The Truth About SwedenCare

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As a Swede currently living in the United States, with actual experience of Swedencare, I must reply to the delusions propagated by professor Robert H. Frank in his June 15 [article in the *New York Times*](http://www.nytimes.com/2013/06/16/business/what-sweden-can-tell-us-about-obamacare.html), titled “What Sweden Can Teach Us About Obamacare.”

It is surprising to read something so out of line with basic economic theory from an economics professor. But theory aside, it would have sufficed for professor Frank to have taken a field trip down to the nearest public emergency room to have his illusions irreparably shattered. The reality is that Swedish healthcare is the perfect illustration of the tragedy of central planning. It is expensive and — even worse — it kills innocent people.

Free universal healthcare came about in the 50s as part of the Social Democratic project to create the “People’s Home” (Folkhemmet). This grand effort also included free education on all levels, modern housing for the poor, mandatory government pension plans and more. Let us grant benefit of the doubt and assume that some of its proponents had good intentions; as so often, these intentions paved the road to a hellish destination.

It has taken awhile, but it is now becoming obvious even to the man on the street that *every* aspect of this project has been a disaster. He may not be able to connect the dots, but he can see that the system is definitely not working as advertised, and it is rapidly deteriorating.

Before the utopian project got under way, Sweden had some of the absolute lowest taxes in the civilized world and, not surprisingly, was ranked at the top in terms of standard of living. The project changed Sweden into a country with the second highest tax rate in the world (Denmark is higher), periods of rampant inflation, and a steadily deteriorating economy.

There is nothing economically mysterious about health care — it is just another service. Like any other it can be plentifully provided on a free market at affordable prices and constantly improving quality. But like everything else, it breaks down when the central planners get their hands on it, which they now have. To claim that the problems are due to a “market failure” in health care is like saying that there was a market failure in Soviet bread production.

Let us look at what happened when health care was provided for free by the Swedish government (i.e., taxpayers). Note that the same economic principles and incentives apply to any service that the government decides to take over and provide for free. The same principles will apply to Obamacare, with some slight variations.

First it was understood in Sweden that free healthcare was only for the poor. It would not affect those who were happy with their existing provider. But when government suddenly offers a free alternative, many will leave their private practitioner in favor of the free goods. The public system will have to be expanded, while the private doctors will lose patients. The private doctors are then forced to either take employment within the public system or leave the profession. The result is one single public healthcare monolith. Can one find economies of scale within its operations, as professor Frank claims? Maybe. But if they exist, they will be dwarfed by the costs and inefficiencies of the bureaucracy that inevitably grows to manage the system.

These results are clearly visible in Sweden. There are very few private practices left. Of the few that are left, most are part of the national insurance system. A huge bureaucracy has been erected to take on all the necessary central planning of public and pseudo-private healthcare.

When Swedes go to the polls every four years, they vote on three levels of government: national, *landsting*, and *kommun*. A *landsting* is a regional mid-level type of government and there are 20 of them. The *landstings* are almost entirely devoted to managing public healthcare. They are always short on funding and regularly make losses.

The advantage of a free market system, as I am sure the venerable professor Frank knows, is that supply and demand meet to form prices. These prices are signals to the practitioners and tell them what their patients need and value most. If there were a sudden surge in demand for open-heart surgery, the price of that service would, *ceteris paribus*, rise. The practitioners would be motivated by the rising price to move into fields where they can make higher profits. More doctors would move to provide open-heart surgery, the capacity for open-heart surgery would increase, the increased demand satisfied and the price would drop again. Some people protest and think that it is immoral for doctors to maximize profit and live well on other people’s medical problems. But why is it any more immoral than farmers profiting from peoples’ hunger?

Thus, free-market systems systematically allocate capacity (“supply”) and reallocate it quickly to satisfy patients’ needs (“demand”). Due to competition it has the added advantage of always striving for lower prices and higher quality. This principle is as true for medical services as it is for cell phones or gardening services.

The bureaucracy of a public healthcare system cannot use market prices to allocate resources. It must use some other means. First it will try to plan according to estimated demand. It will try to guess the number of bone fractures, open-heart surgeries and kidney transplants in the coming year. The estimates will invariably be wrong, causing shortages in some places and overcapacity in others — at the same — which translates into human suffering and economic waste.

Without the profit motive, there is no incentive to adapt to reality, to utilize expensive equipment to the optimum capacity, to improve the level of service, or treat patients with dignity. All change will have to be pushed down from the planners above by decree. Doctors and nurses will be frustrated because they are not free to exercise their art to the best of their ability and help people as much as they would like to. Many of the best leave for other fields.

It is impossible to put a number on it, but it is obvious that the level of energy in the medical professions in Sweden is low compared to America. It can be seen on several levels, from doctors and even down to students. An American medical student and friend of mine spent a year at a major Swedish hospital. He was shocked when he realized that students never spent any of their spare time in the operating room; there was no drive to become the best. There are of course enthusiasts who love their work regardless, and do a fantastic job, but the system is not conducive to this attitude.

Planning always fails. The planners come to realize that the market is superior but they will not back off. Rather they will try to *mimic* a market, using trendy techniques such as “New Public Management,” voucher systems, or healthcare exchanges. The results of these solutions are usually even more disastrous than outright planning. In order to work, they will have to reduce every medical condition to a code, every patient to an ID number, and every procedure to planned (arbitrary) cost and income numbers.

It was recently revealed in one of the major newspapers that doctors were told to prioritize patients based on their value as future taxpayers. Old people naturally have a low future-taxpayer-value, so they naturally became low priority in the machine and less likely to receive proper treatment. In a private healthcare system you can make your own priorities, you can for example sell your house and spend the proceeds on becoming well. In a socialized system somebody else sets the priorities.

As we know, every planner-induced action gives rise to five equal, opposite, and unintended reactions, each of which will be met with yet more planner-induced actions. Eventually you end up with a broken system such as the Swedish one, where service is “free,” but not accessible.

For non-emergency cases in Sweden, you must go to the public “Healthcare Central.” This is always the starting point for anything from the common flu to brain tumors. You must go to your assigned Central, according to your healthcare district. Admission is by appointment only. Usually they have a 30-minute window every morning, when you call to claim one of the budgeted slots. Make sure to call early or they run out. Rarely will you get an appointment for the same day. You will be assigned a general practitioner, probably one you have never met before; likely one who does not speak fluent Swedish; and very likely one who hates his job. If you have a serious condition, you will be started on a path of referrals to experts. This process can take months. Contrary to what professor Frank believes this is not a “feature” of the system, to ensure maximum capacity-utilization. This is an unavoidable characteristic of central planning, analogous to Soviet bread lines, which nobody refers to as a “feature.”

This healthcare “bread line” is where people die. It happens regularly that by the time a patient gets to see an expert, his condition has progressed beyond remedy. It also happens frequently that referrals get lost. Bureaucracies create listless employees, who don’t care, who refuse to go the extra mile, and who are never responsible for failures.

If you have an emergency you will go to the emergency room at one of the huge Soviet-size hospitals. Professor Frank praises these monstrous facilities for providing “economies of scale.” Stockholm had two huge hospitals. In 2004 they were merged [into one](http://en.wikipedia.org/wiki/Karolinska_University_Hospital) by a big-name consulting firm. Of course the “merger” was a failure, so for many years there have been discussions about splitting them up again.

The emergency room is a different experience altogether. Unless you are suffocating or are hemorrhaging profusely, you should expect to wait 5-7 hours to see a doctor. You can only hope for this “high” level of service if you arrive on a workday and during office hours. After hours, or on weekends, it is worse. Doctors are mostly busy filling out forms for the central health care authorities, scribbling codes in little boxes to report services rendered, instead of seeing patients. There have been cases reported where patients have seen a doctor immediately, but such cases are rare.

It is important to plan any major health problems you intend to have outside of June, July, and August, because during the summer months, hospitals are virtually shut down for vacation.

Due to a lack of profit motive, free services not only become bad but also very expensive. One of the major banks (Swedbank) recently came out with a report stating that the average earner pays about 70 percent tax of his income to the government, including the invisible big chunk withheld from his paycheck. Because free systems become more expensive with time and it is impossible to compensate by constantly raising taxes, every year more conditions are classified as non-life-threatening, and are therefore no longer covered.

In the final stage of a central planning failure, the planners simply give up. They want to wash their hands of the whole thing, and decide to “privatize”the services. In practice, this means that they unload hospitals at fire sale prices to well-connected “entrepreneurs.” The planners turn themselves into overseers and guarantors of quality. This creates a highly protected “market” wherein the “entrepreneurs” are only required to deliver government-quality services at prices determined by what it would cost government to do the same. Obviously this creates permanent margins so huge you could drive an ambulance through them, and there is no competition to stop it.

This is a general pattern that is seen not only in healthcare but also in all pseudo-privatized and heavily regulated industries, such as education, pharmacies, and old-age care.

When people find out that the enormous profits are moved to tax havens they promptly demand that profits in healthcare be outlawed and that government nationalizes the industry. And then we have come full circle.

This process is obvious in Sweden where there is now broad consensus across the political spectrum and among media pundits that profits in healthcare, especially on tax funds, are immoral and should be outlawed. It is likely that, in time, there will be legislation to this effect.

The market for private healthcare in Sweden is small. Few people can afford it since they already pay 70 percent tax for all of their “free” stuff. The politicians have private health care, though, naturally paid for by taxpayers. Apparently they are such special people that the healthcare systems they have designed for others are not good enough for them.

When I moved to the U.S., our family health insurance took three months to kick in. One of my family members broke a leg in this period. We found a“five-minute clinic” half an hour away, had the leg X-rayed, straightened and casted, with no waiting time — all for $200 cash. That kind of service is non-existent in Sweden. It is an example of how a market, not yet totally destroyed by the state, can create affordable and high quality services.

The reason American insurance-based healthcare is so expensive is that it is heavily regulated and legally connected to the equally-regulated insurance industry. Both are well protected from competition by regulation. Obamacare will make them even more expensive, bureaucratic, and inaccessible. The way to fix U.S. healthcare is by excising the central planners and regulators from it, not by implanting droves more of them.

I have seen (and lived in) the future of American health care, and it does not work.