# ESPN Thematic Report on Inequalities in access to healthcare

## Sweden

## 2018

Janne Agerholm and Johan Fritzell
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Directorate-General for Employment, Social Affairs and Inclusion
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## European Social Policy Network (ESPN)

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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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## Summary/Highlights

In line with the overall characteristics of the Swedish welfare state, the healthcare system is based on the principle of universality and has a strong focus on equality. There is a full formal coverage since all Swedish residents are granted access to care regardless of nationality.

On a macro level, total healthcare expenditure in Sweden is around 11 per cent of GDP. The healthcare system is mainly financed by taxes. Out-of-pocket payments do exist, and make up around 3.3% of household consumption and around 15.2% of total health expenditure. In dental care, out-of-pocket payments are much larger. It is estimated that 61% of total spending on dental care is in the form of out-of-pocket payments.

There is a national ceiling for outpatient healthcare costs in any 12-month period, set at SEK 1,100 (€110). When the ceiling has been reached, the individual pays no further charges for that period. For out-of-pocket payments for prescribed drugs, a separate ceiling exists of SEK 2,250 (€225). The relatively low level of the cost ceiling is an important way to tackle economic barriers to healthcare access. Moreover, some types of healthcare are free of charge: maternity care, all outpatient care for people above 84 years, and, in general, healthcare for children.

Organisationally, the Swedish healthcare system is run by the county councils and regions, which make their own decisions on tax rates and how to allocate tax revenues. Marketisation within the healthcare sector, along with greater patient choice, have been increasingly implemented during the past two decades and were further underlined in the 2010 primary care reform. Patients' right to choose a provider in primary care and within a wide range of specialist care is no longer restricted to care providers appointed by the county councils. In addition, all private providers are free to establish primary care clinics wherever they want. As a result, the counties now have to regulate the 'market' by specifying requirements and reimbursement systems, instead of deciding how many primary care clinics can be established and where.

Since 2005, there has been a national care guarantee concerning acceptable waiting times. If these waiting times are not met, the patient should be given information about seeking care from another provider. Despite the guarantee, around 25% of patients in specialist care presently have waiting times exceeding the guarantee, and the issue of waiting times is high on the political agenda.

Many studies have shown clear socioeconomic inequities within several parts of the Swedish healthcare system, both in treatment and utilisation. Marketisation within the healthcare sector during recent decades has been shown to have mainly increased access to care for groups with better health and lesser healthcare needs.

Our recommendations are set out below.

a) There is a clear potential conflict between freedom of choice on the one hand and equity on the other, and there is a need for politicians to consciously consider this dilemma when implementing new policies.

b) The high level of out-of-pocket payments in dental care is in clear conflict with the goal of equity. Possibilities for including dental care within the healthcare system should be investigated.

c) Resources must be devoted to strengthening the capacity of disadvantaged groups to access healthcare, as well as the healthcare system's ability to reach out to them, particularly in disadvantaged areas.

d) Monitoring of healthcare treatments and results should not only report on averages across county councils or hospitals, but should also (to a higher degree than currently) monitor results from the perspective of socioeconomic equity.

# 1 Description of the functioning of the country’s healthcare system for access

In line with the overall characteristics of the Swedish welfare state, the healthcare system is based on the principle of universality, has a strong focus on equality, and relies for its financing on taxation. All Swedish residents are granted access to care regardless of nationality. Refugees also have the same rights, but restrictions apply to asylum-seekers and undocumented migrants, who only have a right to emergency health and care. The same applies to dental care. A fundamental principle, explicitly supported by legislation, is to provide ‘equal access for equal need’, regardless of sex, age, socioeconomic position, ethnicity, and geographical location (Health and Medical Services Act, SFS 1982:763). Despite the heavy reliance on taxes, out-of-pocket payments do exist both within medical care and − at a very high level − with regard to dental care.

Organisationally, the Swedish healthcare system is run by the 21 county councils and regions. Primary healthcare forms the foundation of the healthcare system and there are over 1,185 primary healthcare units throughout the country. There are about 70 hospitals at the county level, while specialised care is concentrated in the seven regional/university hospitals. County councils as well as municipalities make their own decisions on tax rates and how to allocate tax revenues.

The national level primarily governs through establishing laws, economic incentives and ordinances or by reaching agreements with the Swedish Association of Local Authorities and Regions (SALAR), a collaborative national organisation which represents all county councils and municipalities.

Total healthcare expenditure in Sweden is around 11% of GDP[1], which is higher than the EU average. In relative terms Sweden uses inpatient care to a lesser extent than many other EU countries, and also has the lowest number of hospital beds in the EU in relation to population size. However, the relative number of physicians and nurses is slightly higher than the EU average.

**Out-of-pocket payments in medical care**

Out-of-pocket payments do exist, making up around 3.3% of household consumption and around 15.2% of total health expenditure, which is slightly lower than the EU average (OECD, Eurostat and World Health Organization 2017). Separate financial regulations exist for medical and dental care. In dental care, the out-of-pocket payments are at much higher levels than in medical care (see further below).

Patient fees in primary care currently vary between 150 and 300 SEK (€15-30) depending on the county council, although one county council has abolished fees. Fees for specialist care vary between 200 SEK (€20) and at most 400 SEK (€40). Patient fees for inpatient care also vary between county councils (and sometimes according to age, income, or duration) (SALAR 2018a). Most importantly for availability, there is a national ceiling for outpatient healthcare costs set at SEK 1,100 (€110) over a 12-month period. When the ceiling has been reached, the individual pays no further charges for that period. For out-of-pocket payments for prescribed drugs, a separate ceiling exists: up to SEK 1,100 (€110) the patient has to pay the full amount, and the maximum amount during 12 months is SEK 2,250 (€225).

Some types of healthcare are free of charge. Healthcare for children is generally free of charge: however, some counties charge for emergency care visits. Maternity care is free of charge, as is all outpatient care for people above 84 years.

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[1] Note that national health expenditure covers much more than inpatient and outpatient care, including (for example) long-term care and collective services.

## Out-of-pocket payments in dental care

The pricing of dental care is at the discretion of the provider, and prices therefore differ substantially between providers and between different kinds of procedures. Instead of a fixed price for all patients, the cost of dental care is subsidised by 300 or 600 SEK/year (€30 or €60) depending on age. There is also a cost ceiling on dental care: if the total cost during one year exceeds 3,000 SEK (€300), patients are refunded with 50% of the total cost. Costs exceeding 15,000 SEK (€1,500) get refunded by 85%. Dental care for children (up to 22 years in most counties) is free of charge. People with illnesses that require dental care as part of the treatment will be covered by the same regulation as for medical care. The financial regulations for dental care mean that the bulk of costs are borne by patients, and it is estimated that 61% of total spending on dental care is made up of out-of-pocket payments (Government Offices of Sweden 2018).

## Waiting times

Since 2005 there has been a national care guarantee concerning acceptable waiting times, referred to as the '1-7-90-90 rule'. A patient should be able to establish a contact with primary healthcare the same day as it is initiated, and to get an appointment with a primary healthcare doctor within seven days. An appointment with a specialist should be offered within 90 days, and an intervention should be offered within 90 days after being prescribed. If these waiting times are not met, the patient should be given information about seeking care from another provider. Despite the guarantee, around 25% of patients in specialist care presently have waiting times exceeding 90 days. The issue of waiting times and queues is without doubt the most topical healthcare issue in political discussion.

Figures from spring 2018, provided by SALAR (2018b), show detailed achievement levels relative to the waiting time guarantee. The national overall achievement level for establishing contact with a general health practitioner on the same day was 86%; for getting an appointment with general health practitioner within seven days it was 89%; for getting an appointment with a specialist within 90 days it was 82%; and for having an intervention within 90 days from when the decision was taken it was 73%. The achievement levels differ between different regions in Sweden, in particular between the northern region and the Stockholm region regarding specialist care. The achievement level for getting an appointment with a specialist within 90 days was 67% in the northern region and 94% in the Stockholm region. The achievement level for getting a medical intervention within 90 days after medical assessment was only around 60% in the northern region, compared with 87% in the Stockholm region.

## Private healthcare insurance

Given the historical emphasis on universality and the strong social insurance system in Sweden, the role of private insurance for healthcare was almost non-existent until the early 1990s. Since then we have seen a steady increase: in the 1990s there was around a five-fold increase in the take-up of private healthcare insurance, and during the 2000s there was another five-fold increase. By 2017, the number of people with private healthcare insurance had reached 633,000 (Insurance Sweden 2018). In the vast majority (70%) of cases it was paid for by employers as part of the employment contract. The main reason for such insurance is to avoid the problem of waiting times.

## Increasing freedom of choice and marketisation of Swedish healthcare

Free patient choice of healthcare provider has been seen as an increasingly important value in the political debate about healthcare and has been implemented gradually to a greater and greater extent during the past two decades. Freedom of choice was further underlined in the 2010 primary care reform. The patient's right to choose a provider is no longer restricted to healthcare providers appointed by the county councils. Patients can now be listed in any primary care facility in any county, and all interested private providers are free to establish primary care clinics wherever they want. This has had a huge impact on the ability of counties to influence and regulate primary care. Instead of deciding how many primary care clinics could be established and where, the counties now have to regulate the ‘market’ by specifying requirements and reimbursement systems. Patient choice has also subsequently been extended to include certain kinds of specialist care.

Since 2010, more than 270 new private for-profit primary healthcare practices have been established (Burström et al. 2017). The trend towards marketisation of healthcare is part of a larger shift in the organisation of the welfare state, with privatisation being introduced in many other areas such as the basic school system, long-term care and the pharmacy market.

Although the primary care reform was introduced in all counties through government legislation, there are large differences between the counties in terms of what type of care is regarded as part of primary care (and therefore regulated by the primary care reform), and what type of care is not (and therefore still within the control of the counties).

Another area where large differences between counties exist is the reimbursement system. Most counties have chosen a mix between fee-for-service and capitation, with a smaller percentage (0-6%) basing it on ‘pay-for-performance’. In most counties the largest part of the reimbursement (around 80%) is based on capitation, but in a few counties it is much smaller. The weightings applied within capitation also differ between counties; this was especially true when the reform was first implemented. In some counties only age differences were weighted, while in other counties there were different attempts to weight reimbursement according healthcare needs − e.g. according to a care need index (CNI) or adjusted clinical groups (ACG). During the past eight years there have been changes to the reimbursement system in several counties, and most counties now have some type of need-weighted capitation to a greater or lesser extent.

# 2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

From a cross-national perspective the Swedish healthcare system must be regarded as fairly equitable. It is primarily financed through taxation and is equally available to all citizens according to the Swedish healthcare act. Nevertheless, inequities do exist in both utilisation of care, the type of care received, and health outcomes after treatment.

There are at least three different areas where inequity in access to, and utilisation of, healthcare in Sweden have been shown to appear:

- variations in individual predisposing and enabling factors;
- variations in medical treatment and quality of care;
- changes in health policy and the organisation of healthcare services.

These three categories do of course overlap in many aspects, but it is a way to distinguish between the different aspects of inequity and the different attempts to tackle it.

**Variations in individual predisposing and enabling factors**

Actual utilisation of healthcare is the final part of a process of varying length. Many factors influence whether a certain health status is perceived as giving rise to a healthcare need, and whether this creates a demand for, and ultimately use of, healthcare services. Health literacy has been defined as one such factor influencing both the perceived need and the demand for healthcare services. Problematic and inadequate health literacy has been associated (in a recent study of refugees in Sweden) with a higher probability of refraining from seeking healthcare in spite of perceived need. Language problems and lack of knowledge about the system were some of the reasons for refraining, as well as not believing that the healthcare system could help (Wangdahl et al. 2018).

Individual enabling factors, such as economic resources, also affect healthcare utilisation in Sweden. Although out-of-pocket payments are relatively low and capped, individuals with a low socioeconomic position and individuals born outside Sweden refrain from seeking healthcare and dental care due to economic reasons to a much higher degree than more privileged groups (Diaz 2009; Molarius et al. 2014; Westin et al. 2004). This is in spite of a higher healthcare need among those with a lower socioeconomic position.

The high level of out-of-pocket payments for dental care has obvious implications for equality. The commission for equity in health made a proposal that the dental care system should be brought under the financial regulations of the general healthcare system (SOU 2017). Earlier this year, the government therefore commissioned an official inquiry, with the mission to propose reforms to the dental care system − with a special focus on tackling inequalities (Government Offices of Sweden 2018). The final report of that inquiry will be delivered in 2020.

Since January 2017 individuals above 84 years have been exempt by law from co-payment, and can access all outpatient care free of charge. This was to reduce the risk of older persons refraining from seeking healthcare due to financial reasons. Children are also exempt from out-of-pocket payments. For all other individuals (18-84 years) the relatively low level of the cost ceiling is an important way to tackle economic barriers to healthcare access. There are very few initiatives of other kinds from central government to tackle inequities due to variations in predisposing and enabling factors. There are, however, several examples of more local initiatives to tackle these differences.

An example of a more local initiative is the Rinkeby extended home-visiting programme in the city district of Rinkeby-Kista in Stockholm municipality. The programme was a response to the poor health status among children in this area. Rinkeby is considered to be one of the most disadvantaged areas in Stockholm county, with a high percentage of residents who are foreign-born, unemployed, with a low educational level, and/or on low incomes. The programme was offered to all first-time parents in the area and consisted of six home visits conducted by a nurse and a parent advisor from the social service centre. The programme was intended to support parents in their parenting role and increase their awareness of how to improve the health of their children and to access healthcare (Marttila et al. 2017).

This programme fits well with some of the proposals from the recent commission for equity in health, which stress the importance of investing in healthcare investment in disadvantaged areas (SOU 2017).

### Variations in treatment and quality of care

In 2009 a comprehensive review was conducted for SALAR of studies of equity in Swedish healthcare. The review found many examples where disadvantaged groups also had poorer healthcare access: however, it concluded that the limited scope of studies in this area made it difficult to draw general conclusions about inequity in the healthcare system (Diaz 2009). Many studies were based on data from one or a few counties, and generalisation of the results to the entire country was often difficult, as medical practice varied between counties.

One area where Sweden has a general reputation for fair and equal care is in oncological care for children. In many regards oncological care for children has been put forward as a 'golden standard' for other countries to follow, and healthcare for children is in general found to be delivered in an equitable way that evens out some of the social differences in health among children (National Board of Health and Welfare 2006)

At the other end of the age spectrum there is room for improvement; for example, older people with a lower education level more often receive older medication and are at higher risk of having inappropriate drugs or drug combinations than older people with higher education. Such differences are likely to be produced by a multitude of factors, such as differences in health literacy, ability to make demands, and different likelihoods of getting demands met (Wastesson et al. 2015). There is a shortage of systematic countrywide studies of equity in access to healthcare in the older population, but regional studies are available. A study of healthcare costs during the last year of life in Stockholm county showed that healthcare costs increased with income (Hanratty et al. 2007). Similarly, there are income differentials in outpatient healthcare utilisation in the older population, particularly in specialist care (Agerholm et al. 2013).

Another example of inequity in the healthcare system is in the treatment of cardiovascular diseases. Revascularisation is an established treatment for unstable coronary health disease that lowers the risk of mortality and further myocardial infarctions (MI). A study looking at income differentials found that higher-income groups were 2-3 times more likely to receive this procedure than lower-income groups (Rosvall et al. 2008). Another part of the treatment for MI is lipid-lowering medication: but in spite of a higher need for these medications among people with lower educational level, higher-educated people receive them more often. A recent report to the Swedish commission for equity in health gives estimates of differences in treatments and results after MI by educational groups: on almost all of the 15 indicators, those with a higher education level have much better outcomes, especially for survival after 28 and 365 days (Kristenson 2017).

One way to tackle inequities in treatment and quality of care is through national guidelines and regional care programmes for different diagnoses. The National Board of Health and Welfare currently has 13 guidelines for different diagnoses with recommendations for treatment and setting priorities, based on the most recent evidence. Several counties have developed their own guidelines and care programmes for many other diagnoses and treatments in order to ensure that all patients receive the best possible care. Although adherence to these guidelines is evaluated for some aspects, they are very seldom evaluated for equity and it is therefore not possible to assess the equity impact of these guidelines.

### Changes in health policy and the organisation of healthcare services

Several changes have been made in the organisation of the Swedish healthcare system during the last decade that potentially affect equity. In general, there has been a trend towards the marketisation of Swedish healthcare during the past 20 years. In order to increase competition between providers, the healthcare sector has been disaggregated into more specialised entities. Moreover, legislation has been changed in order to facilitate provision by the private sector. Patient choice has been promoted as a way to ensure quality and efficiency, and the share of publicly funded private providers has steadily increased, especially in the larger cities. Few of these changes have, however, been evaluated from an equity perspective, and the implications for equity in access to healthcare are seldom part of the political debate.

An analysis of the arguments put forward during the parliamentary process before implementation of the most recent choice reform in primary care from 2010 showed that equity aspects were not properly addressed, in relation to either utilisation patterns before the reform or the possible effect of the policy changes (Fredriksson et al. 2013). This is surprising in a Swedish context, where the values of equity and social solidarity have otherwise been guiding principles in health policy − and should be so according to the Health and Medical Services Act.

The choice reform was designed to increase access to primary care and make it easier for private providers to establish new clinics in the Swedish healthcare ‘market’. It is a reform that drastically changed the way healthcare is regulated, and subsequent analyses of its implementation have shown implications for equity in several respects. Many studies and reports evaluating the primary care reform have come to the conclusion that although the goal of increasing access to primary care might have been achieved, this increase has not been related to patients’ needs, and patients with more complex care needs have been disadvantaged by this reform (Agerholm et al. 2015; Burstrom et al. 2017; Riksrevisionen 2014).

There is a potential contradiction between increasing patient choice and equity. Different patient groups value choice differently and have different prerequisites for making informed choices. Those with little or limited capacity to choose are often the ones in higher need of healthcare services. Another concern is that demand, instead of need, determines healthcare utilisation to a higher degree when choice becomes the leading value.

Further, the ability of county councils to ensure quality in primary care was in some aspects reduced when the free choice of provider was combined with the freedom for providers to establish new facilities. The responsibility for maintaining quality was instead shifted towards the patients, as they, by their own decisions, are expected to choose high-quality providers and disregard low-quality providers.

These market-oriented reforms have led to greater fragmentation within the healthcare sector, making coordination and integration between providers more complicated (SOU 2016). This might especially be problematic for patients with more complex healthcare needs and patients with lesser ability to make informed choices and navigate the healthcare sector. To a large extent, the needs of patients with multi-morbidity, frail older people, and asylum-seekers and immigrants seem to be disregarded.

### Private healthcare insurance

It perhaps goes without saying that the marked increase in the use of private healthcare insurance affects inequality. As already noted by the Swedish welfare commission in 2001 (Grip 2001; Palme et al. 2001), those who are most in need of healthcare will not be insurable. At that time, only around 115,000 persons had such insurance. Given the present incidence of private healthcare insurance, it seems likely that this system has an impact on public healthcare, especially in terms of equity. From July 1st 2018, private insurance policies paid for by the employer will be taxed. To what extent that will influence the steady increase in their use remains to be seen.

### Unmet healthcare needs

Dental services aside, financial barriers to healthcare are, according to available data, relatively minor in Sweden. Nevertheless, according to OECD data, there is still a small percentage of people (3.9%) who refrain from seeking healthcare consultations due to financial reasons. This is, however, much lower than the OECD average of 10.5% (OECD 2017). A somewhat larger percentage (6.8%) refrain from taking prescribed drugs due to financial reasons, much closer to the OECD average of 7.1%. The proportion with unmet needs, according to EU-SILC, is even lower: in 2016, only 0.4% reported having unmet care needs due to financial barriers. Given that this is relatively rare, and given non-randomness in response rates, these numbers are likely to be an underestimate.

Socioeconomic differences in the propensity to refrain from healthcare services due to financial reasons are quite extensive. Among those on low incomes, the percentage of people refraining from either healthcare or prescribed medication is 16%, compared with the average of 7% in Sweden (OECD 2017). It is often the groups with greater need who are more likely to refrain from seeking healthcare. Own analyses based on available survey data from the 2014 Stockholm public health cohort show that people on a disability pension are twice as likely to refrain from seeking healthcare as the average population, and people receiving social assistance benefits are more than seven times more likely to refrain. For dental care, the percentage of people refraining is much greater due to the higher out-of-pocket payments. We do not have updated data on this, but in 2002 the percentage of people aged 18-64 refraining from dental care due to economic reasons was almost four times higher than the percentage refraining from other healthcare (Burström et al. 2007).

## 3 Discussion of the measurement of inequalities in access to healthcare in the country

In general, the measurement of access and quality in healthcare has improved considerably, not least due to the so called ‘open comparisons’ that SALAR and the National Board of Health and Welfare produce. However, these comparisons very seldom include inequalities by socioeconomic factors, and instead are mostly broken down by county councils or hospitals. The same could be said for the many different quality registers that each year compile data for different diseases.

Sweden has extensive register data with very high coverage, and many studies rely on these registers when evaluating equity aspects within the healthcare system. However, they have their limitations when it comes to comparing outcome measures over time or between areas. Registration practice can differ between counties and over time. This is especially true where registration (for example, of diagnoses) is linked to reimbursement systems: there is a risk that registration practice can change with changing reimbursement schemes. Another example is the evaluation of the primary care reform, which has largely been focused on comparing numbers of visits to primary care providers before and after the introduction of the reform. In Stockholm, where the reimbursement system changed at the same time from a system based on need-weighted capitation to a system based primarily on fee-for-service, there is no guarantee that a visit before the reform is comparable with a visit after the reform in relation to length or health issues addressed. This makes comparisons of numbers of visits before and after this system change problematic or even misleading – especially when comparing groups with different levels of healthcare needs and complexity of health issues.

More sophisticated or detailed data are needed to be able to gain a deeper understanding of where and when inequities appear. Survey data have the potential to do that: but, as in many other countries, Sweden has falling response rates in most national health surveys, and this often makes it difficult to draw conclusions in relation to subgroups of the sample, such as disadvantaged groups. However, when it comes to variables that are associated with non-response, such as unmet needs, even the total population prevalence might be highly underestimated. Thorough non-response analyses is becoming increasingly important in order to interpret the results of survey data. Compatible electronic patient records are one way to more easily link data between different healthcare providers and get more detailed background information as well as more qualitative outcome measures. Moreover, the use of qualitative methods could be considered as an important complement to the less detailed register-based analyses.

**Policy recommendations**

In sum, our recommendations are as follows.

a) There is a clear potential conflict between freedom of choice on the one hand and equity on the other, and there is a need for politicians to consciously consider this dilemma when implementing new policies.

b) The high level of out-of-pocket payments in dental care is in clear conflict with the goal of equity. Possibilities for including dental care within the healthcare system should be investigated.

c) Resources must be devoted to strengthening the capacity of disadvantaged groups to access healthcare, as well as the healthcare system’s ability to reach out to them, particularly in disadvantaged areas.

d) Monitoring of healthcare treatments and results should not only report on averages across county councils or hospitals, but should also (to a higher degree than currently) monitor results from the perspective of socioeconomic equity.

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