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Swedish Healthcare in Transition

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User Fees For Health Care In Sweden

A two-tier threat or a tool for solidarity?

By Johan Hjertqvist

Romanow compliments AIMS' health care work

AIMS was the focus of praise during an April 17, 2002 presentation to the Romanow Commission on "The Future of Health Care". Commissioner Romanow expressed much gratitude for the work that AIMS does in the Health Care sector, and further emphasized the value of AIMS thoughtful and scholarly research to the Canadian debate on general issues.
www.aims.ca/commentary/futurehealth.html

For decades in both Britain and Canada, health care experts have debated the issue of user fees for medical services. In Sweden, they have formed an integral part of the health care system from the beginning. That country therefore offers an object lesson on the utility and effects of user fees.

How it all started

Before the Swedish health-care system was socialized in 1970, patients paid out-of-pocket for a fairly large proportion of services. For a fee, doctors and patients could arrange a variety of extras to enhance the quality of a hospital visit, like a semi-private room. The basic fees for a visit to the doctor or a hospital were also paid by patients, who were afterwards reimbursed by the local sick fund.

After the reforms, health-care providers were paid directly by the fund, but to access services patients were still required to pay a uniform user fee, at the start seven Swedish Crowns (Krona), roughly one Canadian dollar. The Social Democratic government that set up this co-payment system – still in use today – believed that patients now freed of the need to pay money in advance could afford a small co-payment. They also feared that reducing the up-front cost might increase demand, and thought that a user fee would limit new demand. A low direct cost would tell people that even socialized medicine was not completely free.

Doctors were supposed to keep the fee, adding to the compensation they could charge the sick fund or the county council. Suspecting they would gradually lose their freedom, the medical community had strongly opposed socialization, and the retention of a user fee helped reduce their resistance. Today, of course, after 32 years and a long period of double-digit inflation, one dollar a visit looks ridiculously low. In 1970, this kind of money still was important.

Known as "the seven-crowns reform," this step was the beginning of trend to increase the power of elected county councils, the level of government responsible for health care. Later steps included regulating the working volume and income levels of GP's, forcing older doctors to retire to reduce "surplus output" and banning doctors from

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opening a new practice without a council agreement. Partly as a consequence, the main dilemma today is a shortage of doctors.

So, it all started with seven crowns. Today the average patient fee in Sweden ranges from 100 krona for a GP visit to 250 krona for seeing a specialist, roughly $15 and $40 in Canadian dollars. There are small variations among the councils, but the span between the lowest and highest fee is no more than 20 percent. Co-payment has become an integrated part of the Swedish health-care system. It supports the funding from taxes, informs the patient about opportunity costs and most likely reduces the marginal demand for services, at least in specific aspects. Representing less than two percent of the total resources devoted to health care, the importance of user fees is more ideological than financial.

User Fees well accepted

The user fee is not a contentious topic in Swedish politics. No one argues for hefty increases in the out-of-pocket payment, and most politicians seem to be satisfied with the present level. More importantly, user fees have not, as many Canadians fear, turned health care into a virtual two-tier system by reducing the public part of the funding. A bottom-line argument in their favour, one that is seldom mentioned, is that they reduce medically less motivated consumption in favour of priority treatments. Without fees, the idea goes, a "luxury" demand would challenge the capacity to satisfy the "true" needs of less articulate citizens. Though they provoke some objections from egalitarian critics, user fees in the Swedish tradition are in fact regarded as an instrument to ensure better health care for weak groups.

What services?

Co-payments are used not only in primary health care and for hospital services, but also in dental care, elderly care and for pharmaceuticals.

In health care there are standardised fees, paid for every visit with a cap maximising the yearly cost, as follows in table 1 below.

The maximum fee a year is 900 krona (about $140 Canadian) for each individual, meaning that you quickly hit the ceiling. Reaching that limit gets you a "green card", which guarantees access during the next 12 months without any further fees. Within this limit there are a number of regional priorities, like giving children free care or using a monthly cap of 300-400 krona.

Pharmaceuticals

The co-payment is important in the purchase of prescribed drugs. The consumer share of the payment has been rather stable since the 1970´s, but as drugs are getting more and more costly the amount of out-of-pocket payment has increased. Today the scheme goes like this:

Generally you pay 25-30 percent of the pharmacy price yourself (in 2000 it averaged 28 percent). Here, too, there is a cap, a total of 1,800 krona a year. Below this level, the consumer pays 100 percent of the cost up to the first 900 krona, and after that a decreasing proportion. When you have passed the cap, prescription drugs are free of charge.

Dental services

Before the deep economic recession of the early 1990´s, the tax subsidy for dental care was very generous. In one generation, it dramatically improved the dental status of Swedish seniors, and bad teeth disappeared as a traditional sign of one's class.

During the second part of the 1990´s the tax subsidy was gradually reduced, a move which forced council-owned dental care units to compete with private dentists on an equal basis. The user fees rose significantly, and made well-maintained teeth a controversial matter again. Since the latest change of rules in 1999 the system is generally characterized by the following:

- There is now a free market for dental care providers, deciding their own prices in concert with the client.
- A cap system covers high, extraordinary costs. A treatment, for example, that costs 15,000 krona will be subsidised by roughly 4,000 krona. The cheaper the treatment, the less the support. You are supposed to pay for ordinary treatment yourself.
- Dental care for children and young people (up to 20 years of age) is still totally free of charge.

Type of Treatment	Patient fee in Swedish Krona (1 krona equals roughly 15 cents Cdn)	Canadian Dollar Equivalent
Physical therapist	50-80 (generally 80)	$7.50 – $45.00 (generally $45.00)
GP/family doctor	100-150 (generally 100)	$15.00 – $22.50 (generally $15.00)
Medical specialist	150-250 (generally 200)	$22.50 - $37.50 (generally $30.00)
In hospital stays	80 a day (in-bed)	$45.00

Table 1

- Between the ages of 20 and 29, there are some cost reductions.
- When a treatment is regarded as necessary for medical and other reasons, the ordinary patient fee rules of health care are used (i.e. a cap of 900 krona a year).

These conditions have generated strong criticism, and there will probably be some kind of high-end reduction. But neither the Social Democrats nor the Conservatives want to abandon the free market principle, and a high proportion of client funding will remain. Generally speaking, except for young people, there is no longer public dental care in Sweden.

Elderly care

Co-payment has also been a Swedish basic principle for elderly care. Residents in nursing homes and other kinds of elderly care services, as well as patrons of day-care facilities, have long been paying fees. Day-care patients have paid small amounts, but live-in residents having been paying a growing amount. Why? Because up till now, the fees have been related to your pension and other income. In the typical Swedish progressive construction, old people with good pensions have been forced to pay 35,000 krona a month in some cities(!). Because these extreme high-payers only get the same services as poor seniors, there has been a lot of pressure for reform.

The old system had a cap, too, which stated that, after having paid all service and housing costs, the senior must be left a certain amount of money for private consumption. This level was quite low – for those remaining in their own residence 3,000 krona a month per person, and for residents of nursery homes only around 1,800 krona. Here things will change.

User Fees Appeal to the Middle Class

Since the birth of the high-tax state in Sweden in the 1960´s, the left and the right have quarrelled over the guiding principles of funding the welfare system. The left has been saying that progressive taxes, together with progressive, income-based fees, are necessary to finance public services, while the right advocated lower taxes and flat-rate fees and argued that progressivity is purely a matter of tax policy. The trench fighting over this issue gave the right increasingly powerful arguments for reform, because the combination of high progressive taxes (long at world record levels) and progressive fees as well (they are fantastic in Sweden) made well-off people dissatisfied and locked low-income people into traps of bizarre marginal effects.

In the 1998 elections, the Swedish PM Göran Persson, a Social Democrat, suddenly turned the tables: there would be caps in fees for child care and elderly care, a reflection of the low flat fee-philosophy of the right. This strategy was completely logical in political terms. To stay in power, the Social Democrats had to attract the middle class and how do you do that more successfully than dramatically cutting their out-of-pocket expenses for social services? A likely side effect will be increased tolerance of the public sector, the fundament of Social Democrat government. The price of his overnight abandonment of 50 years of principle was negligible.

A new focus

To pull this trick off, PM Persson had to shift his focus from old, economically weak people to the fairly well–off bulk of voters. Today, old Social Democrats supporters must pay a large part of their pension to afford the dentist, while young brokers and business managers gain several thousands in krona every month on kindergarten fees that have been cut by two-thirds. The old-timers are stable left-wingers anyhow, but the middle-class is growing and important to cultivate if the Social Democrats are to stay in power. This is not cynical; it's simply the new politics. They worked for Tony Blair in Britain, and no doubt are highly attractive to the pragmatic left in Canada too.

What do we learn from this lesson? That the welfare network will gradually be styled to serve the middle classes rather than – as it once was intended – the poor parts of the population. Again in this respect Sweden will look like most other countries. To those who have, more will be given.

The impact of user fees in Sweden

This political perspective is central to a discussion of the practical implementation of user fees in health care. Canadians often ask why there is so little discussion of the negative aspects of this instrument. The implication is that the effects mainly hit the poor, and when poor people as a pressure group are loosing ground, the focus on disadvantages risks fading away.

Does this suspicion find proof in Swedish practice? What do we know of the impact of user fees in Swedish health care?

- A rather high share of the population has the "green card", providing free services. In 1999, one third of all Swedes 65 years and older had free prescribed drugs and one out of four paid nothing for health care. Of Swedish adult women, one out of six had a green card for health services. All together, more than a million people had free pharmaceuticals.
- This cap system probably explains why so few people in polls and other investigations report that they had to stay away from using drugs or visiting a doctor. In 1999, only 2.3 percent of the total grown-up population and 1.6 percent of those over 60 years old declared they had to some extent avoided medical treatment for reasons of cost. With regard to prescribed drugs, the share was 2.7 and 1.8 percent respectively.

- Close to 5 percent of all families said in 1997 that they had not bought prescribed drugs due to cost.
- A number of public investigations and committees have not found any negative impact on public health from user fees.
- User fees most likely affect the patient's behaviour. It is well documented that people who have a green card ask for more drugs than before. There is also a demand reduction in acute care. An experiment in Stockholm in the late 1990´s introduced fee-free acute childcare in some hospital clinics, while maintaining the fees in local primary care. That change increased the number of visitors by 30 percent. When reintroduced, the fees brought the situation back to the previous pattern.

User fees work well in Sweden

Very few Swedes seem to stay away from care or medication because of the patient fees. Here the safety net seems to work, even if there probably are some problematic individual cases outside the statistics. Patient behaviour regarding health-care visits is probably affected more, because they tend to go to the "cheaper" GP round the corner instead of using facilities with a higher fee.

The high pressure on in-hospital acute care – a typical Swedish problem – reflects the lack of efficiency in primary care. To attack this shortcoming, you need either radically improved local care (my advice) or much higher fees on acute care (the bureaucratic attitude). User fees must always be put in a larger perspective, working together with other information and tools to provide a good platform for informed choice.

Stockholm, May 2002

Johan Hjertqvist

AIMS Activities on…*Health Care*

AIMS PUBLICATIONS

Public Health, State Secret
The study demonstrates that politicians and senior health officials simply don't know where or why medicare is failing because they still lack the proper tools to evaluate the quality or timeliness of the care Canadians receive.

Swedish Health Care in Transition
How to improve health care delivery and manage health care costs are central themes in public policy debate in Canada today. It is not only Canada that faces these challenges however and we need not only look to ourselves for solutions. In AIMS latest commentary series we look at Swedish Health Care in Transition.

Health Care's Hidden Face
This is an interactive research project of AIMS' meant to examine how and why the frontier between public and private medicine has shifted over time within Canada and elsewhere, including when and under what circumstances such shifts have been beneficial in terms of access and quality of care.

Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System
This study garnered considerable attention when it was published in November 1999 for its argument that the health care system could not be properly managed because managers and policymakers did not have access to vital information about the system's performance. The paper also argued that if Canadians wanted to preserve the key elements of the system, and particularly a tax-financed approach that did not distribute medical care on the ability to pay, then greater private sector participation in health care provision was virtually unavoidable.

IN ADDITION to these publications, AIMS has also constructed a Health Care resource page and made available online a wide range of material including media reports, commentaries, public presentations, and links to other sources of information and analysis.
http://www.aims.ca/Main/health.htm

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