulnerable groups

The analysis of regional policies shows that elderly populations, migrants and minorities, and individuals with chronic conditions are the groups most consistently identified as facing disproportionate challenges in accessing healthcare. The three regions frame these vulnerabilities differently, reflecting their distinct demographic, geographic, and socio-economic contexts.

Table 4: Representation of Vulnerable Groups in Regional Strategies

Population Group	Region Skåne	Region Västerbotten	Region Stockholm
Elderly Populations	Rural municipalities with ageing populations are discussed in relation to accessibility, preventive care, and digital healthcare development. Transport and accessibility challenges remain important concerns(Region Skåne 2020; 2021).	Inland municipalities have ageing populations and long travel distances, increasing reliance on primary care, telemedicine, and local healthcare solutions(Region Västerbotten 2020a; 2024).	Healthcare accessibility is generally stronger due to urban concentration, although elderly populations in outer municipalities and archipelago areas may experience accessibility and digital exclusion challenges(Region Stockholm 2024).
Migrants & Minorities	Socio-economic inequalities, inclusion, and health promotion are emphasized, alongside broader commitments to accessibility and person-centered care(Region Skåne 2020; 2021; 2022).	The Sámi population receives explicit policy attention through a dedicated Sámi health strategy focused on culturally and linguistically adapted healthcare. Migrant populations receive less explicit attention in regional strategies(Region Västerbotten et al., 2019).	Multicultural accessibility, patient-centered care, and socio-economic health inequalities are emphasized, particularly in relation to metropolitan populations(Stockholms läns landsting 2005; Region Stockholm 2021).
Chronic Conditions	Preventive care, health promotion, and	Preventive healthcare and chronic disease	Chronic disease management is linked to

	integrated healthcare approaches are emphasized through regional healthcare transformation strategies(Region Skåne 2021).	management are strongly emphasized through the Västerbotten Intervention Programme (VIP) and public health strategies(Region Västerbotten 2024).	healthcare development, digitalisation, and integrated care systems(Region Stockholm 2021; 2024).

Interpretation.
Elderly populations are consistently recognized as a vulnerable group across all regions, reflecting demographic pressures and ageing populations in rural Sweden. However, regional strategies differ in their responses. Skåne and Stockholm place strong emphasis on digital healthcare development and accessibility, which may inadvertently disadvantage elderly populations with limited digital literacy (Blåhed et al. 2024), whereas Västerbotten has invested in local telemedicine solutions and "virtual health rooms" to improve access across long geographic distances.

Migrants and minorities are addressed unevenly across the regions. Skåne and Stockholm explicitly acknowledge socio-economic and migrant-related health inequalities, while Västerbotten places stronger emphasis on Sámi cultural and linguistic rights through its dedicated Sámi health strategy. This suggests that regional priorities reflect local demographic characteristics, although intersectional vulnerabilities—such as elderly migrants with chronic illnesses—remain less systematically addressed(Janlöv et al. 2023).

Chronic conditions are a shared concern across all regions. Preventive initiatives such as the Västerbotten Intervention Programme (VIP) illustrate innovative approaches to long-term disease prevention and rural healthcare delivery, although geographic inequalities in healthcare access and outcomes persist(Region Västerbotten 2024). These findings align with broader research showing that chronic disease outcomes are strongly influenced by geographic accessibility, distance to specialized care, and workforce shortages (Avdic 2016; Janlöv et al. 2023).

4.6 Barriers to Healthcare Access

One of the core themes identified through the document review is the set of barriers that hinder equitable access to healthcare across the three regions. Guided by the Health Equity Framework, these barriers were analyzed under four main categories: **distance, cost, workforce shortages, and systemic issues**. Table 3 summarizes the findings.

Table 5: Barriers to Healthcare Access

Barrier	Region Skåne	Region Västerbotten	Region Stockholm
Distance	Regional inequalities persist between eastern/southern rural municipalities and the more urbanized western parts of Skåne. Accessibility and transport infrastructure are emphasized as important components of regional development and healthcare access(Region Skåne 2020).	Long travel distances and sparse populations in inland municipalities create major barriers to specialist healthcare access. The region promotes telemedicine and digital healthcare solutions to reduce geographic barriers(Region Västerbotten 2020a; 2024).	Archipelago and outer municipalities face accessibility challenges related to geography and transport dependence. Distance to specialized healthcare services remains a concern for some populations(Region Stockholm 2024).
Cost	Universal healthcare reduces direct financial barriers, although accessibility and transport remain important concerns for rural populations(Region Skåne 2020).	Travel costs, accessibility challenges, and socio-economic inequalities disproportionately affect elderly and low-income populations in rural municipalities(Region Västerbotten 2024).	Financial barriers are less explicitly emphasized in policy, although travel and geographic accessibility may create indirect burdens for populations living farther from central healthcare facilities(Stockholms läns landsting 2005; Region Stockholm 2024).
Workforce shortages	Maintaining equitable access to healthcare professionals across the region remains a challenge, particularly outside major urban centers(Region Skåne 2021).	Workforce shortages and recruitment challenges are persistent concerns in sparsely populated inland municipalities. Regional strategies emphasize competence supply, collaboration, and digital solutions(Region Västerbotten 2020a).	Staffing levels are generally stronger in metropolitan Stockholm, although outer municipalities and archipelago areas remain more vulnerable to staffing shortages and service gaps(Region Stockholm 2024).
Systemic issues	Region Skåne emphasizes healthcare transformation, digitalisation, accessibility, and coordination across sectors, although monitoring of rural equity outcomes remains less clearly articulated(Region Skåne 2020; 2021).	Coordination across regional development, public health, transport, and Sámi health strategies remains complex. Geographic conditions continue to challenge equitable healthcare delivery(Region Västerbotten et al., 2019; Region Västerbotten 2020a).	Region Stockholm demonstrates comparatively strong monitoring and reporting systems, although rural–urban differences are not always clearly visible in regional indicators and reporting structures(Region Stockholm 2021; 2024).

The findings across the three regions show that distance remains the most severe barrier in Västerbotten, where sparse populations and long travel times to hospitals create major inequities in access. Region Västerbotten's *Regional utvecklingsstrategi för Västerbotten 2020–2030* highlights that long distances and geographic dispersion create persistent accessibility challenges for inland municipalities(Region Västerbotten 2020a).

In Skåne, distance barriers are less extreme but still affect rural municipalities in the east and south. Region Skåne's regional development strategy acknowledges persistent regional differences between more urbanized western areas and less densely populated eastern municipalities(Region Skåne 2020).

In Stockholm, accessibility challenges are concentrated in the archipelago and outer municipalities, where geographic conditions and transport dependence may affect timely access to healthcare services(Region Stockholm 2024).

Cost barriers are less explicitly addressed in regional policy documents but remain significant in practice. While universal healthcare reduces direct medical expenses, rural residents in all three regions may still face indirect costs related to travel, transport, and access to medicines. Västerbotten's public health strategy emphasizes that social and economic inequalities continue to shape health outcomes and accessibility(Region Västerbotten 2024). Region Skåne also links accessibility and mobility to broader efforts to reduce regional inequalities(Region Skåne 2020).

Workforce shortages cut across all regions, although their intensity differs geographically. Region Skåne identifies competence supply and healthcare accessibility as ongoing regional challenges, particularly outside larger urban centers(Region Skåne 2021). Västerbotten highlights recruitment and retention difficulties in sparsely populated municipalities and emphasizes competence supply, collaboration, and digital solutions to address these shortages(Region Västerbotten 2020a). Stockholm, although generally better resourced, still identifies staffing vulnerabilities in outer municipalities and archipelago areas(Region Stockholm 2024).

Finally, systemic issues reveal continuing challenges in governance, coordination, and monitoring. Region Skåne emphasizes healthcare transformation, innovation, and cross-sector collaboration, although the monitoring of rural equity outcomes remains less clearly articulated(Region Skåne 2020; 2021). Västerbotten's regional strategies similarly stress the importance of coordination across municipalities, healthcare providers, and regional actors in addressing health inequalities and accessibility challenges(Region Västerbotten 2020a). Stockholm demonstrates comparatively stronger reporting and monitoring systems, although rural–urban

differences are not always clearly disaggregated in regional indicators and reporting structures(Region Stockholm 2021; 2024).

Together, these barriers illustrate how structural, economic, and governance-related challenges interact to shape inequities in healthcare access despite universal healthcare coverage. The Health Equity Framework highlights that equity depends not only on the existence of healthcare services, but also on their distribution, accessibility, coordination, and evaluation.

These findings directly inform the research questions by demonstrating how regional healthcare policies both recognize and attempt to respond to persistent barriers. The identification of distance, cost, workforce shortages, and systemic challenges illustrates the extent to which current policies promote equality in healthcare provision and whether existing strategies effectively ensure equitable access in practice. In particular, the recurring challenges associated with geographic distance and workforce distribution suggest that, although equity is consistently emphasized in policy discourse, the practical implementation of equitable healthcare access remains uneven across regions.

Beyond confirming findings from previous rural health research, this study also contributes to the application of the Health Equity Framework in decentralized healthcare systems. Existing applications of equity-oriented frameworks often emphasize structural determinants of health and differential access to services. The findings from Sweden suggest that an additional challenge arises in decentralized governance contexts: equity may be interpreted differently across regions despite shared national commitments. The analysis therefore highlights that healthcare equity is influenced not only by the distribution of services and resources but also by how regional authorities define, prioritize, and operationalize equity within their own policy contexts. In this sense, the study extends existing discussions of the Health Equity Framework by demonstrating how governance structures themselves can shape equity outcomes. The Swedish case illustrates that equity is not solely a matter of healthcare provision but also of coordination, accountability, and the balance between regional autonomy and national objectives.

4.7 Summary of the overall data analysis

The document review of regional healthcare policies in Skåne, Västerbotten, and Stockholm reveals a complex but consistent picture: although the principle of equity is embedded in strategic planning, its practical realization remains uneven across regions and population groups. Each region demonstrates awareness of healthcare disparities and has introduced measures—such as digital healthcare solutions, preventive programmes, and culturally adapted approaches—to reduce inequities. Nevertheless, persistent barriers including long travel distances,

workforce shortages, indirect costs, and limitations in monitoring continue to undermine the goal of equitable healthcare access.

Comparative analysis further demonstrates that equity is interpreted differently depending on regional context. Skåne primarily emphasizes socio-economic inequalities and regional accessibility; Västerbotten places stronger focus on Sámi health, rural accessibility, and geographic inequities; while Stockholm concentrates more heavily on socio-economic disparities, multicultural care, and urban–suburban inequalities. Despite these regional differences, all three regions continue to face structural challenges that disproportionately affect rural residents and vulnerable populations.

The analysis of elderly populations, migrants and minorities, and individuals with chronic conditions further illustrates that, although policies increasingly recognize specific vulnerabilities, intersectional disadvantages remain less systematically addressed. For example, elderly migrants living in rural areas or low-income individuals with chronic illnesses may experience multiple overlapping barriers that are not fully reflected in current regional strategies.

In relation to the research questions, the findings suggest that regional healthcare authorities clearly identify equity as an important policy objective, although the effectiveness of existing measures varies considerably across regions. Strategies such as telemedicine, preventive programmes, digital healthcare development, and culturally adapted care provide promising approaches for reducing inequities. However, their effectiveness remains constrained by structural and systemic challenges, including geographic remoteness, uneven workforce distribution, and limitations in monitoring and coordination.

Overall, the analysis demonstrates that achieving equitable healthcare access requires more than universal healthcare coverage alone. It also requires sustained workforce strategies, stronger coordination and governance mechanisms, targeted support for vulnerable populations, and monitoring systems capable of capturing rural and regional inequalities more systematically.

4.8 Discussion

This chapter discusses the findings of the study in relation to the Health Equity Framework (HEF), focusing on how regional healthcare policies in Skåne, Västerbotten, and Stockholm address challenges related to equitable healthcare access in rural Sweden. The discussion situates these findings within a broader international context, recognizing that many countries with universal healthcare systems face similar challenges in translating equity principles into equitable healthcare outcomes in practice.

The chapter is organised into five thematic areas: equity as policy versus practice; regional interpretations of equity; addressing the needs of vulnerable populations; the role of digitalisation and innovation; and governance and monitoring challenges. Together, these themes highlight both the progress achieved and the persistent gaps that continue to shape the relationship between health policy and equitable healthcare access.

4.8.1 Equity as Policy vs. Practice

Across all three regions, equity is presented as a central principle of healthcare planning. Strategic documents consistently emphasize fairness, reducing health inequalities, and improving accessibility through combinations of universal and targeted measures, reflecting the principle of proportional universalism (Stockholms läns landsting 2005; Marmot 2010; Region Skåne 2020; Region Västerbotten 2020a). These commitments align with Sweden's broader legal and policy framework, which requires healthcare to be provided on equal terms for the entire population(Health and Medical Services Act 1982).

However, evidence from empirical research demonstrates that substantial gaps remain between policy commitments and healthcare realities in rural areas. Studies show that residents in sparsely populated municipalities often experience long travel times to hospitals, frequently exceeding 45 minutes, which has been associated with increased mortality risks for acute conditions such as myocardial infarction(Avdic 2016; Janlöv et al. 2023). In addition, structural workforce shortages remain persistent barriers to equitable healthcare access. Rural primary healthcare centres frequently struggle to recruit and retain healthcare professionals, resulting in greater dependence on temporary agency staff and reduced continuity in patient–provider relationships(Kullberg et al. 2018; Janlöv et al. 2023).

Specialist healthcare services also remain heavily concentrated in larger urban hospitals, making access to advanced diagnostics and treatment more difficult for rural populations and requiring long-distance travel(Blåhed et al. 2024). These challenges are further intensified by demographic pressures. In many rural municipalities, older populations account for a substantially larger proportion of residents compared to the national average, increasing healthcare demand in areas with more limited healthcare infrastructure and workforce capacity(Janlöv et al. 2023; Blåhed et al. 2024).

Together, this evidence highlights a persistent mismatch between policy ambitions and practical outcomes. Although equity is consistently prioritized within regional healthcare strategies, rural populations continue to experience structural disadvantages linked to geography, workforce shortages, and uneven distribution of specialist healthcare services. These findings suggest that universal healthcare

coverage alone is insufficient to ensure equitable healthcare access and that targeted structural interventions remain necessary to reduce persistent urban–rural inequalities(Kullberg et al. 2018; Janlöv et al. 2023).

4.8.2 Regional Interpretations of Equity

The way equity is framed and operationalized varies across the three regions, reflecting both demographic realities and governance priorities. This diversity illustrates both the flexibility of Sweden's decentralized healthcare system and the potential risk of uneven outcomes when regional priorities diverge.

Region Skåne places strong emphasis on socio-economic inequalities, regional accessibility, and inclusion within its regional development and healthcare strategies(Region Skåne 2020; 2021). This focus aligns with demographic realities, as Skåne has one of the highest proportions of foreign-born residents in Sweden, particularly in Malmö, where foreign-background populations constitute a substantial share of the population(Statistics Sweden 2022b). The region's emphasis on accessibility, person-centered care, and inclusion reflects these demographic conditions. However, empirical studies suggest that rural municipalities in eastern and southern Skåne continue to experience workforce shortages and weaker access to specialist healthcare services (Janlöv et al. 2023), indicating that geographic inequities within the region remain less systematically addressed.

Region Västerbotten interprets equity primarily through the lens of rural–urban disparities and the healthcare needs of the Sámi population. Regional strategies explicitly emphasize culturally and linguistically adapted healthcare for Sámi communities(Region Västerbotten et al., 2019). This framing is supported by research showing that Sámi populations experience poorer mental health outcomes and greater exposure to discrimination compared to the general population (Sjölander 2011). At the same time, Västerbotten is characterized by long travel distances to hospitals and specialist services, with some inland residents requiring several hours to access advanced healthcare (Janlöv et al. 2023). Although the region has pioneered telemedicine and preventive initiatives such as the Västerbotten Intervention Programme (VIP), geographic distance and workforce shortages continue to limit the equitable impact of these measures(Norberg et al. 2010; Blåhed et al. 2024).

Region Stockholm frames equity primarily in terms of socio-economic and multicultural inequalities within metropolitan and suburban areas. This emphasis reflects regional demographic realities, as Stockholm has one of the highest proportions of foreign-born residents in Sweden(Statistics Sweden 2022a). Regional strategies therefore prioritize patient-centered care, healthcare

development, multicultural accessibility, and inclusion(Stockholms läns landsting 2005; Region Stockholm 2021). However, archipelago and outer municipalities are less visible within broader equity discussions. Empirical evidence indicates that residents in the archipelago may experience delays in accessing emergency healthcare due to transport dependence and geographic isolation(Blåhed et al. 2024). These findings suggest that Stockholm's strong focus on socio-economic inequalities may unintentionally obscure geographic inequities affecting rural and archipelago populations.

ogether, these regional interpretations of equity reveal a broader pattern: each region tends to prioritize the populations and inequalities most visible within its own demographic and political context—migrants in Skåne and Stockholm, and Sámi populations in Västerbotten—while potentially overlooking other intersecting vulnerabilities, particularly those associated with rurality and ageing populations. This observation aligns with international research suggesting that decentralization can facilitate local adaptation while simultaneously creating risks of uneven equity outcomes in the absence of stronger national coordination and oversight(Smith et al. 2016).

4.8.3 Addressing Vulnerable Groups

Regional policy documents explicitly identify certain groups as being more vulnerable to health inequities, although the focus differs according to local demographic and geographic conditions. These differences are understandable given the contrasting contexts of Skåne, Västerbotten, and Stockholm. However, the uneven attention given to vulnerable populations raises questions about whether some groups risk being overlooked in regional healthcare planning.

Elderly populations are recognized as a challenge across all three regions, particularly in rural municipalities with ageing populations. In Skåne, regional strategies emphasize preventive healthcare, accessibility, and digital healthcare development as important responses to growing healthcare demand(Region Skåne 2020; 2021). However, empirical research indicates that older adults in rural municipalities may experience mobility challenges and digital exclusion, which can limit the effectiveness of digital healthcare measures(Janlöv et al. 2023). In Västerbotten, where many inland municipalities have substantially older populations, these pressures are particularly pronounced(Blåhed et al. 2024). Telemedicine and "virtual health rooms" have therefore been promoted to improve local healthcare accessibility for older adults, although long travel distances, limited transport infrastructure, and workforce shortages continue to reduce equitable access(Janlöv et al. 2023). Stockholm generally benefits from greater concentration of healthcare services in metropolitan areas, although archipelago residents may

still experience barriers related to transport dependence, travel times, and digital exclusion in relation to e-health services(Blåhed et al. 2024).

Migrants and minorities are addressed unevenly across the three regions. Skåne, which has one of the highest proportions of foreign-born residents in Sweden, places strong emphasis on inclusion, accessibility, and person-centered healthcare approaches within regional strategies(Region Skåne 2020; Statistics Sweden 2022a). This aligns with evidence suggesting that migrants in Sweden may experience difficulties navigating the healthcare system and lower levels of institutional trust compared to native-born populations (Wångdahl et al. 2018). In Västerbotten, by contrast, policy attention is directed more explicitly toward the Sámi population, supported by a dedicated Sámi health strategy emphasizing cultural and linguistic adaptation(Region Västerbotten et al., 2019). This emphasis is supported by research showing persistent inequalities affecting Sámi populations, particularly in mental health and experiences of discrimination (Sjölander 2011). Migrants in Västerbotten receive comparatively less explicit policy attention, despite evidence that migrants settling in rural municipalities may face language barriers and difficulties accessing consistent healthcare services(Janlöv et al. 2023). In Stockholm, which also has a large foreign-born population(Statistics Sweden 2022b), regional policies emphasize multicultural accessibility, patient-centered care, and inclusion within healthcare development strategies(Stockholms läns landsting 2005; Region Stockholm 2021). However, migrants living in outer municipalities and geographically peripheral areas appear less systematically integrated into regional healthcare strategies.

Individuals with chronic conditions constitute a third vulnerable group identified across all three regions. In Skåne, regional healthcare strategies emphasize prevention, health promotion, and integrated healthcare approaches targeting chronic conditions such as cardiovascular disease and diabetes(Region Skåne 2021). Nevertheless, rural residents may still experience delays in accessing specialist healthcare services, limiting the effectiveness of prevention and long-term disease management (Janlöv et al. 2023). Västerbotten stands out through its long-running Västerbotten Intervention Programme (VIP), which provides preventive health screening and has been associated with positive public health outcomes (Norberg et al. 2010). However, empirical research also suggests that participation and healthcare accessibility remain more challenging in geographically remote municipalities (Blåhed et al. 2024). Stockholm similarly links chronic disease management to healthcare development, digitalisation, and integrated care systems(Region Stockholm 2021). Despite these efforts, archipelago populations may still experience longer waiting times and reduced access to specialist services due to geographic conditions and transport dependence(Region Stockholm 2024).

Taken together, these findings suggest that regional policy priorities largely reflect local demographic realities: migrants in Skåne and Stockholm, Sámi populations in Västerbotten, and ageing populations across rural municipalities. Although this alignment is understandable, the intersection of vulnerabilities remains less systematically addressed. For example, elderly migrants or low-income individuals living with chronic conditions may experience multiple overlapping barriers that are rarely treated as distinct policy concerns within regional healthcare strategies. These findings indicate a need for more intersectional approaches to regional healthcare planning in Sweden, consistent with broader international evidence demonstrating that health inequities often overlap and reinforce one another (Flores 2006; Peters et al. 2008).

4.8.4 The Role of Digitalisation and Innovation

Digitalisation is a central theme across all three regions, reflecting both national healthcare reforms and regional strategies aimed at addressing inequalities in healthcare access. Policy documents consistently present telemedicine, e-health platforms, and digital healthcare solutions as important tools for overcoming geographic barriers and improving service accessibility. At the same time, the analysis demonstrates that digital innovations, although promising, may also reinforce inequities unless accompanied by investments in infrastructure, digital literacy, user support, and culturally adapted services.

Region Skåne integrates digitalisation into broader healthcare transformation and regional development strategies, emphasizing digital healthcare, accessibility, and closer care as tools for improving healthcare delivery across the region(Region Skåne 2020; 2021). Empirical studies nevertheless highlight important limitations. Older adults in rural municipalities may experience lower digital literacy and reduced access to reliable digital infrastructure, limiting their ability to benefit fully from e-health services(Janlöv et al. 2023). Migrants may similarly encounter language-related challenges when navigating digital healthcare systems that are primarily designed for Swedish-speaking populations (Wångdahl et al. 2018). These findings suggest that although digitalisation may expand healthcare availability in theory, practical accessibility remains uneven across different social groups.

Region Västerbotten has emerged as a national leader in digital healthcare innovation, particularly through the introduction of telemedicine and “virtual health rooms” in sparsely populated inland municipalities(Region Västerbotten 2020a). These initiatives directly address one of the region’s most significant barriers: extreme geographic remoteness. The WHO report on primary healthcare in Southern Lapland and Region Västerbotten further indicates that telemedicine and digital healthcare solutions have improved healthcare accessibility for residents

living in sparsely populated rural areas while reducing the burden of long-distance travel for care(Berggren 2021). Nevertheless, digitalisation has not eliminated rural inequities entirely. Limited broadband infrastructure in some remote areas, together with persistent workforce shortages, continues to constrain the integration of telemedicine into everyday healthcare practice(Blåhed et al. 2024).

Region Stockholm similarly promotes digital healthcare platforms as part of broader efforts to improve patient-centered care, healthcare accessibility, and service efficiency(Region Stockholm 2021). Given Stockholm's relatively strong digital infrastructure and high population density, digital services may be more accessible than in northern rural regions. However, the benefits remain unevenly distributed. Older adults in archipelago municipalities may still experience digital exclusion alongside persistent geographic barriers linked to transport dependence and travel times(Blåhed et al. 2024). Furthermore, although Stockholm demonstrates comparatively advanced monitoring systems, rural–urban differences in the use and accessibility of digital healthcare services are not always clearly visible within regional reporting structures.

From the perspective of the Health Equity Framework, digitalisation may improve both availability and accessibility by enabling healthcare services to be delivered without physical co-location and by reducing travel requirements. However, the acceptability dimension remains more problematic because digital healthcare services are not equally usable across all population groups. Older adults with limited digital literacy, migrants facing language barriers, and residents in areas with weak broadband infrastructure may continue to experience exclusion from digital healthcare systems.

International comparisons suggest that these challenges are not unique to Sweden. Rwanda, for example, has successfully used digital healthcare and community health worker systems to extend primary healthcare access and reduce geographic inequities(Binagwaho et al. 2014). By contrast, research from the United States and parts of Europe demonstrates that "digital deserts" continue to affect many rural communities where broadband access, digital skills, and technological infrastructure remain limited(Benda et al. 2020). These examples illustrate that digitalisation is not inherently equitable; its effects depend heavily on how healthcare systems are designed, implemented, supported, and monitored.

For Sweden, these findings suggest that digitalisation should be accompanied by targeted structural measures, including investments in rural broadband infrastructure, digital literacy support for elderly populations, culturally and linguistically adapted services for migrants, and stronger monitoring systems capable of identifying differences in digital healthcare use across rural and urban populations. Without such measures, digitalisation risks functioning as a two-tier

solution that disproportionately benefits urban and digitally literate populations while leaving more vulnerable groups behind.

4.8.5 Governance and Monitoring Challenges

Governance and monitoring are central to how equity goals are translated from policy into practice. The Health Equity Framework emphasizes that governance functions as a "determinant of determinants," shaping the distribution of resources, workforce capacity, and healthcare services (Braveman et al. 2011). Effective governance therefore requires that equity be not only articulated as a policy principle but also systematically monitored through measurable outcomes and accountability mechanisms. The analysis of regional healthcare strategies reveals both strengths and limitations in this regard.

Region Skåne promotes a "health in all policies" approach, linking healthcare to broader regional development and social sustainability strategies(Region Skåne 2020). This framing reflects recognition that health inequities are shaped by wider social, economic, and geographic conditions. However, although regional strategies emphasize innovation, accessibility, and coordination, mechanisms for systematically monitoring rural equity outcomes remain less clearly articulated. As a result, it is difficult to evaluate whether healthcare policies targeting rural municipalities in eastern and southern Skåne are producing measurable improvements in healthcare access and equity. Without clearer equity-focused indicators and follow-up systems, governance risks remaining more aspirational than accountable.

Region Västerbotten similarly acknowledges governance challenges associated with coordinating healthcare, public health, regional development, and Sámi inclusion across municipalities and institutions(Region Västerbotten et al., 2019; Region Västerbotten 2020a). The existence of multiple overlapping strategies demonstrates a broad commitment to inclusion and equity but may also contribute to fragmentation in implementation and accountability. For example, although the Sámi health strategy emphasizes culturally and linguistically adapted healthcare, the integration of these objectives into broader healthcare planning structures is not always fully clear. Likewise, workforce and competence supply challenges in inland municipalities continue to place pressure on healthcare accessibility and continuity of care(Janlöv et al. 2023). These governance challenges are particularly significant in a region where geographic distance and workforce shortages already undermine equitable healthcare access.

Region Stockholm demonstrates comparatively more advanced governance and monitoring systems. Annual reports and healthcare development strategies provide detailed information on healthcare delivery, organizational performance, research

integration, and evaluation systems(Region Stockholm 2021; 2024). Nevertheless, important limitations remain. Monitoring systems frequently disaggregate inequalities according to socio-economic status but less consistently according to geography. This may reduce the visibility of rural and archipelago-specific inequities, particularly where transport dependence and geographic isolation affect healthcare accessibility. The absence of more geographically sensitive indicators therefore risks obscuring inequities experienced by rural populations within the region.

From the perspective of the Health Equity Framework, these regional differences illustrate uneven levels of accountability and monitoring capacity. Skåne and Västerbotten strongly emphasize equity rhetorically but demonstrate more limited systems for evaluating rural healthcare outcomes, whereas Stockholm demonstrates comparatively stronger monitoring systems but less consistent visibility of rural inequities within reporting structures. This pattern reflects wider international experiences. In the United States, for example, rural hospital closures have been associated with financing and governance models that insufficiently account for the needs of sparsely populated communities(Meit et al. 2014). By contrast, Brazil's *Sistema Único de Saúde* (SUS) demonstrates how decentralized healthcare delivery can be combined with stronger national coordination mechanisms to improve healthcare equity across disadvantaged regions(Paim et al. 2011).

These findings suggest that decentralisation without sufficiently robust national coordination may contribute to fragmented equity outcomes. The three regions interpret and operationalize equity differently—Skåne emphasizing socio-economic inequalities, Västerbotten prioritizing Sámi inclusion and rural accessibility, and Stockholm focusing primarily on urban socio-economic disparities. However, the findings suggest that stronger national monitoring and coordination mechanisms could help promote more consistent equity objectives across regions while still allowing flexibility in how these objectives are implemented according to local needs and circumstances.

In summary, governance and monitoring play a critical role in determining whether regional commitments to healthcare equity translate into measurable improvements in healthcare access and outcomes. Without equity-sensitive indicators and stronger accountability systems, policy commitments risk remaining symbolic rather than transformative. Strengthening monitoring, coordination, and accountability—both regionally and nationally—therefore remains essential for ensuring not only universal healthcare coverage, but also genuinely equitable healthcare access across rural and urban populations.

4.8.6 Integrating Barriers into a Swedish and International Learning Perspective

The findings from this study demonstrate that three barriers consistently undermine equitable healthcare access across Skåne, Västerbotten, and Stockholm:

1. Long travel distances, particularly in inland Västerbotten and the Stockholm archipelago.
2. Persistent workforce shortages, especially in rural municipalities in Skåne and Västerbotten.
3. Governance and monitoring limitations that reduce the visibility of rural healthcare inequities.

These challenges are not unique to Sweden but reflect broader patterns observed in other countries with universal healthcare systems. The purpose of engaging with international examples is not to shift attention away from the Swedish context, but rather to identify lessons that may strengthen Swedish approaches to rural healthcare equity.

Geographic distance and isolation remain among the most persistent barriers to healthcare access in rural Sweden. Similar challenges have been documented in Canada, where Indigenous and northern communities often experience long travel distances to specialist healthcare services, contributing to poorer health outcomes and reduced continuity of care(Reading & Wien 2009). Canadian approaches, including community-based healthcare delivery and mobile healthcare services, illustrate the importance of combining digital innovation with locally accessible care structures. For Sweden, this suggests that initiatives such as Västerbotten's "virtual health rooms" may provide important opportunities for improving healthcare accessibility, particularly if accompanied by sustained investments in local infrastructure, staffing capacity, and transport systems.

Workforce shortages similarly remain a persistent challenge in rural Skåne and Västerbotten. Australia has faced comparable difficulties in delivering healthcare services to Aboriginal and Torres Strait Islander populations in geographically remote areas. Policies including rural training pathways, financial incentives, and targeted recruitment initiatives have produced mixed but partially positive outcomes in strengthening rural workforce capacity(Australian Government Department of Health 2020). These experiences highlight that sustainable rural healthcare provision requires more than workforce recruitment alone; it also depends on supportive working conditions, career development opportunities, housing availability, and long-term retention strategies.

Governance and monitoring limitations also affect all three Swedish regions, although to varying degrees. Brazil's *Sistema Único de Saúde* (SUS) provides an important comparative example of how decentralized healthcare delivery can be combined with stronger national coordination and equity-focused reporting mechanisms(Paim et al. 2011). Sweden's decentralized healthcare model may similarly benefit from stronger national coordination and monitoring systems that support common equity objectives across regions while still allowing flexibility in how these objectives are implemented according to local demographic and geographic conditions.

Taken together, these international experiences suggest that Sweden's rural healthcare equity challenges are not caused by the absence of universal healthcare coverage, but rather by persistent structural and geographic inequalities that continue to exist within universal healthcare systems. Achieving equity therefore requires more than universal coverage alone. It also requires targeted investments for rural and vulnerable populations, stronger coordination mechanisms to reduce fragmentation, and more systematic monitoring capable of identifying inequities across geographic and social groups.

In conclusion, Sweden's healthcare system possesses significant strengths in terms of universal access, regional autonomy, and public healthcare provision. However, lessons from countries such as Canada, Australia, and Brazil suggest that stronger coordination, targeted rural workforce strategies, and more equity-sensitive monitoring systems may help Sweden narrow the persistent gap between policy commitments and the everyday realities of healthcare access in rural communities.

4.8.7 Equity, Equality and Regional Variation

A key insight emerging from this study concerns the distinction between equality and equity. Equality implies that healthcare services are distributed uniformly across populations and territories, whereas equity recognizes that different populations may require different forms of support in order to achieve comparable health outcomes(Marmot 2010; Braveman et al. 2011). From this perspective, regional variation is not necessarily a problem. The differing priorities observed across Skåne, Västerbotten, and Stockholm partly reflect legitimate differences in demographics, geography, and healthcare needs.

For example, Västerbotten's emphasis on Sámi health and long-distance accessibility reflects challenges that are less prominent in Stockholm, while Skåne places greater emphasis on migrant health and socio-economic inequalities. These differences are consistent with an equity-based approach because they seek to respond to distinct local circumstances rather than applying identical solutions across all regions.

However, the findings also suggest that regional flexibility alone does not guarantee equitable outcomes. Certain barriers, particularly workforce shortages, travel distances, and access to specialist healthcare, remain persistent across multiple regions. The argument advanced in this thesis is therefore not that national authorities should impose identical policies across Sweden, but rather that stronger national coordination could support common equity objectives while still allowing regions to adapt strategies to local needs. In this sense, national coordination and regional flexibility should be viewed as complementary rather than contradictory.

The findings therefore support an equity-based approach rather than a purely equality-based approach. The challenge is not to eliminate regional differences but to ensure that regional variation does not translate into systematic inequities in healthcare access and outcomes.

5. Conclusion and Recommendations

This thesis set out to investigate how regional healthcare planners in Sweden address challenges related to equitable healthcare access in rural areas, guided by the Health Equity Framework (HEF). The study addressed two research questions:

1. How do regional healthcare policies and strategies in Sweden frame and address equity in healthcare provision across rural and urban areas?
2. What strategies and approaches are described in regional healthcare policies to improve healthcare access for rural populations, and what challenges and limitations are identified in relation to these strategies?

The findings demonstrate that although equity is consistently presented as a central principle within regional healthcare strategies, significant barriers to equitable healthcare access remain in practice. These barriers include long travel distances, workforce shortages, indirect costs related to access, and limitations in coordination and monitoring across governance levels(Janlöv et al. 2023; Blåhed et al. 2024).

In relation to the first research question, the analysis revealed that all three regions—Skåne, Västerbotten, and Stockholm—express strong commitments to healthcare equity, although these commitments are interpreted differently according to local demographic and geographic contexts. Skåne primarily emphasizes socio-economic inequalities, accessibility, and inclusion within healthcare planning(Region Skåne 2020; 2021), Västerbotten places stronger focus on Sámi inclusion and rural accessibility challenges(Region Västerbotten et al., 2019; Region Västerbotten 2020a), while Stockholm focuses mainly on socio-economic and multicultural inequalities within metropolitan and suburban contexts(Stockholms läns landsting 2005; Region Stockholm 2021). Although these regional differences reflect local adaptation and decentralised governance, they also contribute to uneven interpretations and implementation of equity across the country (Kullberg et al. 2018).

In relation to the second research question, the study identified several strategies intended to improve healthcare access, including digitalisation, telemedicine, preventive healthcare initiatives, and workforce-related interventions. However, these approaches demonstrate uneven effectiveness across different regions and population groups. Digital healthcare solutions, for example, may reduce geographic barriers but can also unintentionally exclude elderly populations and individuals with limited digital literacy (Blåhed et al. 2024). Workforce initiatives similarly remain insufficient to resolve persistent recruitment and retention challenges in rural municipalities (Janlöv et al. 2023). In addition, although regional policies increasingly acknowledge vulnerable populations, they less consistently

address intersectional vulnerabilities, such as the overlapping disadvantages experienced by elderly migrants living with chronic conditions (World Health Organization 2010).

Overall, the findings indicate that Sweden's decentralized healthcare system provides important opportunities for regional flexibility and local adaptation. At the same time, however, the findings suggest that stronger national coordination mechanisms may help improve consistency in how healthcare equity is monitored, implemented, and evaluated across regions, while preserving the flexibility needed to address local needs(Braveman et al. 2011). The study therefore highlights a broader structural tension within Swedish healthcare governance: decentralisation enables regional tailoring of healthcare strategies, yet also contributes to variability in how equity is interpreted, prioritized, and implemented across regions. These findings align with earlier research demonstrating that although Swedish healthcare is universal in principle, healthcare access and outcomes remain uneven in practice due to regional differences in resources, demographics, geography, and political priorities (Burström 2009; Anell et al. 2012). For example, Västerbotten's emphasis on Sámi health and telemedicine reflects the realities of a sparsely populated rural region, whereas Stockholm's healthcare strategies are more strongly shaped by metropolitan socio-economic and multicultural inequalities. Nevertheless, although national health and public health frameworks provide guidance on equity and accessibility, the findings suggest that existing national mechanisms may not be sufficient to address persistent rural healthcare challenges such as workforce shortages, long travel distances, and uneven access to specialist services across regions.

The persistence of geographic and workforce-related inequalities illustrates what Avdic (2016) describes as "structural inequities": disadvantages embedded within patterns of geography, infrastructure, and resource distribution that cannot be resolved through local innovation alone. Similarly, Janlöv et al. (2023) argue that although Swedish primary healthcare reforms were intended to strengthen local healthcare provision, rural municipalities continue to face persistent challenges related to workforce recruitment, service accessibility, and infrastructure limitations. Together, these findings reinforce the argument that achieving equitable healthcare access requires not only regional adaptation, but also stronger national coordination, sustained investment, and more systematic monitoring of rural healthcare inequities.

5.1 Recommendations

Based on the findings of this thesis, it is evident that although Sweden's universal healthcare system provides a strong foundation for healthcare equity, rural

populations continue to face structural barriers that require more targeted and sustained policy responses. The recommendations presented below draw both on the broader literature and on the comparative analysis conducted in this study of Skåne, Västerbotten, and Stockholm. In particular, they respond to the key challenges identified in the findings, including workforce shortages, long travel distances, digital exclusion, governance and monitoring limitations, and the uneven attention given to intersecting vulnerabilities among rural populations. Together, these recommendations aim to strengthen the capacity of regional and national healthcare systems to promote more equitable healthcare access across rural and urban populations.

Table 6: Policy recommendations for strengthening healthcare equity in rural Sweden

Area of Action	Key Recommendations	Contribution of this Thesis
National Coordination	Strengthen national coordination, monitoring, and accountability mechanisms for rural healthcare equity while preserving regional flexibility in implementation. Funding and resource allocation models should also be reviewed to better reflect the higher costs associated with providing healthcare in sparsely populated areas(World Health Organization 2010; Janlöv et al. 2023).	The comparative analysis demonstrates how regional autonomy may contribute to fragmented interpretations of equity, highlighting the need for stronger national coordination and oversight.
Workforce Shortages	Strengthen recruitment and retention through rural incentives, career development pathways, housing support, and expanded rural internships and training programmes(Kullberg et al. 2018; Region Västerbotten 2020a).	The analysis identifies persistent workforce shortages in rural Skåne and Västerbotten as major barriers to equitable healthcare access, suggesting that regional initiatives alone remain insufficient.
Transport & Infrastructure	Invest in transport infrastructure and rural accessibility measures; strengthen integration between healthcare planning and transport systems to reduce geographic barriers to care (Avdic 2016; Hult et al. 2021).	The findings demonstrate that digital healthcare solutions cannot fully replace physical accessibility, particularly for elderly populations and geographically isolated communities.

Inclusive Digitalisation	Expand digital literacy support for elderly populations and migrants; strengthen broadband infrastructure and culturally adapted digital healthcare services in rural municipalities (Benda et al. 2020; Blåhed et al. 2024).	The analysis shows that although digitalisation may improve healthcare accessibility, it may also deepen inequities where digital exclusion is insufficiently addressed.
Intersectional Approaches	Develop healthcare strategies that more explicitly address overlapping vulnerabilities, including the combined effects of ageing, migration, chronic illness, and rurality (Braveman & Gruskin 2003; Flores 2006).	The study demonstrates that intersectional vulnerabilities remain weakly represented within current regional healthcare strategies, leaving some populations insufficiently visible in policy planning.
Monitoring & Accountability	Strengthen monitoring systems by requiring more systematic disaggregation of healthcare indicators according to geography, age, socio-economic status, and other equity dimensions (World Health Organization 2010; Meit et al. 2014).	The analysis demonstrates that even comparatively advanced monitoring systems, particularly in Stockholm, may insufficiently capture rural–urban inequities, thereby limiting accountability for rural healthcare outcomes.

Discussion

In formulating these recommendations, this thesis has sought not only to synthesise insights from existing literature and policy documents, but also to contribute an independent comparative perspective on healthcare equity in rural Sweden. The contribution of this study can be understood in four main areas.

First, the findings demonstrate that although regional flexibility allows healthcare strategies to be adapted to local demographic and geographic conditions, it may also contribute to fragmentation in the interpretation and implementation of equity. The comparative analysis revealed that each region operationalizes equity differently, with some rural challenges receiving less attention depending on regional priorities. This suggests that stronger national coordination mechanisms may be necessary to ensure more consistent equity outcomes across the country.

Second, the study highlights the need for a more critical understanding of digitalisation within rural healthcare policy. Regional policy documents frequently present digital health solutions as mechanisms for overcoming geographic barriers and improving healthcare accessibility. However, the analysis demonstrates that

digitalisation may also reproduce or deepen inequities when issues such as digital literacy, broadband access, language adaptation, and population ageing are insufficiently addressed. These findings suggest that digital healthcare should be understood not as a universal solution, but as one component within a broader strategy for equitable healthcare access.

Third, the study emphasizes the importance of adopting more intersectional approaches to healthcare equity. While regional strategies increasingly recognize specific vulnerable groups—including migrants in Skåne and Sámi populations in Västerbotten—they less consistently address overlapping forms of disadvantage. Groups such as elderly migrants, low-income patients with chronic illnesses, or geographically isolated minority populations remain comparatively underrepresented within regional healthcare planning. The findings therefore suggest that intersectional vulnerabilities represent an important blind spot within current Swedish healthcare strategies.

Finally, the analysis identifies governance, monitoring, and accountability as critical dimensions of healthcare equity. Although progress has been made in developing monitoring systems, important gaps remain in the visibility of rural inequities. Even in Stockholm, where reporting systems are comparatively advanced, rural–urban disparities may remain insufficiently visible due to limited geographic disaggregation of healthcare indicators. This weakens the capacity of healthcare authorities to systematically evaluate whether equity objectives are being achieved in practice.

Taken together, these recommendations reflect both established knowledge within the field and the comparative insights generated through this thesis. The contribution of the study lies in bringing these perspectives together and demonstrating how rural healthcare inequities may persist even within a healthcare system internationally recognized for universalism and strong welfare provision.

5.2 Reflection

Working on this thesis has been both intellectually demanding and personally meaningful. Sweden's healthcare system is widely regarded as one of the strongest in the world, and at the beginning of this research I assumed that rural healthcare inequities would be relatively limited. What surprised me most was how persistent and structural these inequities remain despite strong commitments to universal healthcare and equity. The realization that geography, workforce shortages, and cultural adaptation continue to shape access to healthcare—even within a highly resourced healthcare system—was both striking and humbling.

One of the most challenging aspects of this project was working with policy documents. On the surface, many of them express strong commitments to fairness, accessibility, and equity. However, as I compared and analysed documents across regions, I increasingly questioned the extent to which these commitments translate into practical outcomes. Distinguishing between policy ambition and actual implementation was not always straightforward, and this required me to remain cautious and critical throughout the analysis. In this regard, the Health Equity Framework proved particularly valuable because it provided a structured way of moving beyond policy rhetoric to examine how equity was operationalized in practice.

Another important challenge involved translation and interpretation. Since many of the policy documents were written in Swedish, I had to reflect carefully on how meaning might shift across languages and administrative contexts. At times, I found it difficult to determine whether I was fully capturing the nuances of particular policy concepts and terminology. This experience reinforced the importance of reflexivity and transparency in qualitative research, especially when working across linguistic and cultural contexts.

In terms of learning, one of the most significant insights for me was that healthcare equity involves far more than universal coverage alone. Equity also depends on how healthcare services are distributed, accessed, adapted, and experienced by different population groups. My professional background in rural Nigeria provided an important comparative perspective, and I was struck by the similarities between the Swedish and Nigerian contexts despite their obvious differences in resources and healthcare systems. Long travel distances, workforce shortages, and the marginalization of vulnerable populations appeared in both contexts, although at very different scales. This reinforced my understanding that healthcare inequities cannot be resolved through resources alone; they also require strong governance, accountability, and deliberate attention to vulnerable populations.

Looking ahead, I see several important directions for future research. First, more empirical studies are needed to examine how digital healthcare solutions affect rural populations in practice, particularly elderly populations and migrants who may not benefit equally from digital innovations. Second, intersectional approaches should be developed further to better capture the overlapping disadvantages experienced by groups such as elderly migrants living with chronic conditions. Third, comparative international research could provide valuable insights into how different healthcare systems balance regional autonomy with national equity goals.

Ultimately, this thesis has not only deepened my understanding of Swedish healthcare governance but also strengthened my awareness of the broader global challenge of translating healthcare equity from principle into practice. The most

important lesson I take from this work is that equity must be actively pursued and continuously monitored; it does not emerge automatically, even within highly developed and universal healthcare systems.

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