Lessons from Sweden's Universal Health System: Tales from the Health-care Crypt

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You cannot buy a new Lexus for $20,000. Small budgets cannot buy first-class medical care either. Yet one of the most persistent arguments for single-payer health insurance is that it will somehow give everyone gold-plated care at little or no cost.

There are a lot of dry statistics to prove just how wrong this notion is. But there is a side of this issue that rarely is told, especially not by advocates of a government medical monopoly. It is the story of those who pay the price for the serious rationing in a single-payer system.

Universal Rationing: Real-Life Examples

Rationing of care is a reality under universal health insurance. Yet, its advocates seem universally oblivious to it. In an effort to unmask the reality of "universal coverage," here are some actual case histories of real people with real experiences. They were reported by Swedish news media, in some instances numerous times. Sweden has longer experience with socialized medicine than almost any other country in the world.

In October 2003 Mrs. A., who lives in Malmo, Sweden, gave birth to a baby boy.[1] She was signed out from the hospital *six hours* after delivering the baby. There are not enough beds, so delivering a baby "without complications" is an outpatient procedure. Budget cuts have eliminated beds and medical staff.

The next day Mr. and Mrs. A. noticed that their baby was weak and did not want to eat. As is common in Sweden, they did not call a doctor. Instead they called the tax-paid "TeleMedicine" service. Nobody advised them to go see a doctor right away.

The following day their baby died of pneumonia.

In May 2006 another couple lost their three-year-old son to the budget-starved medical system.[2] When Mr. and Mrs. B.'s son suffered from diarrhea and had been vomiting for almost two days, they took him to the emergency room at the nearby university hospital. A doctor ordered a supply of intravenous fluids, and the boy was sent on to the pediatric clinic to have them administered. When he arrived, the nurses had no time for him. Mr. and Mrs. B. repeatedly called on the medical staff to ask why nobody was coming to give their son the intravenous fluids he so desperately needed.

Every time they got the same answer: nobody has time. They have too many patients and too little staff.

Six hours later the three-year-old boy died of heart failure.

You do not have to be a child to die from denial of care in Sweden. In April 2005 Mr. C., 61 years old, became concerned about an unusual feeling of fatigue.[3] He went to see a doctor at the local government-run clinic. The doctor sent him home with some encouraging words.

Mr. C. came back a while later with worsened symptoms. Again he was sent home after a superficial examination and with more reassurance.

Over the next year and a half Mr. C. visited this tax-paid local clinic a total of 14 times. He had no choice—all Swedes have to go through a government-run primary care physician at a tax-paid clinic in order to see a specialist. He developed blood in his urine. But the doctors refused even to take a blood test.

They told Mr. C. and his son that they were denying him the blood test because of budget restrictions imposed by government bureaucrats.

When, finally, Mr. C.'s son convinced the doctors to do one blood test, they found out that Mr. C. had cancer. He was referred to a regional hospital. There they established that his cancer, originally curable, had spread throughout his body. There was nothing left to do. He died shortly after.

Even those who do not die from encountering denials of care suffer considerably under Sweden's universal coverage. Mr. D., a multiple sclerosis patient, lives in Gothenburg, a city of 500,000.[4] His doctor told him about a new medicine that is considered a breakthrough in MS treatment. But, when the doctor put in a request to have Mr. D. treated with it, the request was denied. Reason: it would cost 33 percent more than the old medicine, and that was more than the government was willing to pay.

For most Swedes there are no longer any subsidies for prescription drugs. People with exceptionally high pharmaceutical costs get some subsidies, but they have to pay the greater share themselves.

When the government denied Mr. D. the new medicine on the grounds that the subsidies would cost too much, he offered to pay the full cost of the medicine himself. He was denied the option to pay full cost out of his own pocket because, the bureaucrats said, it would set a bad precedent and lead to unequal access to medicine. In Sweden, there is no way to obtain access to medication outside the government-run system.

There are other absurd examples. How many times have you gone to see your doctor only to find security guards posted in the waiting room?

This is reality in Malmo, Sweden's third largest city.[5] To see a physician the 280,000 residents of Malmo have to go to one of two local clinics before they can see a specialist. Except during business hours, only one of the two clinics is open to serve all the city's residents.

As a result the clinic is severely overcrowded. The security guards serve two functions. They keep patients from becoming unruly as they sit and wait for hours to see a doctor, and they keep new patients from entering the center when the waiting room is considered full.

Opening the second clinic during off-business hours is considered too costly.

Government control over medicine also leads to government arrogance. In Gothenburg, a hospital was blessed with having a talented orthopedist on its staff.[6] Dr. Leif Sward worked part time for the government-run hospital, part time for a local soccer club at its private orthopedic clinic, and part time for the British national soccer team.

You would expect a man with such credentials and experience to be considered a prized asset in a tax-supported hospital. But the government bureaucrats were unhappy with the fact that Dr. Sward was not working full time for them. They considered his work for the private health clinic "competing employment"—the soccer players should come to the tax-supported hospitals instead so as to increase their revenues. So they gave Dr. Sward an ultimatum: quit the private sector or leave us.

Dr. Sward chose the latter.

By giving Dr. Sward this ultimatum, the medical bureaucrats showed that their priority was to control and stifle competition and choice, an action contrary to the interests of patients.

In the midst of all this, you would expect Sweden, oft cited as the epitome of equality, to at least care for women's health better than any other nation. Not so. Sweden is suffering badly from lack of physicians with expertise in interpreting mammograms. The city of Uppsala, with 200,000 people, well known for one of Europe's oldest universities, has only one specialist in mammography.[7] This is not unique. Sweden's National Cancer Foundation reports that the situation is so precarious that within a few years most women in Sweden will not have access to mammography. This is, in part, because all medical schools are under government control and subject to the same budget-cap policies as the rest of the system.

Delayed Consequences

What these horror stories from the health-care crypt can tell us is that universal health insurance is bad for patients in a very profound, direct sense.

But there is also an indirect effect, and over time an even more dangerous side to having the government starve a nation's medical system. Dr. Olle Stendahl, professor of medicine at Linkoping University, pointed this out in the national Swedish daily newspaper *Dagens Nyheter*.[8] Referring to the 2005 Nobel Prize in Medicine, awarded to Dr. Barry Marshall and Dr. Robin Warren for their discovery of *Helicobacter pylori*, Dr. Stendahl explained that part of the reason for their innovative research was a medical system that encouraged research and innovation. But, he continued, discoveries of this magnitude are ruled out in Sweden:

> In our budget-governed health care there is no room for curious, young physicians and other [medical] professionals to challenge established views. New knowledge is not attractive but typically considered a problem [that brings] increased costs and disturbances in today's slimmed-down health care…. Primarily the system endorses health care regions and administrative directors who can show a surplus in their budget. Quality of care and patients' well-being are second-tier goals.

But what exactly is it that causes universal health systems to experience these problems? Mere government inefficiency is a contributing factor, but it only accounts for part of the problem.

A more comprehensive explanation lies in the very form of funding, which in Sweden's case is entirely through taxes and co-payments. Swedish medicine gets the bulk of its funds from a 12-14 percent income tax. This tax is part of the 30-33 percent income tax that the average Swedish family pays. Those earning above a threshold roughly equal to the median family income pay an additional 20 percent.

In such a high-tax climate it is difficult for politicians to raise taxes further.

The Cost of a Transplant to America

While it may seem as though the Swedish tax rates are off the chart compared to American taxes, it would not take us long to get there if the United States made the mistake of adopting socialized medicine for all.

It has been estimated that a Swedish-style single-payer health insurance system in America would cost the median-income household some $17,200 per year in health care taxes.[10]

Even if this were to replace the cost of private insurance policies, it is far from certain that employers would increase workers' paychecks by the amount they now spend on health benefits. More likely, employers would keep that part as increased profits.

Some suggest a business tax to pay for a single-payer system. That would effectively be the same as a tax on working families, either in the form of lower salaries or fewer jobs, or in the form of a mark-up on business sales. The end result is the same.

As in Sweden, politicians would promise to freeze the tax to pay for a hypothetical American single-payer system at a fixed rate. In the 1994 Clinton plan, this was to be in the form of a 7 percent payroll tax that would never go up. The effect of this is easy to see if we imagine that we had created a Clinton-style system 50 years ago. Over the past half century, medical costs have risen just over twice as fast as the payroll on which the tax would be levied. To avoid raising the tax, Congress would have to have curbed spending one way or the other. This would have resulted in a combination of three things: (1) a significant lag in implementing new medical technology; (2) massive reductions in staff, beds, and number of clinics and hospitals; and (3) widespread transfers of responsibilities for medical evaluations and treatment downward in the skills pyramid: from physicians to physician assistants (PAs), from PAs to nurses, from nurses to nurse assistants, etc. In short, less skilled staff would be would be operating with yesteryear's technology in clinics and hospitals of greatly diminished capacity.

Conclusion

If we implement a universal, single-payer model in America today, the negative effects will reliably occur about a generation from now. The question that we need to ask ourselves as we enter the election season is this: Are we willing to send that bill down the road for our children to pay?

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