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The recommodification of healthcare? A case study of user charges and inequalities in access to healthcare in Sweden 1980–2005

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ABSTRACT

Background: User charges in Swedish healthcare have increased during recent decades. This can be seen in terms of the recommodification of healthcare: making healthcare access more dependent on market position. This study investigates whether the increase in user charges had an impact on educational inequalities in access to healthcare in Sweden between 1980 and 2005.
Methods: Data from the Swedish Living Conditions Survey were used to calculate the odds ratios of access to healthcare for the low and higher educated in Sweden, and the results were stratified by health status (*Good* and *Not good* health) for each year 1980–2005. These odds ratios were correlated with the average user charge for healthcare.
Results: There were no educational differences in healthcare access in the group with *Good health*. In the group with *Not good health*, the higher educated had higher rates of healthcare access than the lower educated. Inequalities in access to healthcare were relatively stable over time, with a slight increase among those with *Not good health*.
Discussion: Recommodification has had only a small association with access to healthcare in Sweden. The Swedish system has integral protections that protect the vulnerable against rising healthcare costs. This is an important caveat for other countries that are considering introducing or raising user charges.

1. Introduction

Access to healthcare is a well-recognised social determinant of health [1], and inequalities in access to healthcare exacerbate problems caused by wider social inequalities [2]. Access to healthcare affects inequalities in avoidable mortality, which is defined as the number of deaths that could be avoided through the timely application of medical care. There are significant socio-economic inequalities in avoidable mortality across Europe [3]. Healthcare usage is lower in lower socio-economic groups, even though their health needs are higher [4]. European healthcare systems have been substantially reformed during the past

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few decades. The reforms largely served to increase the market's role in healthcare provision, and have included changes to system financing (away from general taxation and social insurance), the introduction of direct purchasing arrangements (an increase in co-payments and user charges), and changes in the organisation of service provision (privatisation, outsourcing and marketization of services) [5]. It can be argued that such reforms have recommodified healthcare—making access more dependent on an individual's ability to pay, and thus largely on his or her labour market position. Many have speculated on the impact of such changes, but little research has been carried out into how recommodification has affected inequalities in access to healthcare [5]. The research that has been carried out has not employed a theoretical framework of recommodification. This paper presents a case study of reforms in the Swedish healthcare system and examines longitudinally the association between increases in user charges and inequalities in healthcare access between 1980 and 2005. It also examines whether recommodification has taken place.

1.1. Healthcare reform as the recommodification of health

Over the last 25 years, the healthcare systems of most European countries have experienced extensive – and commonly market-based – organisational and financial reforms. These changes have been remarkably similar between different countries and under successive governments, regardless of their political affiliation. The emphasis has unswervingly been on promoting choice, competition and the role of markets in healthcare. The stated aims have been improving quality, stimulating innovation and promoting equity. Critics of the reforms have consistently questioned whether these aims have been achieved, contesting the evidence base for them and arguing that the reforms increase inequalities in access and reduce quality [5]. This has affected healthcare systems of different types, including national health systems (as in Sweden and the UK) and social insurance ones (as in Germany and France) [6].

Sweden has strong local government with tax-raising capabilities [7]. The 20 county councils own and run both hospitals and primary care clinics, although some county councils have sold their primary care clinics to the private sector [7,8]. User charges were set centrally until 1991, when the decision was devolved to the local level. At the same time, choice reforms were implemented by many county councils [9,10]. Between 1970 and 1998, user charges in healthcare increased faster than the consumer price index [11]. The average user charge for a visit to the primary care system is roughly 200 SEK and the charge for outpatient specialist care is roughly 350 SEK [12].

These reforms can be seen as part of a process of recommodifying the welfare state. The expansion of the welfare state and the incorporation of social rights into the model of citizenship that occurred during the post-war period resulted in a significant decommodification of health [13]. "Decommodification" refers to the extent to which individuals and families are able to maintain an acceptable standard of living, regardless of their market position [14]. Welfare states decommodify by providing both cash transfers and public services. Although transfers have received the most attention, Bambra [15] applied the concept to healthcare and constructed a healthcare decommodification index based on the proportion of private funding, the proportion of private provision of healthcare, and the rates of public coverage. "Healthcare decommodification", therefore, refers to the degree of market involvement in healthcare. In more decommodified healthcare systems (largely national health systems), the role of markets is minimised and access to services is usually a right of citizenship. Markets are not simply another method of service delivery: for a market to work, there must be a commodity [16]. The establishment of market mechanisms in healthcare thus commodifies healthcare – or in a historical sense, recommodifies it [16]. The healthcare reforms in Europe since the 1980s must be understood within a wider context of the recommodification of labour and the retrenchment of social citizenship, and as part of a wider neoliberal project to rebalance the relationship between labour and capital [17].

1.2. Case study: user charges in Sweden

User charges are one example of the commodifying character of recent healthcare reforms and one with particular implications for equity in healthcare. The use of user charges to make up the shortfall in tax financing can be considered to be an extra tax on the ill [18]. Furthermore, vulnerable groups such as people on low incomes, single parents, unemployed people, and social assistance recipients are more likely to be price-sensitive than other groups, thus exacerbating socio-economic inequalities in healthcare access and consequently in health outcomes amenable to healthcare [11,19]. There is evidence from both the US and European countries (France, Italy and Germany) that user charges have a greater impact on healthcare in low-income groups [20,21]. A recent review [5] found that market-style reforms, and especially reforms to payment methods (increased use of out-of-pocket payments and private health insurance) in healthcare reduce equity, while evidence regarding the marketization of service provision is less conclusive.

User charges mainly act to control consumption, and contribute a very little to financing the healthcare system in Sweden [11]. A limit to the charges that any single user pays in any one calendar year has been implemented to avoid placing an undue burden on the chronically ill: once a person has reached the limit, any further healthcare during that year is free [21].

The Swedish healthcare system had a pro-poor bias during the 1980s, and people on low incomes were more likely to visit the doctor. By the 1990s, however, there was no difference in consumption rates by income [19,22]. Similarly, in 1988/89 there were no significant differences in reported unmet care needs, while by 1996/97 the people in the lower-income quintiles had higher odds of reporting having care needs for which they had not sought help [22].

Economic reasons are cited by almost 20% of those who have refrained from seeking needed care [23]. More people