

It may be a hard pill to take – Canada has a lot to learn from Swedish medicine

Strong Public Social and Health Systems, not User Fees, Explain Sweden's Health Care Success

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"Make the sick pay!" would be one way of presenting the rallying cry arising from Jean Chretien's recent visit to Sweden. Chretien, and a number of media commentators, appear attracted to the Swedish practice of charging patients for visits to their family doctors, or to the hospital. Ironically, Chretien is responding to a problem he has helped to create. Both provincial and federal Canadian governments are making tax cuts a higher priority than adequate health care funding. The result is a health care system under severe stress.

But whatever the cause of Canada's health care ills, could Swedish-style user fees be part of the solution? Some Swedish authorities believe that the policy discourages unnecessary doctor visits. In comparison to Canadians, who use the health care system an average of six times per year, Swedes make an average of only three visits each year.

Furthermore, Sweden spends less of their national wealth on health care than does Canada. As a proportion of their gross domestic product on health care, 8.4%. Canada spends 9.5% of its GDP on health care.

These figures make Sweden's health care system look attractive. But is it really user fees that are responsible for the apparent Swedish efficiency?

As it turns out, there are other, better explanations for Sweden's relative health care success than user fees. They include lower poverty levels, more public and less private health care spending, and a better way of paying doctors.

When most people think of maintaining their health, they think of doctors and hospitals. Social and economic factors are, however, at least as important. At birth, boys of Canadian families with the highest income level can expect to live 5.6 years longer, and girls 1.8 years longer, than those with the lowest income. Ontario Health Survey data show that 69%

of those with high incomes report very good or excellent health in comparison to 43% of poor Ontarians. Four percent of the wealthy, but 19% of the poor, report a long-term activity limitation.

Sweden has a more progressive tax system than Canada, and Sweden's social programs are much more extensive. The result is that the difference in income between the wealthy and poor is much less in Sweden than Canada. While 18% of Canadian families with children live in poverty, Sweden has one of the worlds lowest rates of poverty.

Poor people are sicker, and need more health care. Sweden's lower poverty level is likely one factor in its decreased health care use.

Other explanations come from differences in the health care system. Despite their user fees for physician and hospital care, a larger proportion of health services are publicly funded in Sweden than in Canada. In Canada, 30% of health care costs are user-pay. In Sweden, private spending represents only 16% of health care dollars.

The biggest reason for the difference in public versus private health care spending is that, in Sweden, the government pays for most prescription drugs. In Canada, about 15% of the population has no drug coverage, and is likely to have trouble affording expensive medication. Ironically, when you can't afford medication, you are likely to be sicker, and require more visits to the doctor or hospital.

The final reason for the differences in doctors visits is the way doctors are paid. In Canada, the physician, rather than the patient, initiates many doctors visits. This is particularly true in family medicine or general practice, which is often called primary care. The doctor generally decides on when patients should make well-baby visits, have check-ups for chronic conditions like high blood pressure or diabetes, and follow-up visits after an illness.

In Sweden, doctors are on salary. Canada uses a fee-for-service mechanism to pay most physicians. Fee-for-service payment means that Canadian doctors receive a fee each time the patient visits. There is no payment for phone calls, or extra payment for dealing with two patient problems in the same visit.

Fee-for-service creates what some have called "perverse incentives" for physicians. If doctors want to maximize their income, they will have patients come in for a visit rather than deal with a problem over the phone. They will insist that their patients visit them for prescription renewals, suggest extra (possibly unnecessary) visits for monitoring chronic conditions, and deal with only one problem per visit.

Salaried physicians have no such perverse incentives. They can manage patients most efficiently, minimizing unnecessary visits without having to worry about negative effects on their income.

The differences in the way doctors are paid in Sweden and Canada is likely to explain some of the gap in numbers of health care visits between the two countries.

Looking back at the overall picture, if Canada wishes to have the healthiest possible population, and the most efficient health care system, we have much to learn from Sweden. First, we will adopt social policies that decrease the gap in wealth between rich and poor. Second, we will follow the recommendations of the Canadian National Health Forum of 1997 that suggested a national pharmacare plan to finance prescription drug payment. Third, we will trash fee-for-service, and adopt an alternative mechanism for paying physicians.

These, rather than user fees, are the lessons Mr. Chretien should have brought back from his trip to Sweden.