

Universal Access to Healthcare: Lessons from Sweden for the United States

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Fear less, hope more; eat less, chew more; whine less, breathe more; talk less, say more; hate less, love more; and all good things are yours.

- *Swedish proverb*

## **Introduction**

The American healthcare system is in crisis. The United States ranks in or near last place among industrialized nations of the world when comparing several indicators of health (Raphael 2000). Despite innovative medical technology, Americans have one of the highest rates of child mortality (8 deaths per 1,000 children under age 5 in 2002) and one of the shortest life expectancies (77.3 years in 2002) in the industrialized world (World Health Organization [WHO] 2004a).

Former U.S. Surgeon General David Satcher suggests that the United States has “the best medical specialists in the world, and...an overemphasis on technology, [but] many people can’t get to those specialists or that technology” (Guthrie 2002, p. D6). How can such inaccessibility exist in a country that spends a greater percentage of its gross domestic product (GDP) on healthcare than any other country in the world (13.9% of GDP in 2001; WHO 2004b)? In spite of this spending, many Americans cannot access needed healthcare services.

Access to healthcare involves the capacity to fund healthcare, publicly or privately via insurance coverage (Bovbjerg and Ullman 2001). In 2003, 45 million Americans were uninsured (U.S. Census Bureau 2004), due to numerous access barriers. For many, medical costs overshadow the perceived cost of sickness. A national survey found that 53% of respondents chose to forego medical care because they could not pay their deductible, 29% could not make a doctors appointment, and 25% could not leave work or find childcare in order to visit a physician (Altman et al. 2002).

In the United States in 2003, 84.73% of persons had access to healthcare (U.S. Census Bureau 2004). In Sweden, 100% of persons had access to healthcare in 2003, as everyone is insured. The universal healthcare coverage in Sweden seems to be benefiting the health of Swedes. Life expectancy in Sweden is among the highest in the world (80.3 years in 2002), and child mortality rates are among the lowest in the world (3.5 deaths per 1,000 children below age five in 2002; WHO 2004c). Bovberg and Ullman (2001) suggest that being uninsured is associated with more frequent health problems.

Outcomes in Sweden suggest that the United States could benefit from universal coverage. However, good medical care is not a guarantee of good health (Dye 1998). A perfectly replicated Swedish healthcare system in the United States may yield dissimilar results, and offering universal access could reduce the quality of services offered, as limited healthcare resources are spread over a larger population (Lamm 2001). This paper compares the national healthcare systems of the United States and Sweden and discusses the pros and cons of adopting universal healthcare in the United States.

In the United States, most health insurance is private (55.6%) and employer-based, and public coverage (44.4%) has strict income or age requirements (WHO 2004b). Education, income (Sturm and Gresenz 2002), and income inequality (Lynch et al. 2000; Marmot and Wilkinson 2001; Wilkinson 1996) are correlated with health outcomes, because deficiencies in these areas represent barriers to healthcare access. Thus, education, which increases the chances of finding a job, has a marked impact on healthcare access. Gruber and Levitt (2002) suggest that for every percentage point increase in unemployment, 1.2 million additional people become uninsured. Many people are members of an uncovered “gap” population, unable to afford their own insurance and not offered coverage by their employers (who are not required to do so).

These variables are less relevant in Sweden, because medical coverage and income are independent. As Hogue and Hargraves (1993) suggest, “the provision of free, high-quality health care for all,” acts to “uncouple poverty and health” (p.10). How does Sweden accomplish this system of universal coverage?

### **Historical background**

When comparing two countries' healthcare systems, their histories must be considered. Until recently, Sweden has been an almost homogeneous population. (Very unlike the melting pot of immigrants that is the United States.) Swedes see themselves as one people, and are more willing to contribute to the public good than Americans are. This allowed Sweden to espouse a highly socialized healthcare system. Whereas in the U.S., “survival of the fittest” ideology reigns, in Sweden a sense of unity exists that implies that helping one's fellow man is in turn helping oneself. Sweden is a model example of a social welfare democracy (Esping-Anderson 1996), where “all power of the state...emanates from the people (Sveriges Riksdagen 2002).

After centuries of war, and a serious food shortage in 1932, the Swedish government hoped to abolish unemployment by establishing a *folkhemmet*, or “home of the people.” This movement provided Swedes with universal welfare, free of stigma (Lagerqvist 2001, p.174). In 1946, the National Health Insurance Act (implemented in 1955), prepared for universal coverage by determining a reimbursement schedule for the county councils, and in 1982 the Swedish parliament passed the Health and Medical Care Act, with the goal “to ensure good health and provide care on equal terms for the entire population” (Landstingsforbundet 2002a, p.9), marking the true beginning of universal healthcare in Sweden.

## **Organization of the Swedish Healthcare System**

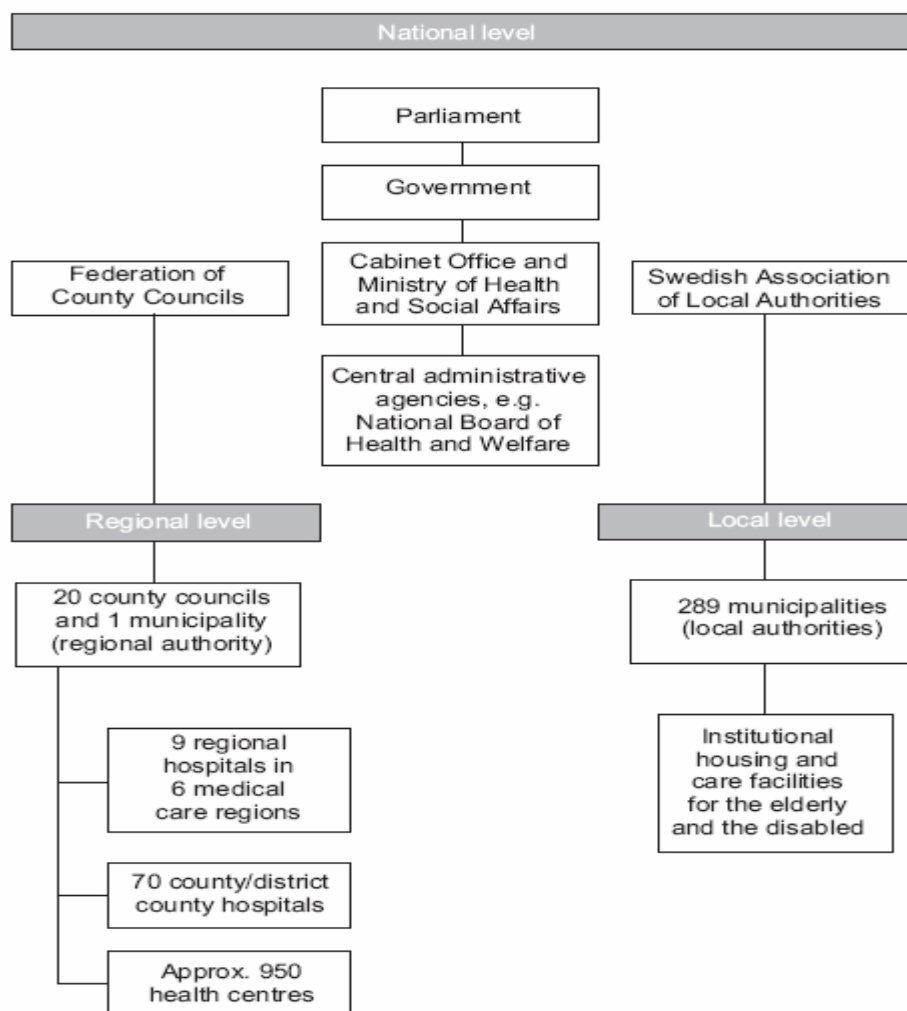
There are three levels of healthcare organization in Sweden: national, regional, and local (Figure 1). At the national level, the Ministry of Health and Social Affairs (Swedish Ministry of Health and Social Affairs 2003) is responsible for healthcare legislation and regulatory oversight of the lower levels of government to ensure compliance with the national legislation. The National Board of Health and Welfare (Socialstyrelsen) is the national government's chief agency for regulation and oversight. The Socialstyrelsen establishes operational and professional standards nationwide (Dudgeon 2002). It also serves as a healthcare safety net by providing financial assistance if an individual cannot pay their portion of their healthcare costs (Socialstyrelsen 2003).

At the national level, the Swedish Federation of County Councils (Landstingsförbundet), is an advocacy group for the regional level of healthcare organization, the county councils. The Landstingsförbundet is not responsible for healthcare delivery, but ensures that the county councils work together towards the goal of the Health and Medical Care Act, presents research findings, offers guidance, and assists in contract negotiations on behalf of the councils. The Swedish Association of Local Authorities (Svenska Kommunförbundet) is the national organization for the municipalities.

Beneath the Landstingsförbundet are 21 county councils representing the regional level of healthcare organization (Landstingsförbundet 2002). The county councils assume the burden of healthcare delivery for their residents as mandated by the Health Care Act of 1982, which decentralized healthcare. They have authority to raise revenues, determine fee-schedules and healthcare organization, and provide care. The councils also regulate private practice, deciding who receives government reimbursement. The Landstingsförbundet (2003) defines the function

of the county councils as being “responsible for matters of common interest which are too extensive and too costly for individual municipalities to manage. This mainly concerns health care, which is the county councils’ major task...”

*Figure 1. Organization of the Swedish Healthcare System*



Source: Landstingsförbundet, 1997.

The local level consists of 289 municipalities, which are not subordinate to the county councils, and whose responsibilities after the ADEL-Reform of 1992 include education, childcare, and long-term care of the elderly and disabled. The system is highly organized, ensuring at least one hospital in every county council and at least “adequate” access to citizens

(Landstingsförbundet 2002). Health services are uniform for all. As Johan Hjertqvist (2002a), a leading Swedish healthcare policy analyst states, “You will get the same kind of bed and food as other patients; you cannot upgrade by paying extra” (p.12)

### **Financing of the Swedish Healthcare System**

Swedish healthcare is financed by government taxes, employer-paid national social insurance, out-of-pocket user fees, and private insurance. In 2001, Sweden spent 8.7 percent of GDP, or \$2,150 per capita, on healthcare. Public expenditures accounted for 85.2% of healthcare services, while 14.8% of expenditures were private (WHO 2004d). Physicians “at public hospitals are employed and salaried by the county councils. Their income depends on neither the number of patients treated nor on the volume of their work” (Hanning and Spangberg 2000, p. 18). Conversely, U.S. physicians are compensated based on how many patients they see (with the exception of capitation and MCO salaried physicians).

Since the 1970 Seven Crown Reform, Swedes visiting a physician have been charged a user fee that began at only 7 Swedish kronor (US\$1) but has since increased to 100 kronor (US\$14) for primary physician visits and 250 kronor (US\$35) for specialist visits. The fee serves to reduce overuse and abuse of the inexpensive Swedish healthcare system, while allowing low-income persons access to care (the old system required up-front payment followed by reimbursement). The fees represent 2% of total healthcare expenditures (Hjertqvist 2002c).

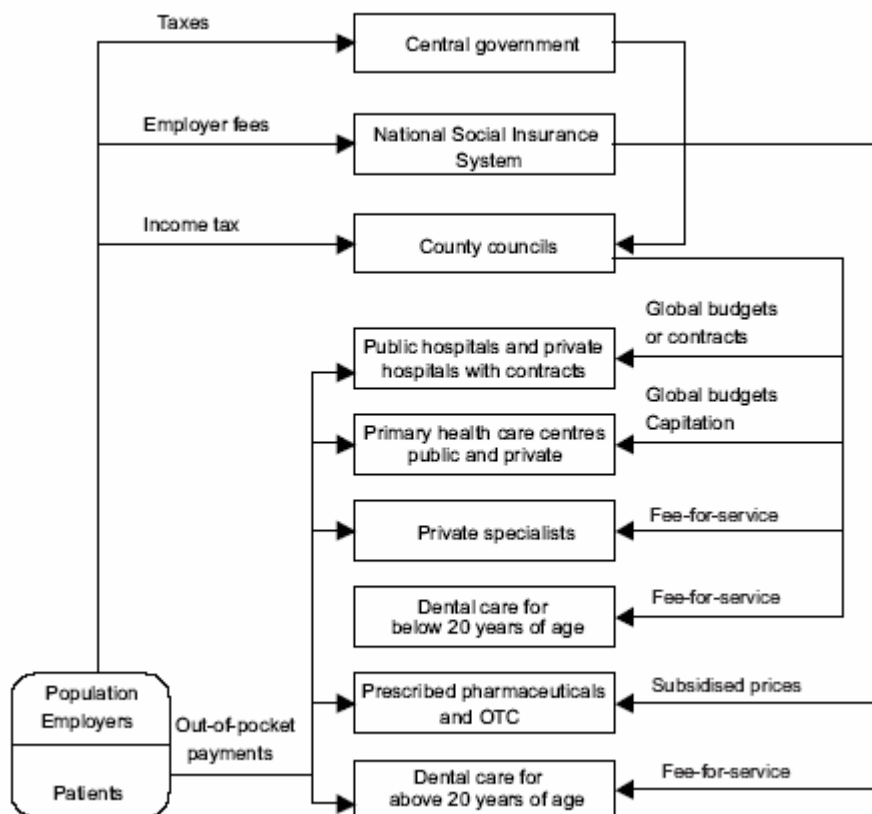
A maximum annual co-payment is established, after which an individual receives a *frikort* card, providing free care for the next twelve months (Parker 1998). Currently, this co-payment is only 900 kronor per year (US\$128). A similar system exists for pharmaceuticals, with an 1,800 kronor (US\$256) annual co-payment. Both co-payments are lower for children (Hjertqvist 2002c). To keep track of co-payments, Swedes have two cards, one which is stamped

at each doctor's visit (hogkostnadskort for sjukvard), and one which is stamped for each prescription filled (hogkostnadskort for lakemedel; Parker 1998). Once full, the stamp card becomes a *frikort*. Co-payments and deductibles are an aspect of most private insurance programs in the U.S., but they are typically much higher than those of the Swedish system, and are based on the calendar year; not so beneficial if you get sick in December (Claxton 2002).

The Swedish government allocates resources to needed services to ensure a minimum level of healthcare, while not "wasting" resources elsewhere. Vaccines for infants and the elderly are free, while vaccines for foreign travel and flu shots for low-risk people are paid out-of-pocket. The government withholds "unnecessary" benefits in order to contain costs, and avoids paying for abuse of the healthcare system (Bergit Magaard, personal communication, August 8, 2002).

In 1999, Sweden's healthcare system shifted from a nationally centered provision of expert services, to a subsidy approach. A DRG reimbursement mechanism adopted in 1990 from the United States, aided the purchaser-provider split, resulting in a network of third party providers (Hjertqvist 2002b). The government subsidized *Praktikertjanst*, a private physician's co-op in Stockholm, and contracted with St. Gorans hospital, the first privately run, publicly funded hospital in Sweden. Management operates within a framework of minimum treatment guidelines and maximum price levels established by the government. St. Gorans hospital is now the most efficient hospital in Sweden, with administrators creating an additional profit margin due to their administrative expertise (Hjertqvist 2002a). Reimbursing hospitals only for services provided, instead of from global budgets based on predicted productivity for which there were previously no incentives for compliance, resulted in a 30 percent increase in productivity (Hjertqvist 2002b).

Figure 2. Swedish Healthcare Financing



Source: European Observatory on Health Care Systems, 2001

### Unintended Consequences of Universal Coverage

Unintended consequences in Sweden include increased waiting times, overuse and abuse of the relatively generous system, and inequality between county councils. The Maximum Wait-Time Guarantee of 1992 has reduced waiting times and increased consumer sovereignty, by mandating a three month treatment window for waitlisted patients needing certain procedures. The county council hospital must pay all costs, including transportation and accommodations, for the procedure to be done elsewhere in the country if the deadline cannot be met (Regeringens skrivelse 1990/91:97, 1991). The *frikort* often leads to abuse of the system in the form of moral hazard. Once Swedes have satisfied their co-payment and received their *frikort* for pharmaceuticals, they request more prescriptions from their doctor (Hjertqvist 2002c). The

regional delivery of healthcare has introduced a degree of inequality, because more densely populated counties have a larger tax base, more funding, increased demand, and longer waiting times, than sparsely populated counties that have less financial resources. The government does try to redistribute tax revenues in a more balanced manner (Hjertqvist 2002a).

Eligibility rules may be universal (meaning everyone gets benefits) like in Sweden, or targeted (only a certain population gets benefits) like in the United States (Chambers 2000). Swedish eligibility requires only Swedish residence, but U.S. eligibility hinges on strict requirements for various programs. Furthermore, “citizens [may] receive benefits... ‘in proportion’ to their relative need for them,” or “in absolutely equal amounts irrespective of their need” (Chambers 2000, p. 99). The Swedish Health and Medical Care Act offers absolute equity, providing care “on the same conditions for the entire population” (Westerhall 1998, p.50). The U.S. provides proportional equity, favoring select groups, and leaving uninsured those who do not fall neatly into any category (Schneider 2002). Additionally, benefits may be vertically “allocated to those with the most severe need,” or horizontally “allocated to all those in need” (Chambers 2000, p.149). The U.S. favors vertical equity, providing benefits to low income and disabled individuals, except for Medicare, which provides benefits based solely on age, irrespective of need. Sweden favors horizontal equity.

## **Conclusions**

My findings suggest that the universal coverage in Sweden offers better access to healthcare than the targeted coverage in the United States, which is often restricted by employment and social status, as evidenced by the correlations of education, income, and income inequality, with health outcomes. By not associating healthcare coverage with income level or social class, Sweden avoids an enormous amount of inequality in healthcare access. While 45

million Americans are uninsured, all Swedes have insurance. Sweden's publicly centralized system makes its organization much clearer and more concise. Conversely, the elaborate mix of public and private healthcare in the U.S. results in a tangled web that can hardly be called a health system.

From a rationalist perspective, a cost-benefit analysis finds the U.S. healthcare system lagging behind the Swedish healthcare system, paying more, and receiving less; a sort of double loss. Investing more resources into healthcare should mean more benefits, but this has not been true in the U.S. The Swedish focus on universal coverage is paying off in longer life expectancy and lower child mortality at a much lower cost (WHO 2004c,d).

The United States must redesign eligibility rules to offer need-based or universal coverage, but not non-need based coverage like that of Medicare (Lamm 1999). Universal coverage would mean a dramatic shift from private to public insurance, which many stakeholders would oppose. The United States believes in individual freedoms, democratic government, and the free market economy, which, together with the protestant work ethic, keeps health insurance coverage tied to employment in the U.S. However, healthcare does not operate according to free market ideals. Social unity is not an American priority (Lamm 2001). Americans invest heavily in their own futures, but expect everyone else to fend for themselves economically. U.S. citizens are distrustful of government, and are therefore much more resistant to government redistribution of wealth than Swedes, to the point of stigmatizing welfare recipients. Accordingly, people in the U.S. prefer the private provision of social services and oppose paying high taxes to fund a government they do not intend to utilize heavily (Furrow et al. 1998). Historical and cultural traditions in the U.S. are the biggest obstacles to achieving universal coverage, but achieve it we must.

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