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# Private health insurance in Sweden: Fast-track lanes and the alleged attempts to stop them

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ABSTRACT

According to the Health and Medical Services Act (1982:763), those who have the greatest need for healthcare shall be given priority. This is being challenged by the rapid emergence of private health insurance which increases the share of private funding and creates fast-track lanes where some people get faster access to healthcare than others. The Stop Law, implemented by a Social Democratic government in 2006, was generally regarded as a way to put an end to the fast-track lanes in Swedish healthcare. Based on a thorough examination of the law and its legislative history – official reports, propositions, comments on official reports – this article argues that the Stop Law was so full of exceptions and loopholes that it did not threaten the existence of fast-track lanes. The same goes for a similar Social Democratic proposal from 2016, which is also examined in the article. Further, the article analyses centre-right wing positions on fast-track lanes in Swedish healthcare. In summary, it is argued that politicians of all stripes have allowed the development to proceed in spite of unanimous support for the idea that Swedish healthcare shall be provided to all on equal terms.

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## 1. Introduction

In contrast to the liberal and conservative welfare models, one of the characteristics of the so-called Social Democratic welfare model was that welfare services such as healthcare were publicly delivered and publicly funded. The idea was to build societies where high quality services were offered to all people on equal terms, thereby avoiding stigmatising means-testing that was seen to be a result of other types of welfare regimes [1].

This way to organise welfare services reached its peak in Sweden in the 1970s and 1980s, and it was one of the most distinguishing features of the Social Democratic model [2,3]. Since the 1990s, however, public delivery and public funding of Swedish welfare services is not as all-embracing as it used to be. One example is Swedish healthcare [5–7], where the latest statistics show that private delivery increased its share of total delivery from 12 to 17% between 2006 and 2014 [38]. A field less explored is incremental changes in the pattern for *funding* of healthcare. One example of increased private funding is the rapid rise of private health insurance, which is now signed up by 10% of the working-age population [8].

The Swedish version of private health insurance is characterised by providing rapid access to healthcare. An increasing number of Swedish healthcare facilities use different queuing systems for publicly and privately funded patients, where the latter get faster access to care than the former. When I did a study of 108 of the 115 private healthcare providers that the insurance company *Länsförsäkringar* mentions as partners on its website, I found

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that 62 of the 108 providers also received publicly funded patients in accordance with the rules that correspond to that group of patients (it may also be added that most of the other 46 providers provide healthcare that is not included in the public commitment, such as occupational healthcare, naprapathy and different kinds of spa treatments) [39]. 62 out of 108 thus had two different queuing systems for their two different groups of patients. The phenomenon – known as fast-track lanes – has been politically controversial because it challenges the pillars of the Health and Medical Services Act (1982:763), which say that 'Those who have the greatest need for healthcare shall be given priority'.

Indeed, there were always individuals who had access to health care outside the public system, something that was made possible through fully private (privately run and privately funded) healthcare facilities. But, first, this did not occur on today's massive scale, with over half a million Swedes holding private health insurance. And, second, the two systems were not mixed in such a way that publicly funded healthcare had the same provider as privately funded healthcare.

How did that happen? Of course, there are a number of driving forces behind the rapid rise of private health insurance in Sweden.

Legally, it has been made possible partly by the privatisation of delivery referred to above. Without a countrywide net of private providers on all healthcare levels, insurance companies like *Länsförsäkringar* would have nowhere to send their 640 000 customers. This is so because the publicly delivered healthcare does not agree to give privately funded patients faster access than publicly funded patients.

Economically, income distribution has been characterised by growing inequality during the last decades and are now comparable with figures of the 1930s [4]. This increases purchasing power among some societal groups and hence their demand for topping-up possibilities not only within healthcare but also within other welfare services such as education and elderly care. Meanwhile, the recurrent tax cuts of the last decades have had effects on the quality of the public welfare system [50].

Organisationally, long waiting times within publicly funded healthcare have been of major importance for the rapid rise of private health insurance. This is a long standing problem with a wide range of suggested causes and solutions [9,40,41], and there is an increasing number of employers and employees who claim that they cannot afford to wait that long for treatment.

Politically, however, the rapid rise of private health insurance can be seen as somewhat unexpected. There is a continuous support of publicly funded and equally accessed healthcare in the rhetoric of all political parties, and one could thus expect them to take different types of measures against the development of fast-track lanes within Swedish healthcare.

This article deals with the political parties and their *alleged attempts* to stop fast-track lanes in Swedish healthcare. Theoretically, the issue can be related to research on incremental institutional change and especially the concepts of *layering, drift and conversion* [10–12], which are three tools to understand how welfare state retrenchment happens in an incremental and sometimes hidden way, i.e. how institutions and the rules of the game can be changed without obvious changes in policy on the highest level.

Actually, the concept of *alleged attempts* may be a fruitful contribution to this vein of institutional theory. While there are interesting concepts used to understand how new rules are implemented alongside old ones (layering) and how actors can interpret old rules in new ways (conversion) and how failures in updating institutions to modern standards gradually undermine them (drift), there is no concept for politicians and policymakers who claim they are turning the tide when they actually allow the development to proceed.

From this perspective, it is interesting to dig into the archives and ask how the political parties have positioned themselves in relation to the emergence of fast-track lanes in Swedish healthcare. To answer that question this article examines the so-called Stop Law implemented by a Social Democratic government in 2006 and abolished by a centre-right wing government a year and a half later.

The Stop Law was generally regarded as a way to put an end to fast-track lanes. Based on an examination of the law and its legislative history – official reports, propositions, comments on official reports – it will however be argued in this article that the Stop Law was so full of exceptions and loopholes that it did not threaten the existence of fast-track lanes. The same goes for a similar Social Democratic proposal from 2016, which is also examined in the article.

## 2. Material, methods and definitions

### 2.1. Material and methods

The purpose of the article is not to explain the rise of private health insurance in Sweden, neither to analyse the consequences for the public healthcare system. The purpose is to investigate the discrepancy between political rhetoric and reality with regard to the rapid rise of private health insurance and fast-track lanes. My starting point is the Social Democratic bill on the Stop Law [16], supposedly implemented to put an end to fast-track lanes in Swedish healthcare.

Did the Stop Law have such an effect? Was it even implemented for that reason? The questions are well suited for a Critical Discourse Analysis (CDA), which is an interdisciplinary method and approach to examine ideologies and power relations involved in discourse [52]. Speaking exactly about government bills, one of the founders of CDA suggests that [48]:

> The gap between rhetoric and reality in this case is the gap between the language of the Bill and the language of New Labour's political discourse about the Bill./. . ./So the gap between rhetoric and reality in this case is not between language and something else—it is between language used in one place and language used in another: language used in political discourse and language used in government action.

CDA aims to trace this kind of gaps through close analysis of the texture of texts [48]. By a careful reading of central documents and as much as possible surrounding them (see

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