The Swedish national dental insurance and dental health care policy

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Sweden instituted a national dental insurance program in 1973. The program is outlined; current problems and political issues are described; the benefits and limitations are discussed.

Sweden is a land a little larger than California with more than eight million inhabitants, of whom 95% have the same cultural and ethnic background. Swedes enjoy one of the highest living standards in the world, and the capitalist economy is one of Europe's most productive. Taxes are high, but, surprisingly, the majority have not complained much because the services derived from tax money seem never ending. Pension plans, sickness insurance, and medical services are comprehensive, accessible, and of good quality. The bureaucracy is well developed and seems larger than our own. Swedes maintain a sense of humor about inevitable bureaucratic snafus and are skillful at finding ways around them.

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Approximately half of the 7,800 Swedish dentists¹ are private practitioners and half are salaried employees of the national dental service—the Folkandvården. The ratio of dentist to population is roughly 1:1,050. Folkandvården is responsible for the

dental care of all persons from birth to age 19, as well as about 20% of all adults. The private sector, therefore, treats approximately 80% of the adult population. At its current rate of expansion, Folkandvården is expected to treat 35% of the adult population in the near future.

Historical background

In the mid-1960s, it became obvious to most of the Swedish dentists that something had to be done to combat the decreasing numbers of dental patients seeking treatment. Prices had been set by the dentists themselves, except in the public sector. Folkandvården's fee schedule during the 1950s and 1960s lagged further and further behind real costs, forcing a limitation on the number of adults who could be treated in Folkandvården, as child care was the priority of public dentistry. The lack of consistency of fee schedules between private and public sectors had partly created decreased demand in private practice. Private dentists had aggravated the situation by not allowing free price competition within their own market sector. At the same time, costly re-

forms in the medical field threatened to deprive public dentistry of financial resources and delayed the expansion of children's dentistry.

Judged by the cultural and political traditions of the country, it was no surprise that the Swedish government passed the Dental Reform Act of 1973. A similar medical reform act had been passed in 1970. The dental reform act provided for increased building of public dentistry facilities and instituted a national dental health insurance program. Most dentists, both private and public, were in favor of the national insurance plan.

But just before the dental reform act, the Swedish Dental Association lost its credibility with the government as a guiding force in determining dental health care policy, mostly by its own error, according to Runo Cronström, current association president (personal communication, October 1980). The association had been involved in government-directed committee work and had agreed in principle with all other members of the task force to the provisions in the proposed dental reform act. Some months afterward, the Swedish Dental Association suddenly changed its opinion from the original agreement and became involved in partisan politics, mainly through urgings from a small, more militant faction in the association. As a result, government officials decided that the dental insurance would need to be mandatory. The government had pre-

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ferred. Until 1976, the government was run by the Social Democratic party, which originally spearheaded the dental reform act. Since 1976, a less socialistic government has been slashing the budget. This particular decision can put a severe dent in the international reputation of Sweden as a leader in organized preventive dental programs. The whole dental corps, regardless of political preference, is very disappointed.

In June 1974, private practice "establishment control" came into being. Through an edict from the National Insurance Board preventing establishment of new private practices, it was hoped graduating dentists would enter the expanding public Folkandvården facilities, especially in areas of dentist shortage. Old private practices may still be taken over from retiring or chronically ill dentists. The limitation is expected to be

organized dental health care system.

INNOVATIVE OFF-SHOOTS OF NATIONAL DENTAL INSURANCE. With the national dental insurance and the huge, instant influx of patients, certain experiments in public health have been contrived. The "Lycksele model" of "phased treatment" involves an extended period of maintenance.¹³ Adult patients are drawn from waiting lists, examined (with radiographs made), instructed in oral hygiene, and have a short session with the dentist for immediate problems, if not complete treatment. Patients are called again after 12 to 15 months. Having gone through the list once, dentists can provide a more enriched phase of treatment the following time. The advantage is that such an overview of the dental health status of the whole community can help in reallocation of resources. It also tends to decrease the

Swedish dentists' current struggle leads this observer to hope that dentists continue to be major policy makers in the delivery of dental health care. A national dental health insurance in itself may not be the whole answer to all of America's dental health care problems, but exploring new avenues and combinations of government support and private initiative may provide some exciting, innovative solutions to the problems involved in the delivery of dental health care.

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temporary (until 1982), but there is no guarantee. The Swedish Dental Association accepts establishment control as part of the Dental Reform Act.

The quality of dentistry under this system of high demand and pressure to produce has been pondered; in the opinion of many,¹¹⁻¹² the quality of care is generally good. However, the working intensity is tremendously stressful in Sweden, especially for the private practitioners. Many dentists have expressed concern that they feel pushed to the limit. The Swedish Dental Association is genuinely concerned about the quality of dentistry in the future. In the public sector, at the county level, there has been a gradual but consistent rise in statistical goals and quotas. But there have been far fewer attempts at organizing realistic qualitative goals in child and adult treatment. As a result, dental health status levels vary from county to county—and even clinic to clinic. With the backlog of patients continuously decreasing and preventive services increasing, the pressures on dentists may soon reach a more normal level and alleviate the growing pains of an

load of patients with acute problems.

One county is making promising efforts to coordinate private and public dentistry through local insurance office distribution points. The intention is to share the load of 20- to 29-year-old patients between private and public dentists.¹⁴ The plan seems to be working well. Private dentists in most counties are showing new interest in the organized care of 20-year-old adults and county emergency services. Regional coordination between Sweden's private and public dental sectors appears to be off to a start.

Conclusions

To draw conclusions from the Swedish dental insurance plan or dental care system and try to apply them directly to the American delivery system would be foolish. The difference in population size and ethnic diversity make extrapolations from one system to the other difficult.

It is important to remember that the leadership of a dental corps in any country must hold the confidence of the consumer and government. The

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tended to see prevention of disease, wherever possible, as the goal of the compulsory national health insurance programs.² They believe that there is little or no incentive in the private sector to emphasize prevention, as the majority of dentists derive most of their income from reparative, surgical, and prosthetic treatment.

American ideas, such as capitation fees and other prepayment plans, were discussed in some detail, but gradually lost support in Sweden because such plans were not compulsory in nature. It was thought that an organized approach toward a dental health care policy for all citizens in Sweden could best be accomplished through a compulsory national dental insurance and a commitment to organized preventive dentistry, according to Dr. John Hedlin, dental director of the National Board of Health and Welfare (personal communication, August 1980).

Even chief representatives of the private dentists in the Swedish Dental Association expressed skepticism about capitation fee plans modeled on the current American system, preferring that Sweden keep the national fee schedule system with adjustments toward the advantage of prophylaxis procedures.⁴ It seems that the Swedes have come to think of dental health much the same way that Americans came to regard compulsory education at its inception. The Swedish commitment to improving dental health is shown in that dentistry accounted for 10% of the total Swedish health care spending in 1977.⁷ By contrast, dentistry accounted for only 6.2% of America's total health care bill⁸ for the same year.

Commitment to organized prevention is shown most clearly in the plans for the development of its corps of prevention personnel. There were 390 dental hygienists in 1978 but, at the current rate of education, there will be 1,500 in 1985 and 2,350 in 1990. Several categories of dental assistants with up to one month's extra education also provide expanding prophylaxis and fluoride rinse program ser-

vices. All counties in Sweden have a school-based regular fluoride rinse program. In one report, an estimated 800 to 1,000 prophylaxis assistants and 150 to 200 dental hygienists could prevent the need for the reparative services provided by approximately 900 dentists.¹

Problems and controversies

Even though almost all private and public dentists and the Swedish Dental Association have agreed in principle to the national dental insurance policy, there are some controversial and often rather heated issues.

In spite of the high ratio of dentist to patient, the backlog of adult patients became tremendous after the reform. With much pressure from potential dental consumers, the National Insurance Board preferred that dentists accept new patients from the huge demand. The board found it difficult to guide private dentists into thinking of dentistry in a larger perspective. For example, on numerous occasions, the board has expressed the view that, if dentists could decrease the amount of time spent doing partial dentures without lowering the quality of care, many new patients could be treated sooner. The director of the National Insurance Board (not a dentist) has indicated that, before the insurance reform 11% to 12% of the private dentists' time was devoted to fixed partial dentures, compared with 27% in 1977.^{9,10} The board can do nothing directly to affect how dentists treat patients.

The dental division of the National Board of Health and Welfare has a passive advisory role with the National Insurance Board about the "weight" of items on the fee schedule. The schedule is intended to be as neutral as possible so that no particular area is emphasized over another. But the final decision on price increases and general policy lies with the National Insurance Board and the Department of Health and Social Affairs of the Swedish government (nondentists). In

the Dentistry Delegation, the dental association has been acting only in an advisory capacity, often having to "loudly recommend" higher fee schedules for private dentists' needs for capital improvements and increased office expenses. There have been no arbitration powers for dentists. After the National Insurance Board decided to disregard dental association recommendations for a higher fee schedule in November 1979, the dental association strongly protested and left the Dentistry Delegation. On Nov 16, 1979, dentists picketed outside the Parliament building in Stockholm. Private dentists went on a two-day strike. As of October 1980, the association was still holding out until they became full bargaining partners with the National Insurance Board and have a third, neutral, arbitrating party.

The board released a fee schedule on Sept 1, 1980, that provides for a 13.2% increase, of which 3.3% is retroactive compensation for dental cost increases between January and August 1980. The dentists' demands are slowly being met. The political situation is not one of bitterness, but resolute difference of opinion. Both private and public dentists seem united and are determined to have an equal voice with government in the shaping of dental health care policy.

Another controversial issue is the neutral fee schedule. Private dentists would like to see more weight placed on the prophylaxis items in the schedule so they could afford hygienists and prophylaxis assistants. Most hygienists and nearly all prophylaxis assistants work in the public sector. Apparently, little initiative is being shown by the private sector, and even less by the public sector, to cooperate with one another to effect regional coordination of preventive or general dental services or both. It is more or less taken for granted that the county councils (public sector) will take responsibility for the whole population, even though private dentists are currently serving 80% of the adult population.

Until recently, the dental insurance coverage had been 75% of all prophylaxis and complete denture services. Surprisingly, the government decided as of July 1, 1980, that half the cost of these services was to be paid by the pa-

ferred the support of the dental association, but the dental reform was going to happen with or without its full support at such a late date. According to Cronström, the Swedish Dental Association had made a mistake by changing its stance and is still struggling to regain credibility with the government.

By October 1973, approximately 85% of private dentists and all public dentists had voluntarily entered the national insurance plan. All knew in June 1973 that the national insurance would become mandatory in January 1974. Mainly through the efforts of the Swedish Dental Association, the insurance became voluntary again in 1975. Today, fewer than 50 dentists practice outside the insurance plan.²

SWEDISH NATIONAL DENTAL INSURANCE. Under the insurance plan, the adult patient pays half the cost of the treatment up to a limit of 2,500 Swedish crowns (approximately \$580). When the treatment is more expensive, the patient pays only 25% of the cost over this limit.³ This insurance covers all Swedish citizens and foreign residents 17 years of age and older. From birth to the age of 17, all Swedes are entitled to free dental treatment, and certain counties have extended coverage to the age of 19. Providing dental care for the entire child population is a formidable task. In 1979, more than 86% of the children from ages 6 to 16 were examined, and treatment was completed. Quality of the care of the primary dentition is not outstanding, judged by American pedodontic textbook standards, but it is adequate, considering the numbers of patients.

The private dentist who works within the system must adhere to a rather complicated scale of fees. Standard treatment items are given one fixed fee, and up to four different fee levels provide latitude for more difficult cases. The same latitude does not exist within the national dental service, which has only two fee levels. On some procedures (private or public), a fixed fee applies (approximately \$55 per hour as of Sept 1, 1980). An estimated 85% of treatment is on the fixed-fee basis and the remainder on the fee-per-hour basis. Hygienists receive approximately \$27 per hour. Technical fees are figured separately

from dentists' fees. Although all materials are now paid for by the insurance, as the result of a government budget proposal the patient will soon be paying a part of gold costs.

The insurance works as a fee-for-service system with patients paying their part of the cost directly to the dentist. Monthly claims are sent to the local insurance office for the remainder. One additional feature of the insurance plan is that a pretreatment estimate of fees must be submitted, with X rays, to the local "confidence dentist" for estimates greater than a total of 3,000 Swedish crowns (approximately \$700) in any treatment period, usually a year. The "confidence dentist" is a dentist hired by the state insurance office to process claims almost entirely from the private sector. The clinic chief of each public clinic processes nearly every pretreatment estimate within Folkandvården. During 1979, a total of 71,321 pretreatment claims were made and only 717 were disputed.⁴

Wages earned by dentists in the public and private sectors vary to some degree. An average wage of a private den-

tist is approximately \$27,900 a year, compared with \$23,300 for the second- or third-year public dentist, although some private dentists earn more than \$100,000 a year. Starting salary for public dentist interns is approximately \$20,000 a year.

The wide differences in the fee schedules between private and public dentistry no longer exist. Each new increase in the national dental fee schedule is decided by the National Insurance Board, an arm of the government Health and Social Affairs Department. Within the National Insurance Board is an advisory council called the Dentistry Delegation. Delegation representatives come from the Swedish Dental Association, the National Board of Health and Welfare, the Federation of County Councils, the Swedish Dental Technicians' Association, and internal representation from the National Insurance Board (illustration).

PREVENTION: A PUBLIC COMMITMENT. Most Swedish government officials, politicians, and academics concerned with health care matters have