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Private Health Insurance in Sweden

Implications for the legitimacy of the public health care system

LINN KULLBERG

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Abstract
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The market for private health insurance (PHI) is growing in many countries with public, tax-funded health care systems. In Sweden, this development has generated an at times intense and polarised debate, exposing that the principles on which the public health care system rests in many aspects collide with the construction of PHI. Two dimensions have been suggested as being important for maintaining the legitimacy of public health care systems. The first is that citizens support the normative principles underpinning the system, including solidaristic funding through general taxation. With this comes the willingness of the population, and in particular the middle classes as net contributors, to pay tax to support the system. The second dimension is related to how the population perceives the performance of public services, as it has been suggested that public services need to be of sufficiently high quality for private alternative to be considered redundant. The growing market for PHI, where people can duplicate the public health care coverage with private health care services, raises concerns regarding the legitimacy of public health care. The aim of this thesis was, therefore, to investigate how PHI affects the legitimacy of the public health care system in Sweden. Three research questions were raised, addressing the prevalence and scope of PHI in Sweden, whether the experience of having PHI affects willingness to pay tax towards public health care, and satisfaction with public services. Four studies consisting of two quantitative cross-sectional studies and two qualitative interview-based studies were conducted to answer these questions. The results indicate that PHI in Sweden provides benefits foremost for the healthy and wealthy. The findings furthermore suggest that the first dimension of health care legitimacy (willingness to pay tax towards public health care) does not seem to be reduced by the experience of having PHI. Regarding the second dimension of legitimacy (satisfaction with the public services), the results are mixed. PHI-funded services were preferred over publicly funded services in terms of access and service quality within the primary care sector, while the medical quality of the public sector was considered high. In conclusion, the legitimacy of the public health care system in Sweden appears fairly resilient to the impact of PHI, although decreasing satisfaction might, in the long run, challenge the stability of the system.

Keywords: Private health insurance, Voluntary health insurance, Public health care, Sweden

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To family and friends

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I. Kullberg, L., Blomqvist, P. and Winblad, U. (2019), ‘Health insurance for the healthy? Voluntary health insurance in Sweden’, *Health Policy*, 123(8), pp. 737–746.*

II. Kullberg, L., Blomqvist, P. and Winblad, U. (2021), ‘Does voluntary health insurance reduce the use of and the willingness to finance public health care in Sweden?’, *Health Economics, Policy and Law*, 17(4), pp. 380–397.*

III. Kullberg, Kullberg, L., Blomqvist, P. and Winblad, U., ‘Why are private health insurance holders still willing to pay tax towards public health care? Evidence from Sweden’ (*Submitted)*.

IV. Kullberg, Kullberg, L., Blomqvist, P. and Winblad, U., ‘Navigating between the public and private in health care: The use of private health insurance in Sweden’ *(Manuscript)*.

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Abbreviations

PHI	Private health insurance
NHS	National Health Service
SHI	Social health insurance

Preface

I began my doctoral studies in Health Services Research with a Master's degree in Political Science oriented toward studies of the welfare state. Health Services Research is a multidisciplinary, applied research field, including disciplines as diverse as health economics, medicine, medical sociology, political science, public policy, and public health (Mullner, 2009: xxix). Within the broad field of Health Services Research, the organization, function, and performance of health care systems are studied at the micro, meso, and macro level. From a political science perspective, a typical research topic could be to investigate how a particular reform or change in policies transform the health care system at the macro level. Researchers approaching the field from other disciplines might focus on other aspects, such as cost-effectiveness or how the daily work in a clinic is affected.

The number of individuals with private health insurance (PHI) has been growing in Sweden, particularly among the middle classes – a development which intrigued me. With a background in political science and welfare studies, and located in the Health Services Research group, I was mainly interested in the effects of PHI on the Swedish health care system, which has historically been based mainly on public funding and provision of services. With this starting point, the Swedish public health care system is considered as an ideal type, characterized by its guiding principles and the formal legislation governing the system. Thus, the complexities and the deficiencies of the Swedish health care system are not the focus of this thesis.

In this thesis I have chosen to investigate how the growth of PHI affects the legitimacy of the public health care system. Choosing this theoretical starting point for a research project inevitably implies that other perspectives are excluded. The increase of PHI raises several interesting research questions, such as how a growing market for PHI affects the medical staff and their working conditions, or whether it has an impact on medical outcomes, to mention only two others. However, legitimacy can be considered the basis upon which any publicly funded system rests, and detrimental impacts on legitimacy can have far ranging consequences for all aspects of the health care system.

Introduction

> I had been depressed for a long time but put off seeking help. When I finally called the primary care centre, I was scheduled for an emergency appointment the following day. I was given antidepressant drugs and a referral for psychological treatment at any provider that accepted patients from public health care. I called all psychologists I could find online. Most of them did not accept new patients, and the ones that did had a minimum waiting time of three months. I remembered that I had a private health insurance through my employer. The day after contacting the insurance company I received the response: "We apologize, our earliest appointment with a psychologist is 3 days from today, is that OK?"

This story, narrated by a friend of mine, is not unique. During the last two decades, the number of individuals with a private health insurance (PHI) in Sweden has grown from 100,000 in 2000 to over 700,000 individuals in the end of 2021, corresponding to about 7 per cent of the population (Insurance Sweden, 2022a). However, PHI is not evenly distributed in the population; among the people employed within finance, law and economics, more than 30 per cent hold PHI (Palme, 2018). PHI in Sweden is mainly *duplicating*;[1] this type of insurance provides coverage for a selection of privately funded and provided health care services, in addition to the services included in the public health care system, to which all citizens and permanent residents have access. Thus, PHI holders have, for a selection of services, double coverage. PHI is attractive as it offers fast access to health care and a greater choice of clinics (Thomson *et al.*, 2020).

The growth of PHI in Sweden has generated a public debate that has been both intense and polarised. Advocates argue that PHI means that health care, on the whole, receives more resources, which is assumed to lead to shorter waiting times also within publicly funded health care. The opponents, on the other hand, emphasise that PHI leads to unequal health care, where the young and healthy are assumed to benefit at the expense of the old and sick. To understand why a growing market for PHI gives rise to such a debate, one must understand the principles underpinning the public health care system in Sweden and why the construction of PHI in many aspects collide with these.

[1] This type of PHI is sometimes referred to as 'supplementary PHI' (Mossialos and Thomson, 2002; Thomson and Mossialos, 2009; compare Sagan and Thomson, 2016). Wasem *et al.*, (2004) call this type of PHI 'complementary'.

The public health care system in Sweden is a comprehensive, tax-funded system of the same type as is found in the United Kingdom (UK) and the other Nordic countries. Such systems are financed by general taxation, with low patient fees. Entitlement is based on citizenship, which means that the system provides universal access to health care services to everyone. The government usually has a central role both in the regulation and provision of health care services, which traditionally have been publicly organised and provided (Saltman *et al.*, 1997). A distinguishing feature of tax-funded systems is an emphasis on equity. The overriding objective in these systems has been to offer comprehensive, high-quality health care on the basis of *medical need*, available to the entire population regardless of economic or social status (Anderson *et al.*, 2022; Webster, 2002).

The characteristics of tax-funded health care systems makes them distinct from the logic of PHI. First, in regard to *funding*, a tax-based system is funded by general taxation, while PHI is funded by individual or group-based premiums, where higher age implies a higher price of the premium. In addition, a more comprehensive set of services also implies higher premiums. Second, while the severity of *medical need* is the basis for prioritisation in tax-funded health care systems, with PHI, access to health care is first decided by the conditions in the insurance plans and then by the medical need. In addition, because pre-existing conditions – that is, medical problems that an insurance holder had before purchasing the insurance – are usually excluded from insurance plans, PHI for an individual with large care needs will be highly restricted. Taken together, these examples show that the logic of PHI in several aspects collide with the principles of the tax-funded health care system, particularly in regard to equity.

The legitimacy of public health care systems has been suggested to rests on two central dimensions: support for the normative principles underpinning the system, such as willingness to pay tax towards it, and satisfaction among the population with the performance of the system (Kohl and Wendt, 2004; Missinne *et al.*, 2013). With the growth in PHI, concerns regarding the legitimacy of public health care systems have been raised (Lapidus, 2015, 2022). If a growing proportion of the population gains access to PHI-funded health care, some have perceived a risk that the willingness to pay tax towards the public health care will decrease (Busemeyer and Iversen, 2020; Propper, 2000). With the possibility to choose PHI-funded health care services, there has also been concern that satisfaction with the public health care sector will decrease. However, the empirical research investigating such effects is still relatively limited, especially in countries with a tax-funded health care system, such as the Nordic countries.

Aim and research questions

This thesis investigates whether PHI in Sweden affects the legitimacy of the public health care system. Three specific research questions are addressed:

- What characterises holders of PHI in Sweden and what health care services are typically covered by the insurance plans?

- Does the experience of having PHI affect the willingness to pay tax towards public health care?

- Does the experience of having PHI affect satisfaction with the public health care system?

This thesis consists of four studies. Study I addresses the first research question. Studies II and III address the second question, and in Study IV the third question is addressed.

Before the methods and the findings of the four studies are presented, a background chapter presents the principles of tax-funded health care systems and two central dimensions of health care legitimacy. This is followed by a chapter on the setting for the studies: the health care system in Sweden. The four studies of the thesis are then briefly presented. In the last chapter, the discussion, principal findings and empirical contributions are discussed, followed by theoretical and policy implications, before we end with some methodological considerations and avenues for future studies. At the end of the thesis, a Swedish summary can be found.

Background

Tax-funded health care systems

In Europe, public health care systems are often described as belonging to one of two types: tax-funded health care systems, often referred to as National Health Service–type systems (NHS), or social health insurance–based systems (SHI) where health care is funded by different SHI funds (Böhm *et al.*, 2013). In SHI systems, which is common in continental Europe, governments usually play a more limited role as the provision of services is mainly private. The funding is predominantly based on compulsory-contributory insurance, collected through multiple sickness funds, together with tax financing, private voluntary health insurance and out-of-pocket payment (Immergut, 2021; Saltman *et al.*, 2004; Zee and Kroneman, 2007). Historically, SHI systems have not always been universal in the sense that the whole population has access to affordable health care, although during the last decades reforms have been implemented in many countries to reach universal coverage (Immergut, 2021; Saltman *et al.*, 2004). In contrast, tax-funded health care systems tend to be universal, as entitlement is based on citizenship (permanent residents are also often covered). Tax-funded systems differs from SHI systems in that funding is based on general taxation, and governments have a central role in regulating the system as well as in providing health services (Saltman *et al.*, 1997).

The archetype of the tax-funded health care system is the British NHS, which was launched in 1948. The system was designed to offer comprehensive health care to the entire population, where access was to be based on medical need rather than on ability to pay. It was funded by general taxation, and all services should be free at the point of use (Anderson *et al.*, 2022). The political ambition was to create an egalitarian model for health care provision for the entire population where second-class-type treatment would be eliminated, as the best standard treatments were universally extended to all British citizens (Webster, 2002).

Besides the UK, tax-funded health care systems are found in the southern parts of Europe, were the transition from former SHI-systems was initiated in the 1970s and 80s (Toth, 2010). The Mediterranean tax-based systems differ from the systems in the UK and the Nordic countries in that they have lower health care expenditures, a higher share of private hospital beds, less comprehensive public health care services and lower levels of satisfaction with the

health care system in general (Böhm *et al.*, 2013; Burlacu and Roescu, 2021). More similar to the British NHS are the health care systems found in the Nordic countries[2] (Saltman *et al.*, 2004). Although there are several differences among the Nordic countries in how their health care systems are organised, the similarities are still considerable, which makes it possible to talk about a Nordic model of health care (Immergut and Oskarson, 2021; Magnussen *et al.*, 2009). First, and in contrast to the British NHS, the Nordic health care systems are, to a varying decree, decentralised public governance structures, where all or parts of the health care system are governed by local municipalities, counties or regions. In addition, in Norway and Sweden, local politically governed authorities have the right to levy taxes to fund parts of the health care system. The Nordic systems are predominantly funded by income tax, with only a small share of out-of-pocket financing. Regarding the provision of health care services, hospitals are mainly publicly owned while primary care have a mixed ownership structure (Immergut and Oskarson, 2021; Magnussen *et al.*, 2009). In Denmark and Norway, small practitioner-led private primary care clinics are common, while larger publicly owned primary care centres dominate in Sweden (Schoyen, 2021; Vrangbæk, 2021).

Universalism in Nordic health care

The development and implementation of public, tax-funded health care systems in the Nordic countries has been seen as a part of the general welfare state expansion in the post-war area (Böhm *et al.*, 2013). The Nordic welfare state model, also referred to as the social democratic welfare model (Esping-Andersen, 1990), is characterised by a broad scope of social policies, universal social benefits, highly subsidised social services and a high share of public spending. It was created with the intention to 'promote an equality of the highest standards rather than an equality of minimal needs' (Magnussen *et al.*, 2009, p. 4). Comparing the Nordic welfare model with the British NHS, it has been argued that the understanding and meaning of universalism differ in the two settings. The British understanding of universalism refers to a principle of allocation: universal access to same services. In the Nordic context, the concept of universalism implies more than just a policy principle, it is part of a broader political strive to create egalitarian and social integrated societies (Anttonen and Sipilä, 2012). In this sense, universalism has been a leading ideology in the development of the Nordic welfare states (Anttonen, 2002).

Several attempts have been made to develop a definition of universalism that applies not only to social insurance programs but also to welfare *services*, such as health care (Anttonen, 2002; Blomqvist and Palme, 2015, 2020; Moberg, 2016). Drawing on the work of Blomqvist and Palme (2015), Moberg

[2] When discussing the Nordic countries, the following countries are referred to: Sweden, Denmark, Finland, Norway and Iceland, although Iceland is excluded in this description.

identified four dimensions in her definition of universal social services: (i) equal inclusion based on needs; (ii) public funding, potentially combined with subsidised and regulated user fees; (iii) public provision; and (iv) comprehensive usage, implying that a majority of the citizens use the public system rather than private markets (Moberg, 2016, p. 5). Related to the first dimension, inclusion is first of all based on citizenship. Second, in relation to health care, need refers to *medical* need and not economic need, as is the case in more targeted welfare models (Blomqvist and Palme, 2020). The third dimension, public provision of social services, is related to the idea that such an organisation would ensure more uniform services, with the same content for all users (Blomqvist, 2004; Blomqvist and Palme, 2020). The fourth dimension of universalism relates to the adequacy and quality of the provided services. The idea here is that, for the system to be considered universal, the services provided through the public sector should be used by a great majority of the population (Anttonen, 2002).

Universalism in the Swedish health care system

The idea that at least the vast majority of citizens should use welfare services provided by the public system, rather than services provided through the market, has been emphasised when describing the development of the universal welfare model in Sweden (Blomqvist, 2004). It has been suggested that the designing of a universal welfare state, rather than one targeting the poor, was a politically strategic choice by the Social Democratic Party to ensure broad public support for the system (Rothstein, 1994; Svensson, 1994). To achieve this, the provided services should be of such high quality that the middle classes, with the means to turn to alternatives within the private sector, would also remain in the publicly funded system (Rothstein, 1994). The inclusion of the middle classes in the welfare system has been considered particularly important for maintaining broad public support for the system, particularly because this group tends to be net contributors to the system (Jordan, 2010; Rothstein, 2001). The idea was that by ensuring public services of high quality, the better off would not only use the public services, they would also be willing to fund them through their taxes (Esping-Andersen, 1990; Rothstein, 1994, 2001).

Social equity is a central political value in the Swedish health care system. This is evident not least in the prominent place it is given in the main legislation; the Swedish Health and Medical Service Act (SFS 2017:30). It states: ‘the goal of all health care services is good health and health care *on equal terms* for the entire population’, that ‘the person with the greatest need for health care shall be given priority’; ‘on equal terms’ is usually interpreted to mean that people in the same need of health care should have same access to health care, regardless of their residence, gender, age or social status. This principle is also referred to as horizontal equity (Fredriksson, 2012).

PHI in a tax-funded system

PHI is often distinguished from public health care systems, either tax-funded or SHI systems, by its funding and voluntary nature (OECD, 2004; Thomson and Mossialos, 2009). It is paid for privately, either by the individual or by employers on behalf of individuals. In contrast to SHI, PHI is based on risk-related premiums and is not income-related (Mossialos and Thomson, 2002; OECD, 2004; Wasem *et al.*, 2004). With the exception of the Netherlands, Switzerland and Ireland, PHI plays a modest role in Europe alongside the public health care systems, which cover most of the population (OECD, 2022; Sagan and Thomson, 2016).

PHI is often categorised into different types, based on the role played in the country's overall health care system. In tax-funded systems, characterised by a comprehensive set of services (i.e., NHS-type systems), *duplicating* PHI is the most common type, although *complementary* PHI also exists.

Duplicating PHI provides coverage for services already included in the tax-funded health care system, thus duplicating the individuals' coverage. It is attractive, as it offers fast access to care and enhanced choice of clinics. The market is usually limited, ranging between 5 per cent and 30 per cent in European tax-funded systems, with Ireland as an exception, where 46 per cent of the population holds duplicating PHI (Cavazza *et al.*, 2023; OECD, 2021). In Australia, a country with a universal publicly funded comprehensive health care system, a considerable share of the population – almost 50 per cent – hold access to PHI. Compared to the Nordic countries, in Australia, the scope of PHI-funded health care is much broader and also extends to hospital care and advanced treatment, which is not always covered in, for instance, Finland and Sweden (Blomgren and Virta, 2020; Hall *et al.*, 2020; SAHCSA, 2020).

Complementary PHI provides coverage for high user charges or for services excluded from the statutory system, typically dental and vision services, physiotherapy and alternative medicine. This type of insurance exists in Denmark, Finland and the UK, although it is more common in countries with traditional SHI systems (Alexandersen *et al.*, 2016; Sagan and Thomson, 2016).

PHI can either be purchased by individuals or through groups, usually employment-based groups. Group-based insurance is more common, especially in the UK and Nordic countries. In the UK, 75 per cent of PHI holders have group-based insurance (Sagan and Thomson, 2016); in Sweden and Norway, the corresponding numbers are about 90 per cent (Insurance Sweden, 2022a; Tynkkynen *et al.*, 2018). Group-based insurance is usually paid by the employer as a fringe benefit. Other group-based plans are purchased by the individual through an organisation, typically a trade union.

The market for PHI seems to grow out of a gap in the public health care systems. This means that the history and organisation of the public health care systems might, in different ways, influence the extent and role of the evolving

PHI markets (Sagan and Thomson, 2016). Several studies have found an association between low perceived quality in the tax-funded system in Spain and Italy and uptake of PHI (Costa and García, 2003; Costa-Font and Jofre-Bonet, 2006, 2008; Meleddu *et al.*, 2020). Long waiting times in the tax-funded system are commonly suggested motives for purchasing PHI in several countries (Aarbu, 2010; Besley *et al.*, 1999; Higgins and Wiles, 1992; Pianori *et al.*, 2020; Tynkkynen *et al.*, 2018). In the Nordic context, it has been suggested that the increase of PHI is a response to real and perceived gaps and inflexibilities in the public system. However, as the market has been more established, holding PHI has become almost a part of the culture in some socioeconomic groups (Blomgren and Virta, 2020; Tynkkynen *et al.*, 2018).

In several countries, for instance in Denmark, Norway, Italy and Australia, different governmental initiatives have been taken to increase the uptake of PHI (Landon *et al.*, 2021; Marenzi *et al.*, 2021; Sowa *et al.*, 2018; Tynkkynen *et al.*, 2018). Nevertheless, increasing evidence of the inefficiency and inequity of tax incentives has led to a trend where more and more countries have questioned or even abolished tax incentives that are subsidising PHI purchases (Cheng, 2014; Emmerson *et al.*, 2001; Landon *et al.*, 2021; Sagan and Thomson, 2016; Turner, 2015). In Irland, the susbidies were questioned due to their negative effects on equity, as not all segments of the population have access to PHI-funded health care (Turner, 2015). Several studies have shown that acces to insurance is unevenly distributed among the population; in general, PHI holders have higher incomes and higher educational levels compared to the population in general (Artabe and Sigüenza, 2018; Blomgren and Virta, 2020; Kiil, 2012; Martinussen and Magnussen, 2019; Meleddu *et al.*, 2020; Pianori *et al.*, 2020).

Legitimacy of public health care systems

It has been suggested that the popular legitimacy of public health care systems rests on two central dimensions: support for the normative principles underpinning the system and satisfaction among the population with the performance of the system (Kohl and Wendt, 2004; Missinne *et al.*, 2013).

Regarding the first dimension, normative support, two guiding principles can be identified in European health care systems: First, the belief that an extensive public responsibility for health care is desirable (Missinne *et al.*, 2013), and second, the idea that health care should be publicly funded. This idea has long provided an ideological rationale for the transfer of financial contributions from working individuals, either through taxation or compulsory SHI schemes, to those with less means, to provide access to health care for all (Ter Meulen and Jotterand, 2008). When investigating this dimension of normative support empirically, survey data capturing attitudes towards *public spending on health care*, or *willingness to pay tax towards public health care*

have been used (see, for instance, Azar *et al*., 2018; Lee and Park, 2015; Maldonado *et al*., 2019).

The second dimension, related to the performance of the health care system, depends on the experience of those receiving health services, and is often measured through questions about *satisfaction with health care services* (Asensio, 2021; Kohl and Wendt, 2004; Missinne *et al.*, 2013).

Kohl and Wendt suggest that the legitimacy of a health care system will be most stable when both dimensions receive high support – that is, when the population have both a high level of support for the guiding principles of public health care systems and a high level of satisfaction with the provided services. However, they also propose that high levels of satisfaction with services could compensate for lower levels of support for the guiding principles, and vice versa (Kohl and Wendt, 2004). The benefit of separating these two dimensions of legitimacy when studying support for public health care has also been highlighted by other researchers, who argue that it is possible to endorse the value-based principles of public health care while at the same time criticising the performance of the system (Burlacu and Roescu, 2021; Roosma *et al.*, 2014).

Empirical studies investigating health care legitimacy

The concept of legitimacy, as described here, is closely connected to the empirical literature investigating public opinion and attitudes towards the welfare state in general. In the literature focusing on public opinion regarding public health care systems, two central strands can be discerned, which correspond to the two dimensions of health care legitimacy described above (Burlacu and Roescu, 2021). Studies on the legitimacy of public health care systems are often comparative and based on international survey data, such as the International Social Survey Program (ISSP) and the European Social Survey (ESS). An overall aim in many studies has been to investigate determinants for public support for health care by focusing on both individual and institutional factors.

Within the literature relating to the first dimension of health care legitimacy, one question often asked is whether individuals are willing to pay tax towards the public health care system and what determines that willingness. At the individual level, socioeconomic factors such as age, income, educational level and expected health care needs have been found to determine willingness to pay tax towards public health care (Azar *et al.*, 2018; Barnes *et al.*, 2021; Nazim Habibov *et al.*, 2018). In addition to socioeconomic factors, ideology and values have also been found to influence the willingness to pay tax; individuals with egalitarian values or who are politically oriented towards the left tend to be more willing to pay tax (Azar *et al.*, 2018; Nazim Habibov *et al.*, 2018). Perceptions about the quality of the public system have also been found to affect willingness to pay tax towards public health care (Nazim Habibov *et al.*, 2019).

Satisfaction with health care systems has been found to correlate with socioeconomic factors. Being female, having low income, low health status or low satisfaction with doctor's treatment often correlate with lower satisfaction (Burlacu and Roescu, 2021; Footman *et al.*, 2013; Wendt *et al.*, 2010; Yuan, 2021). It has also been found, however, that the impact of factors such as age and education on satisfaction tend to vary by country (Footman *et al.*, 2013; Wendt *et al.*, 2010; Yuan, 2021).

Does PHI affect the legitimacy of public health care systems?

The impact of PHI has rarely been investigated in studies on the legitimacy of public health care systems. However, some studies have discussed, at least on a theoretical level, the potential effects of a growing market for PHI on the support for public health care systems. Writing in a British context, Carol Propper argues that an increase in PHI might lead to a decrease in willingness to pay tax towards the public health care system: If tax-payers with PHI became less willing to pay tax towards the public system, this would undermine the funding of the public system and, in the long-run, lead to a situation where the quality of the public system deteriorates such that it would become a 'poor services for the poor' (Propper, 2000, p. 856). Busemeyer and Iversen argue that the availability of private alternatives, such as PHI, would undermine support for universalistic public systems, because the chance to purchase PHI beside the public health care system could create a division in preferences over taxation and public spending based on class. Those who can afford PHI might then be less inclined to support public spending, because this would imply an element of redistribution and, in the case of duplicating PHI, a double payment (Busemeyer and Iversen, 2020). In a recent work about the development of PHI in Sweden, Lapidus (2022) argues that the growth in PHI undermines the universality of the Swedish health care system, as PHI and the public, tax-funded, health care system build on essentially different logics. However, the empirical evidence in these studies has been weak, and they have mainly built their argument on theoretical reasoning.

The literature on the effects of PHI on willingness to pay tax in support of public health care systems is scarce and inconclusive. One study, conducted in the UK, found a lower willingness to pay tax towards public health care among PHI holders (Hall and Preston, 1998), while another study found no difference in willingness to pay tax between PHI holders and non-holders (Burchardt and Propper, 1999). More recently, a Norwegian study found no difference between people with and without PHI regarding support for the idea that the provision of health care is mainly a public responsibility (Martinussen and Magnussen, 2019).

Several studies have found an association between having PHI and low levels of satisfaction with the performance of the public health care system (Besley *et al.*, 1999; Costa-Font and Jofre-Bonet, 2006, 2008; Meleddu *et al.*,

2020; Pianori *et al.*, 2020). Most of these studies were based on cross-sectional data, which makes it difficult to assess the causal direction of the association – in other words, whether low levels of satisfaction cause people to take up PHI, or whether the experience of using PHI-funded health care enables a comparison in which the public system appears worse than the private alternative. However, a few qualitative studies have suggested that the experience of PHI-funded health care – and the opportunity to compare publicly and PHI-funded health care – might generate more negative perceptions about the publicly funded system (Bishop *et al.*, 2011; Meyer, 2015; Sointu *et al.*, 2021; Ward *et al.*, 2015)

Taken together, to uphold the popular legitimacy of public health care systems, two central dimensions have been considered important: a broad public support for the normative principles guiding the public systems, in particular support for public funding and willingness to pay tax in support of the system; and that the population find the provided health care services satisfactory. As noted above, it has been suggested that the adequacy and quality of welfare services are important for maintaining the universality of a welfare system like the one in Sweden. The idea was that, by providing public welfare services of high quality, the welfare state would also gain the support of the middle classes, who would otherwise be inclined to turn to the private market for such services (Esping-Andersen, 1990; Rothstein, 1994, 2001). Three central ideas can be observed here; first, that the middle classes hold a central position; second, that private alternatives are seen as a threat; and third, that the citizens' satisfaction with publicly funded services is important.

From this perspective, a growing market for PHI can be expected to undermine the legitimacy of the public health care system in several ways. First, if PHI covers the same services as are provided through the public system, this implies a form of 'double payment' for PHI holders, which could lead to a decline in willingness to pay tax towards the public system. Second, access to PHI-funded health services in addition to the public system might challenge the legitimacy of the public system if it also leads to declining satisfaction with the publicly funded services. As we have seen, however, empirical research investigating the influence of PHI on the legitimacy of public health care systems is still limited, especially in the Nordic countries. Thus, the aim with this dissertation has been to contribute to this field by investigating how the growing PHI market in Sweden affects the popular legitimacy of the public health care system.

Setting: Sweden

The Swedish health care system

Sweden has a health care system of the NHS type; it is universal as it provides all citizens and permanent residents with equal access, regardless of employment or ability to pay, to a broad range of health care services at relatively low patient fees (Blomqvist and Winblad, 2021). The main governing legislation, the Health and Medical Service Act (SFS, 2017:30), states that health care services should be distributed on equal terms for all citizen on the basis of medical need, where higher needs are prioritised.

In contrast to the British NHS system, Sweden has a decentralised system in which 21 local authorities, called Regions, are responsible for provision and most of the funding The system is mainly financed by regional income taxation, where the Regions are free to set their own tax rates, which ranges between 10.7 per cent and 12 per cent. The Regions also receive national grants, which constitute about 15 per cent of the total health care budget (Blomqvist and Winblad, 2021). User fees consist of co-payments for visits and hospital stays; these fees are decided by the regions. For a primary care visit, patients should pay between 150 to 300 SEK, with a maximum of 1,200 SEK per year per patent, and a specialist care visit should amount to 200 to 400 SEK. For inpatient care, patients pay 110 SEK a day (SALAR, 2022).

The universal and tax-funded character of the system implies that it is not possible to opt out of the system to choose a private track. Most hospitals and outpatient specialist care units are publicly owned and managed by the Regions. However, the Regions can decide to contract private specialist providers for outpatient specialist care. In 2018, about 20 per cent of all publicly funded visits to outpatient specialist care were done at privately operated clinics. Within the primary care sector, the share of publicly funded but privately operated clinics is larger – about 40 per cent (Blomqvist and Winblad, 2021). However, the share of privately operated clinic varies greatly by region, where the capital Region of Stockholm holds the largest share of both privately operated primary care clinics and specialist outpatient clinics (Isaksson *et al.*, 2016). Publicly operated clinics are not allowed to receive (Swedish) privately funded patients, while contracted private clinics can receive both publicly funded patients and patients funded by PHI or privately out of pocket (Blomqvist and Winblad, 2021).

In international comparisons, Sweden is often top-ranked in medical quality. However, on information and patient involvement, Sweden ranks lower, and long waiting times are another long-lasting challenge (Blomqvist and Winblad, 2021).

PHI in Sweden

An important change in the Swedish health care system is the growth of PHI, which has lately caused a rather intense political debate. The PHI market has grown considerably during the last two decades. In 2001, about 100,000 individuals held insurance, while in late 2021 the number had risen to 720,000 persons. Swedish PHI is duplicating, as PHI mainly covers services also provided by the publicly funded health care system. About 60 per cent of the PHI holders receive their insurance as a fringe benefit from their employer, while 30 per cent purchase it as a group-based insurance, often offered through membership in a union, and 10 per cent purchase it individually. In total, about 14 per cent of the working population, aged between 16 and 74, holds PHI (Insurance Sweden, 2022a).

While quite a large share of the population has access to PHI, the funding only makes up to less than one per cent of the total health care expenditure in Sweden (Almega, 2020). Although the plans cover services from GP visits to less severe cancer treatments, rehabilitation or sessions with a psychologist, the insurance is typically used for outpatient specialist care, such as orthopaedics, dermatology and physiotherapy. Acute medicine and intensive care, fertility and reproductive health and highly specialised health care are not covered by PHI, nor are pre-existing conditions (Insurance Sweden, 2022b).

Whether all employees or only a few are offered employer-funded PHI varies by company. In 2018, after an initiative from the Social Democratic government, a tax was imposed on employees for this fringe benefit. This was a tax of approximately 60 per cent of the value of the premium, which might vary by the scope and benefits included, as well as the age of the insured (SOU 2021:80). The premiums for employer funded PHI are usually set in negotiation between the insurance company and the employer and are also dependent on whether the plans include a deductible or not. About 85 per cent of all plans include a deductible for the insured to pay when using the insurance. Nevertheless, as an indicator of the price, individual PHI is found to cost approximately €200–€600 per year (SAHCSA, 2020).

PHI is more common among men, but the gender differences are, to a large part, explained by occupation, as employer-funded PHI is more common in male-dominated industries. Almost one in three persons employed within finance, law or economic and management consulting receive PHI from their employer. In IT, media and PR, the share is about 18 per cent, followed by construction, real-estate and architecture, where about 10 per cent hold employer-funded PHI, while people employed within the public sector, such as

health care and education, are under-represented. Most PHI holders are found in the metropolitan areas of Stockholm and Gothenburg. In general, employer-funded PHI holders have been found to have higher levels of education and income, are healthier and receive welfare benefits to a lesser extent (Palme, 2018).

The political debate regarding PHI in Sweden

Over the last couple of years PHI has been a highly topical issue in the Swedish political debate. Following prominent reporting in the news media in 2019, the question of whether PHI-funded patients "crowd out" publicly funded patients with greater medical needs became a highly debated issue, and the government at the time (led by the Social Democratic party) appointed several public investigations. In August 2020, an inquiry chair was appointed to lead a government inquiry with the title; 'Limitation of private health insurance influence on publicly funded health care' (Dir 2020:83). One year later, the inquiry chair delivered a 600-page report (SOU 2021:80) to the Government. The report recommended, inter alia, increased public control over private PHI-funded providers who are also contracted by the regional authorities to provide publicly funded health care, and that information about sources of funding should be reported into the National Patient Register (*Patientregistret*). In accordance with the legislative process in Sweden, the report (SOU 2021:80) proceeded a Governmental bill to alter legislation in order to strengthen public authorities' ability to audit private health care providers contracted by the Regions (Prop 2021/22:260).

However, the report (SOU 2021:80) had been criticized for not being far-reaching enough in its ambition to limit PHI in Sweden. In February 2022, the Government appointed an additional inquiry, whose report was presented in July 2022 (Ds 2022:15). The proposals in this report were more far-reaching compared with the previous report (SOU 2021:80), suggesting that private providers contracted by the Regions should be prohibited from also receiving PHI-funded patients, and that publicly funded providers should be disallowed from receiving patients via referral from a PHI-funded clinic. However, before the consultative procedure was finished an election took place in Sweden, resulting in a change of government to a conservative coalition which has not, so far, taken up the proposals in the report (Ds 2022:15). Thus, how the regulation of PHI in Sweden will develop remains an open question.

Methods and Findings

This thesis is based on four studies, all of which investigates PHI in Sweden. The first research question of the thesis – *What characterises holders of PHI in Sweden and what health care services are typically covered by the insurance plans?* – is considered in Study I. In Studies II and III, the second research question is addressed: *Does the experience of having PHI affect the willingness to pay tax towards public health care?* The third research question – *Does the experience of having PHI affect the satisfaction with the public health care system?* – is addressed in Study IV.

Study I is a mixed-method study where both qualitative data about the content of the insurance plans and quantitative cross-sectional data from the Swedish national SOM-survey 2016, were used. The SOM-data was also used in Study II. To gain a deeper understanding of PHI holders' motives for paying tax towards public health care, semi-structured interviews were used in Study III. Semi-structured interviews enabled a deeper understanding of how the experience of using PHI-funded and publicly funded health care affected the respondents' perception of and satisfaction with the services, which also provided an answer to the third research question. Taken together, these studies contribute to meeting the aims of this study, which was to investigate whether PHI in Sweden affects the legitimacy of the public health care system.

Table 1. Overview of design, sample and analysis of the studies

Study	Design	Participants	Data	Data analysis
I	Mixed-method	1,636 individuals Aged 16–84	Survey-data from Riks-SOM 2016, part IV, Document study	Descriptive statistical analysis; binary logistic regression; content analysis
II	Quantitative, Cross-sectional	1.636 individuals Aged 16–84	Survey-data from Riks-SOM 2016, part IV	Linear regression analyses; multinomial logistic regressions
III	Qualitative, Explanatory	20 employer-funded PHI holders	Interview data	Inductive/deductive thematic analysis
IV	Qualitative, Descriptive/ Explanatory	19 employer-funded PHI holders in Stockholm	Interview data	Inductive thematic analysis

Study I: Health insurance for the healthy? Voluntary health insurance in Sweden

PHI is a growing but rather new phenomenon in Sweden. Since 2000, the number of insurance holders has increased by about 500 per cent. However, surprisingly little is still known about who purchases this additional insurance and what the insurance plans contain. Thus, the aim of this study was to provide a comprehensive description of the coverage and content of PHI in Sweden. Two research questions were asked: (i) Who purchases voluntary health insurance in Sweden? (ii) What benefits are provided through standard insurance plans?

Methods

To answer the first research question and examine what characterises holders of PHI in Sweden, cross-sectional data from a national survey, Riks-SOM 2016 part IV, were used. Riks-SOM is an annual survey conducted by the University of Gothenburg, and 2016 was the first wave to include questions about PHI. The survey was sent to 3,400 individuals, constituting a representative sample of the Swedish population between the ages of 16 and 84 years. The survey achieved a response rate of 51per cent, corresponding to 1,636 respondents.

To measure the number of individuals holding PHI, the question: 'Do you have PHI?' was included in the survey. The respondents could choose one of the following responses; 'yes', 'no' and 'do not know'. 'Do not know' was omitted in the analysis, giving a binary outcome. To examine possible determinants of PHI uptake, several demographic and socioeconomic variables from the SOM-survey were included: gender, age, educational level, area of residence, occupation, employment sector, household income and political orientation.

To analyse the data, cross tables with chi-squared test were used to estimate the share of insurance holders for each demographic and socioeconomic variable. In addition, binary logistic regression analyses were carried out to examine the characteristics of greater importance for the likelihood of having PHI.

The second research question was approached through content analysis of insurance companies in Sweden. Product information and insurance terms from seven of the largest insurance companies in Sweden were analysed. The following large companies were selected: Folksam, Länsförsäkringar, TryggHansa, Skandia, If, EuroAccident and SEB. Each company offered between three and eight different plans, directed both to individuals and companies purchasing insurance on behalf of their employees. The material was analysed and categorised to identify the scope and content of the insurance plan (i.e., the benefits included), the requirements for subscription and the price.

Findings

Regarding the first research question, the results from the survey showed that 15 per cent (confidence interval 13%–17%) of the population between the ages of 16 and 84 years held PHI at the end of 2016/beginning of 2017. The analysis indicated that PHI was more common among men, middle-aged people (between 30 and 64), people with higher education, white-collar workers and business owners working in the private sector, people with a family income above €73,000/year and people politically oriented towards the right. However, when taking all of the variables into account, work-related factors such as occupation, employer and income were found to be important determinants of PHI uptake.

Regarding the second research question, the analysis showed that all of the companies offered plans at different levels of comprehensiveness. Prices varied depending on the comprehensiveness of the plans and the age of the insured. All plans included medical care and access to a care coordinator. Medical care implied specialist and general practitioner services, medical surgery and hospital care. The care coordinator helped the insurance holder with booking appointments at suitable care providers. However, all plans excluded pre-existing conditions, emergency medicine and highly specialist care. Beside these restrictions, some insurance companies also excluded injuries related to extreme sports, treatment for chronic conditions and treatment related to fertility and pregnancy. To be able to subscribe, the candidate needed to be 'fully fit for work', or to fill out a health declaration.

In sum, the results showed that primarily better-off groups such as white-collar workers with high salaries obtain such insurance. Thus, work-related factors seem to strongly determine who had PHI. The benefits provided through such insurance plans was primarily aimed at providing access to private care providers, reducing waiting times and providing care coordination services.

Study II: Private health insurance and the effects on the public health care sector: Evidence from Sweden

The growth of PHI in public health care systems has generated debate on the effects on these systems. Two perspectives on the issue are dominant in the scholarly, as well as the political, debate. Critics highlight the risk that PHI can undermine the legitimacy of public health care, while proponents suggest that increased private funding could reduce the burden on the strained public health care sector. However, the empirical evidence is limited. The aim of this study was, therefore, to investigate how PHI affects the public health care sec-

tor. Two research questions were asked: (i) Is there empirical evidence to support the claim that PHI reduces support for public health care? (ii) Does PHI reduce the burden on the public health care sector?

Methods

This study was also based on data from the SOM-survey 2016, part IV. Two outcome measures were used for the first research question – 'do PHI holders have lower support for the public health care sector?': 'willingness to pay health care tax' and 'attitudes to a tax reduction for private health insurance use'. Both variables were measured on a Likert-scale with five options.

The outcome for the second research question – 'does PHI reduce the burden on the public health care sector?' – was 'public health care use', which was measured by the survey question 'How many times in the past 12 months have you sought medical care for your own part – through publicly funded care?' This could be answered with the following options: never, one to three times or four times or more.

PHI, measured in the same way as in Study I, was used as the main explanatory variable in both questions. A number of control variables were included in the analysis to control for potential confounders. For the analysis of the first research question, gender, age, self-assessed health, political orientation and trust in the health care systems were included as control variables. In the analysis of the second research question, gender, age, self-assessed health and use of private health care were included to control for morbidity/care needs.

Linear regression analyses and multinomial logistic regression analyses were carried out to estimate whether there were any differences between insurance holders and non-holders with regard to the different outcomes.

Findings

Taking all of the control variables into account, no association was found between PHI and willingness to pay health care tax. The results suggest that PHI does not affect willingness to pay tax towards health care. Political orientation stood out as a significant confounder in the analyses. For the second outcome of public health care support – 'attitudes to a tax reduction for PHI use', a statistically significant association was found. The association remained when all of the control variables were added. This result suggests that PHI holders are more positive towards a tax reduction than the general population.

The results of the second research question – 'does PHI reduce the burden on the public health care sector?' – suggest that PHI has a limited relieving effect on public health care use. Insurance holders were more likely to never have visited the public health care the preceding year than non-holders. However, for a large part of the users – those using health care between one to three times a year – no difference was found.

Taken together, the findings suggest that willingness to pay tax towards public health care, on the whole, remains despite PHI holding status. Thus, in this regard, PHI does not seem to reduce support for public health care. In addition, the findings point to a limited level of relief for the public health care system, as PHI holders seem to use public health care to a lower extent than non-holders.

Study III: Why are private health insurance holders still willing to pay tax towards public health care? Evidence from Sweden

The results in the second study suggested that the willingness to pay tax towards public health care is fairly resilient to the impact of PHI in Sweden. This raises new questions of why the tax willingness seems to be unaffected: what motivates this sustained support? Thus, the aim of this study was to investigate whether having PHI affects willingness to pay tax to the public health care system and, if not, what motivates this continued willingness.

Methods

To enable a deeper understanding of the motives for supporting and funding public health care, a qualitative approach with semi-structured interviews was undertaken in this study (DiCicco-Bloom and Crabtree, 2006; Patton, 2015). People with employer-funded PHI have usually not made an active decision to purchase PHI; rather, this benefit is something that they just received. To investigate how the growing market for PHI affects the legitimacy of the public health care system (measured as willingness to pay tax in support of the system), this group of insurance holders are particularly interesting. A purposeful, homogeneous sampling of respondents was applied, where we aimed to reach a ‘typical PHI holder’ (Patton, 2002) – that is white-collar workers with employer-funded PHI, working in finance, consulting, tech or IT. Because both the majority of PHI holders and private health care clinics are found in Stockholm, only respondents who lived or worked in the capital area were recruited. To be included in the study, the respondents should have used their PHI as well as publicly funded health care to be able to compare experiences. There is no public register for PHI holders or companies offering PHI to their employees in Sweden; we therefore used personal contacts to recruit suitable participants.

The interviews were conducted between February and October 2022 using the Zoom video meeting software. The interviews lasted between 26 and 83 minutes. Audio files from the video-meetings were saved and transcribed verbatim. All of the interviews were conducted in Swedish, selected quotations

were later translated into English. The respondents were highly educated; all but one had a university degree, many in civic engineering or economics. Among the respondents there were 12 men and 8 women, with an age range between 33 and 59, and a mean age of 45 years.

The included questions covered topics about attitudes towards the publicly funded health care system and willingness to pay tax towards public health care, as well as whether these changed after they received their PHI. In case of a maintained tax willingness, questions about their motives for paying tax were asked.

To analyse the material, a thematic analysis guided by Braun and Clarke (2006, 2013) was undertaken. The material was inductively coded, and the codes were sorted into themes. In addition to this inductive process, the developed themes were, later reviewed to investigate whether three theoretically identified motives for paying tax – self-interest, solidarity and egalitarian values – could be considered applicable for this material. NVivo 1.5 software facilitated the analysis.

Findings

The results indicated that the experience of having PHI did not affect insurance holders' willingness to pay tax to the public system, although, in line with the results in Study II, a few respondents expressed support for the idea of a tax reduction or for a removal of the newly imposed tax on PHI as a fringe benefit. Six themes representing their motives for paying tax to public health care were developed through the analysis*: Publicly funded health care is very important*; *the value of equality in access to health care*; *to support family and friends without PHI*; *one may still be forced to rely on the public system in the end*; *personal experience increased support for public health care* and *ambiguity.* Their motives for continuing to pay tax towards the public health care system were based on both self-interest and solidarity, although egalitarian values stood out as the most important motive. It is noticeable that most of the respondents spontaneously emphasised the importance of equal access to health care as a central motive for tax compliance.

Study IV: Navigating between the public and private in health care: The use of private health insurance in Sweden

To maintain the legitimacy of the public health care system, citizen satisfaction with the provided services is important. With the possibility to compare experiences from PHI-funded services with those from publicly funded health care services, satisfaction with the public system might decline. Thus, the aim

of this study was to investigate whether the experience of having and using PHI affected the satisfaction with the public health care system. Specifically, three research question were asked: (i) When do PHI holders choose to use PHI-funded health care services and when do they rely on the public system? (ii) How does the experience of using PHI-funded health care services affect PHI holders' satisfaction with publicly funded health care? (iii) Would employer-funded PHI holders be willing to purchase PHI privately?

Methods

This study was based on the same empirical material as Study III. However, during the analysis, it was found that one of the participants was living and working outside of Stockholm. Thus, this interview was removed, so the total number of interviews included in this study was 19. To compare the experience of publicly funded and PHI-funded health care, an important criterion for inclusion was that the respondents should have had experience of both publicly funded and PHI-funded health care. The material was analysed inductively through thematic analysis (Braun and Clarke, 2006, 2013). NVivo 1.5 software facilitated the analysis.

Findings

The results suggested that the health care services accessed through PHI were preferred over publicly funded health care services in most cases. The primary reasons for choosing PHI-funded health services were faster access and convenient booking procedures. Three main themes that reflected the respondents' experience of using PHI-funded and publicly funded health care were developed; *access*, *service quality* and *medical quality.* Both access and service quality were considered much better in the PHI-funded sector. The respondents perceived it to be easier and quicker to access a PHI-funded clinic, and they also expressed that their medical needs were taken more seriously when visiting a PHI-funded provider. However, regarding medical quality, the publicly funded sector was perceived to perform well, particularly in specialised care and advanced medicine. Most of the respondents said that their satisfaction with the publicly funded health care system probably had been negatively affected by their PHI experience, although only a few would have considered purchasing the insurance privately if it were not provided to them by their employer.

Ethical considerations

Ethical approval was granted for the SOM-survey 2016 by the Swedish Regional Ethical Review Board of Gothenburg in 2015 (Dnr: 130-15), which

were applicable for Studies I and II in this thesis. Ethical approval for studies III and IV was granted by the National Board of Ethical Review (Dnr: 2020-01982). The data has been stored on protected servers at Uppsala University, which are specifically configured for safekeeping research data and are only accessible to the researchers.

Questions about health care use and attitudes towards the health care systems are considered sensitive as they relate to both personal health and politically oriented issues.

In order to minimize the risk of discomfort, participants in studies III and IV, which were based on interview data, were given clear information about the aim and conduct of the study before recruitment. They were also informed about data collection and management procedures, that the results would be reported in such a way that they could not be identified, and that participation was completely voluntary and could be withdrawn at any time without providing a reason. This information was repeated verbally to all respondents at the time of the interview and all participants provided written informed consent.

The interviews were conducted using the video meeting program Zoom, which might have made the respondents feel safer and freer to talk openly about their experiences and perceptions, since they could do the interviews in their home environment. To ensure that the conversation could be carried out undisturbed, the interviewer used headphones and sat in an unoccupied room. Most of the respondents conducted the interviews during work-hours but from their home. In most cases they sat undisturbed, but it cannot be ruled out that there were people in their homes who may have influenced how they chose to answer the questions.

Recruitment took place both via advertisement in social media, but mainly via contacts, with most respondents recruited via acquaintances and work colleagues. Many indicated that they found the topic interesting and that they therefore wanted to participate. Some said they, by their experience, fulfilled the recruitment description and that they were happy to contribute to research.

The respondents were generally highly educated and qualified, and often held managerial positions.

As the questions can be considered sensitive, the interview guide was carefully designed before being tested in pilot interviews. The interview guide was also reviewed and approved by the National Board of Ethical Review. In order to underline the voluntary nature of participation, open questions were asked where the respondents themselves could choose what and how much they wanted to share, both regarding experiences from health care visits but also about political questions regarding views on taxes and the public health care system.

Discussion

Principal findings and empirical contributions

This thesis aimed to investigate whether PHI in Sweden affects the legitimacy of the public health care system. To do so, three specific questions were raised, which were considered in four different papers. In this section, the principal findings and the empirical contributions of the work are presented.

What characterises holders of PHI in Sweden and what health care services are typically covered by the insurance plans?

This research question was investigated in the first of the four thesis papers. The findings suggest that the distribution of PHI in Sweden is closely connected to work-related factors. Holding PHI was more common among business owners and white-collar workers, while blue-collar workers and people employed in the public sector were less likely to have PHI. Income was also higher among PHI holders compared to the population in general. PHI holders had higher levels of self-rated health, and it was more common to sympathise with political parties oriented towards the right on a left–right scale. The results corresponded with those of previous research from other European countries, where PHI holders were found to have higher income, higher levels of education (Besley *et al.*, 1996, 1998; Christensen and Søgaard, 2013; Costa-Font and Jofre-Bonet, 2008; Pianori *et al.*, 2020), and political sympathies with right-oriented parties (Besley *et al.*, 1996, 1998; King and Mossialos, 2005).

Regarding the scope and content of insurance in Sweden, there was variation between different insurance companies and different types of plans regarding the scope of the included benefits. However, all of the plans included access to a care-coordinator, to open specialist care and elective surgery and hospital stays for some types of treatments. Physiotherapy and sessions with a psychologist were other commonly included benefits. Premiums varied according to policy holder age and the scope of the plans, as well as whether the insurance was purchased individually or collectively as an employment benefit. Some services were not covered by the PHI, such as acute conditions, ongoing chronic care and dementia and highly specialised medical services, which are usually provided only at university hospitals. As a general principle,

no pre-existing conditions were covered. Because the scope of PHI is restricted by the supply of privately funded health care in Sweden, only specialist care for less severe conditions was offered through insurance. Taken together, the results indicate that PHI provides benefits foremost for the healthy, rather than for those with the greatest need.

When this study was carried out, it was the first of its kind in a Swedish context. Since then, a number of reports have been conducted (Palme, 2017; SAHCSA, 2020) that essentially confirm the results in this study. On the whole, we now know more about PHI in Sweden than we did a few years ago, although many questions remain to be answered.

Does the experience of having PHI affect the willingness to pay tax towards public health care?

To answer this question, the findings from Studies II and III were used. The results from both studies indicate a maintained willingness to pay tax towards public health care among Swedish PHI holders. When controlling for political orientation, no differences between PHI holders and non-holders was found in Study II. The findings from Study III suggest a sustained willingness to pay tax among PHI-holders. Although the respondents included in the study could be considered highly educated with relatively high salaries, who indicated regarding other policy areas that they would prefer lower levels of taxation in Sweden, they stated that they found public health care to be very important and a policy area for which they willingly paid tax. These results partly contradict the expectations from the literature, which suggest that an increase in private alternatives to the universal public sector would reduce support and willingness to pay tax towards the public system (see Busemeyer and Iversen, 2020). However, there are some context-specific attributes that might explain this result.

First, as already mentioned, private health care is rather limited in Sweden. When in need of an ambulance, emergency care, maternity care, most cancer treatments or other advanced care, the public sector is the only choice. In this sense, the private health care sector in Sweden is not developed enough to yield a fully two-tier system. Instead, private health care should rather be considered a complement to the overriding public sector. Based on the findings in Study III, this is something that PHI holders are aware of, as they expressed that they might come to need public health care in the future, which motivated them to continue to support the public system.

Second, and in relation to the motive of self-interest, the respondents were concerned about family members and friends who did not have access to PHI, which can be considered a type of extended, group-oriented, self-interest. Therefore, they found it important to support and pay tax towards the public

system so that the public alternative would be able to provide high quality health care for their family members.

Third, the most prominent motive among the respondents to continue paying tax towards public health care was the idea that public health care is very worthwhile, because it is important that all people can get access to high qualitative care on equal terms. This idea is in line with the principles underpinning the public health care system in Sweden – that the government should be responsible for providing health care for the population and that it should be given on equal terms based on medical need and funded out of solidarity through general taxation. This idea corresponds to the findings of Immergut and Schneider (2020), who found that people living in countries where the health care system are mainly funded by public means to a larger extent see health care as a universal right and perceive unequal access to health care as unjust. The findings suggest that the principles of public health care are still stable, even among a group of people with access to a private alternative (see a further discussion under theoretical implications). Taken together, the results from the studies indicate that willingness to pay tax is maintained in the Swedish context among those with access to PHI. In this respect, PHI does not seem to challenge the legitimacy of the public health care system in Sweden.

Previous research on this topic is limited. There are older studies that examined tax willingness among PHI holders in the UK, with mixed results (Burchardt and Propper, 1999; Hall and Preston, 1998). In the Scandinavian context, where universalism characterises not only health care but the entire welfare state, this question has not yet been empirically investigated. This thesis, therefore, contributes with new knowledge indicating that, in a context with a tradition of a comprehensive public system guided by the principles of universalism and equality, willingness to pay tax towards the health care system seems to be resilient to the influence of PHI.

Does the experience of having PHI affect satisfaction with the public health care system?

This research question was considered in Study IV, which was based on semi-structured interviews. To answer the overall research question, respondents were first asked to reflect on how they perceived publicly funded and PHI-funded health care and whether they saw any differences between the sectors. The findings from the study suggest that PHI-funded health care is perceived to be better than publicly funded health care, particular regarding access and service quality. Low or no waiting times, convenient booking procedure, access to a care coordinator and the opportunity to easily get in contact with the treating physicians were considered important benefits of PHI. These aspects related to access and coordination are often considered the Achilles heel of the Swedish public health care system (Blomqvist and Winblad, 2021; SAHCSA,

2021), which might explain why they were highlighted by the respondents. Negative experiences with and perceptions of the publicly funded health care were mainly related to the primary care sector, which was perceived to be inaccessible, overloaded with patients and of low service quality. Several of the respondents shared how they were treated with suspicion when talking about their medical needs, they left with a feeling of not being taken seriously and that they had to push for treatment. Importantly, and something that also distinguishes Sweden from other countries, the medical quality of the public sector was perceived to be high, particularly in the secondary care level, it was mainly the waiting times that differed from the PHI-funded sector. This finding corresponds to results from international comparisons, where Sweden is often ranked high in terms of medical quality, but lower in terms of accessibility and service quality (SALAR, 2018).

Putting these results in relation to previous research, some differences can be found. For instance, in both Australia and Finland, trust and satisfaction with the medical quality within the public sector are much lower among PHI holders. In Australia, the private system is much larger and more comprehensive than the private sector in Sweden, they have a fully developed two-tier system in which the public system is considered to be of lower quality (Meyer, 2015; Ward *et al.*, 2015). Finland has not come that far in terms of a two-tier system, although the private sector is larger than in Sweden. Results from a Finnish study showed dissatisfaction with the public sector but also that the scope of services varied between public and private sectors, where more services were offered in the private sector (Sointu *et al.*, 2021). These results suggest that, to maintain satisfaction with publicly funded health care services, it is important that the quality within the public system correspond to the quality and supply within the private sector.

Several of the respondents said that their perception of the public system had been affected by various factors, such as different experiences with the public health care system over the course of a long life. However, since the respondents almost always preferred PHI-funded health care over publicly funded services, the results suggest that the possibility to compare health care from the two sectors made them more aware of the challenges within the public sector, particularly in relation to accessibility. Thus, the findings point to decreased satisfaction with publicly funded services as a result of the PHI experience. In a sense, these findings suggest that the ambition of the Swedish public health care system to provide services of such high quality that ‘the demanding middle classes’ would prefer them and the private sector would be redundant, has partly failed. However, most respondents had not considered purchasing PHI privately, if it were not given to them as a fringe benefit. This indicates that the publicly funded services are still perceived to be ‘good enough’.

Regarding this question, previous research is also limited, especially in the Nordic context. Thus, this study contributes with new knowledge about how

people in a comprehensive publicly funded health care system perceive differences between privately and publicly funded health care, and how their satisfaction with the public system is affected by having access to PHI.

Conclusion – How does PHI affect the legitimacy of the public health care system in Sweden?

The overall aim of this thesis was to investigate whether PHI in Sweden affects the legitimacy of the public health care system. Drawing on theories on legitimacy, two dimensions were suggested as important for maintaining the legitimacy of the public health care system. The results in this thesis suggest that the first dimension, willingness to pay tax towards public health care, does not seem to be altered by the growth of PHI in Sweden. So far, PHI is mainly seen as a complement, a benefit in addition to the publicly funded health care system, which is considered the primary source of health care in Sweden.

For the second dimension, regarding satisfaction with public services, the results are mixed. Regarding access and service quality, satisfaction with the publicly funded services is lower than with PHI-funded alternatives. However, the medical quality within the public sector is considered high within specialised hospital care. Thus, the results point towards a somewhat lowered satisfaction with the public system.

Taken together, the legitimacy of the public health care system in Sweden seems fairly resilient to the influence of PHI, although perceived low levels of access and service quality in the public system might, in the long run, challenge the satisfaction with and legitimacy of the system.

Theoretical implications

The theoretical starting point of this thesis was the ideas underpinning the principles of universalism, as they have been understood in a Nordic context (Blomqvist, 2004; Blomqvist and Palme, 2020; Moberg, 2016). A central idea is that a universalistic welfare system is more likely to maintain broad public support (Jordan, 2010; Rothstein, 2001) and legitimacy (Missinne *et al.*, 2013; Wendt *et al.*, 2010). As argued above, the middle classes, as financial net-contributors, can be seen as central to the funding of a welfare system. To maintain their support for the system, it has been seen as essential to provide public welfare services of such high quality that the middle classes find them satisfactory and abstain from turning to the private market for the same kind of services. From this perspective, the growth of PHI, which means that a private market for health services can develop, could be considered a threat to both the universality and the legitimacy of the public health care system, if it leads to lower support among PHI holders.

PHI undermines, by its very existence, the universality of public health care

By its very existence, PHI can be seen as undermining the universalism of a public health care system. The existence of PHI as an alternative to the public system implies that this system has become less universal, as a part of the population will get access to a health care sector that does not build on (i) *equal inclusion based in need*, (ii) *public funding* and (iii) *publicly provided health services*. Thus, the universality of the Swedish health care system can be considered to be reduced by the introduction and growth of PHI. How PHI affects the fourth dimension of universalism concerning *comprehensive usage* (i.e., that a majority of the citizens use the public system, rather than private markets), is, however, an empirical question. The question is whether PHI holders continue to use the publicly funded services or if they 'leave' the public sector for the private alternative. The results from this thesis indicated that PHI holders, for the most part, prefer PHI-funded services over publicly funded services, when available. However, because most hospital care and advanced medicine is not covered by PHI, PHI holders in Sweden continue to use the publicly funded health care for these services.

Maintained support for public funding – A policy feedback effect?

This thesis empirically investigated how PHI affects the popular legitimacy of the public health care system. The results suggest that, in regard to the first dimension of legitimacy, normative support, PHI does not seem to challenge the legitimacy of the public health care system in Sweden. This result contradicts many of the assumptions found in the previous literature about the impact of PHI on public health care systems (Busemeyer and Iversen, 2020; Propper, 2000). One potential explanation for why the rise of PHI in Sweden does not appear to undermine the support for public health care can be found in the policy feedback literature. The essential idea in this literature is that the design and organisation of, for instance, welfare policies, will affect citizens' attitudes towards and support for the welfare system. Once institutions are in place, they tend to transform how individuals interpret their preferences. (Béland and Schlager, 2019; Campbell, 2012; Jordan, 2013; Mettler and Soss, 2004; Pierson, 1993). In the case of universal welfare systems, the policy feedback mechanism has been suggested to lead to broader public support for publicly funded welfare programmes, such as tax-funded health care systems (Jordan, 2010, 2013; Rothstein, 1998). Two mechanisms have been suggested to explain why universal health care systems tend to generate greater support for public funding and provision. The first mechanism suggests that, as universal systems entitle the entire population to welfare benefits, they create broader support for such benefits. In this way the universal character of the

system tends to blur the line between contributors and beneficiaries, shifting the focus away from class-oriented conflicts over redistribution (Jordan, 2013; Korpi and Palme, 1998). The second mechanism focuses on a moral logic. According to this reasoning, universal policies are more popular because they are perceived to be more just, as they better correspond to norms regarding equal treatment and fairness (Jordan, 2013; Rothstein, 1998).

When the respondents in this thesis described why it is important to support publicly funded health care, their answers often mirrored the characteristics of the Swedish system, for instance with regards to the normative values of social equality and solidarity in funding. Many stressed the importance of having a system in which everyone has equal rights to health care: it was apparent that they saw this a matter of justice, rather than self-interest. Hence, the universal principles underpinning the public health care system in Sweden seem to have shaped the norms of PHI holders, who, based on theories of economic self-interest, could be expected to be less inclined than others to support and want to pay tax towards the public health care system. In this sense, the feedback effect seems to act as a 'buffer' against the influence of PHI on their attitudes towards the public system.

What is new in this thesis is that the policy feedback theory has been applied at the individual level. The policy feedback literature has mainly been used in internationally comparative studies, where institutional factors in different countries are being compared in relation to support for the welfare state. This thesis contributes by illustrating how policy feedback effects can act as a mechanism at an individual level as well.

Another difference in relation to previous research is that this thesis focused on individuals with access to private services *in addition to* being included in the public health care system. The policy feedback literature has previously tended to focus on variation in privatisation at the national level, rather than between the individuals who have access to private services and those who do not. By focusing on those with access to a private alternative, we investigated what could be considered a *critical case.* The fact that the results show that having access to PHI does not undermine willingness to pay tax towards public health care suggests that the growth of PHI does not represent a threat to the public health care system in this sense.

However, it should be made clear that the results presented in this thesis constitute a snapshot in time of the support for the public health care system and willingness to pay tax in support of it. The characteristics of the respondents in the study could have affected the results; for instance, the average age among the interviewees was relatively high, so most of the respondents were raised during a period in time when the social democratic welfare system dominated and the health care system was basically a public monopoly. If the same study were to be carried out 10–15 years from now, or within a group of people who grew up during the 1990s and 2000s, their attitudes towards the public

system would probably be different. In addition, if the share of the population with PHI increases, the policy feedback mechanisms might point in other directions. For instance, in systems with more private spending on services, public support for private provision is greater (Lindh, 2015), pointing to a policy feedback effect in which a larger market for PHI could, instead, reinforce public support for a more privatised health care system.

Policy implications

From a perspective that it is important to maintain the legitimacy of the public health care system, several policy implications can be proposed based on the results in this thesis.

First, the results indicate that PHI-funded health care was often preferred to the publicly funded options, at least in primary care. However, most PHI holders are still dependent on the public health care system, because not all kinds of health services are available in the privately funded health care market in Sweden. The respondents in the interview studies seemed to be aware of this fact, which also motivated them to continue to pay tax to the public health care sector. This also explains why PHI holders continued to use publicly funded services, which, in accordance with the theory of universalism, is important for the stability of the public system. This indicates that the size of the private sector does matter for the legitimacy of the public system.

Second, the theory of universalism suggests that, to maintain the legitimacy of the public system, the public sector should provide services of high enough quality to also attract the middle classes (Esping-Andersen, 1990; Rothstein, 1994, 2001). The results in this thesis showed that PHI-funded services, for the most part, were preferred over publicly funded services. The main reason for choosing PHI-funded services was a perception that the level of access and service quality in the publicly funded health care system was lower, particularly within the primary care sector. The public sector was perceived to have long waiting times and to be difficult to navigate. Visits to private GPs were perceived as better due to better access, but also because these doctors conducted more thorough examinations and were less stressed than GPs within the PHI-funded sector. These results indicate that the idea that the publicly funded sector should provide services of such high quality that the middle classes would find private alternatives redundant has partly failed, at least in regard to access and service quality.

Third, the findings in this thesis point to a shift towards a more demand-driven, consumeristic attitude towards health care in Sweden. The respondents interviewed in Study IV were getting used to deciding when and where to receive health care treatment. Some expressed how the decisions about whether to use health care was based on a rational decision of whether it would be economically beneficial to pay the co-payment to get access to PHI-funded

health care rather than wait in line for publicly funded health care. Another respondent described how he called the insurance company to ask whether they provided any additional services, just to make sure that he did not miss out on anything. As PHI provides access to specialist care within only a few days, PHI holders become used to a much higher level of access compared with the waiting times in the public system. This experience might amplify the perception that PHI-funded health care out-performs the publicly funded system, which, in the end, risks undermining the legitimacy of the public system.

Methodological considerations

There is no official record of PHI uptake in Sweden, which complicates studies on this population. One way to overcome this hindrance was to collaborate with the established SOM-institute, who annually carries out a survey on a random selection of the population between the ages of 16 and 85 years. The benefits of collaborating with the SOM-institute include that they have wide experience of performing surveys, they are well established and the surveys have relatively high response rates.

Working with the SOM-institute generated access to a great number of socioeconomic and demographic background variables, which were important for our analyses. The downside was that the SOM-survey were general in character and did not allow more specific and detailed questions about insurance uptake and health care use. Another limitation of using SOM-data was the relatively small sample. As the share of PHI holders in the population is limited, the number of respondents in the survey holding insurance was also small, which caused a number of challenges. For instance, it was not possible to distinguish between different types of insurance, such as employer-funded or individually purchased private insurance. This limitation might have theoretical implications, because willingness to pay tax towards public health care might vary between insurance holders who purchase the insurance themselves and those who receive it as an employment benefit. Moreover, the small sample resulted in a lack of precision in the estimates, which is visible in the broad confidence intervals.

Another limitation with the SOM-data was that the measurements of health care use were quite unprecise. To properly answer the question of whether PHI reduces the burden on the publicly funded system, more precise and thorough data on processes and outcomes are needed. Measures on diagnoses, performed medical procedures and care need, both for patients receiving medical care within the publicly funded system and by PHI-funded providers, could be used to improve the analyses. In addition, to take on an even broader perspective on whether the PHI-funded sector reduces the burden on the public sector, total supply and movements of medical staff between the sectors could

also be included in the analysis. However, so far, we lack public data that would enable this type of analyses.

Regarding the qualitative studies in this thesis, the recruitment strategy was challenging. Because there is no public register of PHI holders in Sweden, the characteristics of the population remain unknown. This makes it impossible to strategically select a sample that could be said to be representative of the population in question. Therefore, the recruitment for the interview studies was based on a snow-ball sampling technique, where people with employer-funded PHI recruited people they knew who also had PHI (Patton, 2002, p. 243). The sample might not necessarily reflect the characteristics of the population in general, and the recruitment might be characterised by a few social clusters where educational background and ideological preferences and values may be concentrated. As the research area concerns a politicised issue, this may have consequences for the results of the studies. With a different sample, the respondents' attitudes towards the public health care system – and thus their willingness to pay tax for it – could have looked different. However, what can be said from the results of this thesis is that the respondents' experiences and perceptions, as presented in the studies, do exist within the group of employer-funded PHI holders in Sweden. To what extent they are representative of the whole group of people with PHI remains unknown.

Another aspect that could have affected the results relates to social desirability bias. Considering the strong position the public health care system has had in Sweden, there might be social resistance to expressing a reduced willingness to pay tax towards it. So as not to appear stingy, respondents might have hesitated to express a wish for a tax reduction for using PHI, especially as the majority of the insurance premium was paid by the employer.

Taken together, these aspects could affect the results and the external validity and transferability of the results to the broader population – in other words, to employer-funded PHI holders working in finance, consulting, tech, or IT, located in the region of Stockholm in Sweden.

Avenues for future studies

First, the mean age among participants in the qualitative studies, presented in Studies III and IV, was 45 years, which implies that these individuals were born and raised in a time where the health care system was even more characterised by universal principles of egalitarianism, solidarity and public sector dominance. This could possibly have influenced the results, because it is likely that the support for publicly funded health care is lower among younger PHI holders who were raised during a period when marketisation, individualisation and patient choice were pronounced values in the public debate and who have been living most of their adult life with private alternative available

(Blomqvist, 2004; Missinne *et al.*, 2013). These questions call for future studies to investigate not only a potential generational effect but also whether the amount of time with a PHI and the level of usage affect support, preferably by longitudinal studies.

Second, the studies in the thesis did not allow the distinction between PHI holders who purchase PHI privately from those who receive it as an employment benefit. It is reasonable to assume that persons who purchase PHI privately have stronger incentives to prefer reduced taxation to support public health care, because they bear the full cost of their PHI and therefore experience a *double payment* to a greater extent than those with employer-funded PHI. A bigger sample that enables this distinction based on who pays for the insurance premium would increase our knowledge of the impact of PHI uptake on willingness to pay tax towards public health care.

Third, the development of PHI in Sweden can be studied from other perspectives than those taken in this thesis, such as what the growing market for PHI implies for employers, for the supply of and satisfaction among health care staff and for the total production and cost of health care. Taken together, much remains to be examined regarding PHI in Sweden.

Sammanfattning på svenska

Bakgrund och syfte

Privata sjukvårdsförsäkringar växer i många länder med offentliga, skattefinansierade, sjukvårdssystem. Även i Sverige har privata sjukvårdsförsäkringar ökat kraftigt de senaste decennierna. Denna utveckling har väckt en stundtals intensiv och polariserad debatt. En möjlig förklaring till varför framväxten av privata sjukvårdsförsäkringar varit känslig i Sverige är att de principer på vilket det offentliga sjukvårdssystemet vilar, i många avseenden skiljer sig från hur privata sjukvårdsförsäkringar är konstruerade. Det offentliga sjukvårdssystemet i Sverige bygger på principer om universalism och jämlikhet, där likvärdig sjukvård till hela befolkningen, utifrån medicinskt behov är en grundpelare. Lika så är principen om gemensam finansiering via skatten, där tillgång till sjukvård inte ska baseras på betalningsförmåga.

Denna avhandling tar sin utgångspunkt i frågor om hur framväxten av privata sjukvårdsförsäkringar påverkar den offentliga sjukvården på systemnivå. Två centrala dimensioner har ansetts viktiga för upprätthållandet av legitimiteten i offentliga sjukvårdssystem. Den första dimensionen bygger på att befolkningen stöder de normativa principer som ligger till grund för det offentliga systemet, såsom finansiering genom allmän beskattning. Vilket i praktiken innebär att befolkningen är villig att betala skatt till sjukvården. Den andra dimensionen handlar om hur nöjd befolkningen är med de tjänster systemet levererar. Där det har föreslagits att de offentliga tjänsterna bör vara av tillräckligt hög kvalitet för att privata alternativ ska uppfattas som överflödiga. Ökningen av privata sjukvårdsförsäkringar i länder med offentliga, skattefinansierade, sjukvårdssystem väcker frågor om huruvida denna utveckling utmanar det offentliga systemets legitimitet. Syftet med denna avhandling har därför varit *att undersöka om förekomsten av privata sjukvårdsförsäkringar i Sverige påverkar det offentliga sjukvårdssystemets legitimitet.* Tre specifika forskningsfrågor har behandlats: Vad kännetecknar privata sjukvårdsförsäkringstagare i Sverige och vilka sjukvårdstjänster omfattas vanligtvis av försäkringarna? Påverkar erfarenheten av att ha en privat sjukvårdsförsäkring viljan att betala skatt till den offentliga sjukvården? Påverkar erfarenheten av att ha en privat sjukvårdsförsäkring nöjdheten med den offentliga sjukvården?

Delstudier

Syftet och de tre delfrågorna besvarades genom fyra delstudier. De två första studierna hade en kvantitativ ansats, baserat på enkätdata från den nationella SOM-undersökningen. Delstudie tre och fyra byggde på intervju-data med personer som har en arbetsgivarfinansierad privat sjukvårdsförsäkring.

Studie I syftade till *att undersöka vad som kännetecknar personer som har en privat sjukvårdsförsäkring i Sverige, samt vilka sjukvårdstjänster dessa försäkringar omfattar.* För att besvara första delen av studiens syfte användes tvärsnittsdata från SOM-undersökningen, Riks-SOM 2016, del IV. Enkäten nådde en svarsfrekvens på 51 procent, vilket motsvarar 1636 svarande. För att undersöka om det fanns socioekonomiska och demografiska mönster bland privata sjukvårdsförsäkringstagare i Sverige analyserades data först med hjälp av korstabeller och Chi^2-test där faktorer som: kön, ålder, utbildningsnivå, bostadsområde, yrke, anställning i privat eller offentlig sektor, hushållsinkomst och politisk orientering inkluderades. I ett andra steg genomfördes binär logistisk regressionsanalys för att undersöka vilka egenskaper som var av större betydelse för sannolikheten att ha en privat sjukförsäkring. Den andra delen av syftet besvarades genom en innehållsanalys av olika försäkringsupplägg från sju vanliga försäkringsbolag i Sverige.

Resultaten visade att privata sjukvårdsförsäkringar var vanligare bland höginkomsttagare, personer anställda i privat sektor, samt bland företagare och tjänstemän. Försäkringarna omfattade en variation av olika sjukvårdstjänster, från primärvårdstjänster så som besök hos en specialist i allmänmedicin, till mer avancerad sjukvård så som knä- och höftoperation. Medicinska besvär som uppkommit innan försäkringen tecknades, så kallade ’pre-existing conditions’ exkluderades vanligtvis från försäkringen. Även akutsjukvård, högspecialiserad sjukvård, kroniska tillstånd samt fertilitet- och mödravård var exkluderade från försäkringarna. Sammantaget visade analysen på ett samband mellan arbetsrelaterade faktorer, så som yrke, sektor och inkomst och sannolikhet att ha tillgång till en privat sjukvårdsförsäkring i Sverige. Eftersom försäkringarna innehöll flera restriktioner riktas de framförallt till relativt friska personer.

Studie II syftade till *att undersöka om tillgång till privata sjukvårdsförsäkringar medför en minskad vilja att betala skatt till den offentliga sjukvården i Sverige, samt om privata sjukvårdsförsäkringar kan bidra till att avlasta den offentliga sjukvården.* Data från SOM-undersökningen användes. För att besvara den första delen av frågan användes två utfallsmått; *villighet att betala skatt till sjukvården* samt; *attityder till en skattereduktion för de som använder en privat sjukvårdsförsäkring*, båda mätt på en Likert-skala med fem alternativ. Linjära regressionsanalyser och multinomial logistiska regressionsanalyser genomfördes för att skatta eventuella skillnader mellan de med en privat

sjukvårdsförsäkring och de utan en sådan. För den andra delen av frågan, om privata sjukvårdsförsäkringar kan bidra till att avlasta den offentliga sjukvården användes ett mått på (självskattat) antal besök till privat respektive offentlig sjukvård senaste året.

Resultaten visade inte på några skillnader mellan de som hade och inte hade en privat sjukvårdsförsäkring i vilja att betala skatt till den offentliga sjukvården. Däremot var de som hade en försäkring mer positiv till att införa skatteavdrag för dem som använder sjukvård finansierad av privata försäkringar. Gällande den andra frågan, tyder resultaten på att privata sjukvårdsförsäkringstagare i något lägre grad än de som inte har en sådan försäkring nyttjar den offentliga sjukvården, vilket antyder att det kan finnas en svag avlastande effekt. En majoritet av försäkringstagarna fortsatte dock att använda det offentliga hälso- och sjukvårdssystemet, vilket endast tyder på en blygsam substitutionseffekt. Dock saknas flera viktiga faktorer i analysen, så som tillgång på utbildad personal i de båda sektorerna samt vilka typer av sjukdomstillstånd som behandlats i respektive sektor.

Studie III byggde vidare på Studie II genom att undersöka vilka motiv som kan tänkas förklara varför skatteviljan tycks bibehållen bland de med tillgång till en privat sjukvårdsförsäkring. För att nå detta syfte genomfördes en intervjustudie med 20 personer som hade tillgång till en arbetsgivarfinansierad privat sjukvårdsförsäkring. Intervjuerna som var semi-strukturerade genomfördes via Zoom mellan februari 2022 och oktober 2022. Materialet analyserades genom tematisk analys (Braun and Clarke, 2006, 2013).

Resultaten överensstämmer med resultaten i Studie II; erfarenheten av att ha en privat sjukvårdsförsäkring tycks inte ha påverkat försäkringstagares vilja att betala skatt till det offentliga systemet. Deras motiv för att betala skatt byggde både på egenintresse och solidaritet, men det mest framträdande motivet för att stödja den offentliga sjukvården genom att betala skatt, var idén om lika rätt till sjukvård för hela befolkningen.

Studie IV, syftade till *att undersöka om upplevelsen av att ha en privat sjukvårdsförsäkring påverkar nöjdheten med den offentliga sjukvården*. Denna studie baserades på samma empiriska material som studie III och analysmetoden var tematisk analys (Braun och Clarke, 2006, 2013).

Resultaten tyder på att de hälso- och sjukvårdstjänster som gavs via den privata sjukvårdsförsäkringen föredrogs framför offentligt finansierade sjukvårdstjänster. Det främsta skälet till att de förstnämnda föredrogs var snabbare åtkomst och bekväma bokningsprocedurer. Respondenterna upplevde att deras medicinska behov togs på större allvar när de gick till försäkringsfinansierade kliniker i jämförelse den offentligt finansierade primärvården. De framhöll dock att de var nöjda med den medicinska kvalitén på den offentliga sjukvården, särskilt inom den specialiserade sjukvården. De flesta av de tillfrågade

sa att deras nöjdhet med den offentligt finansierade sjukvården troligen hade påverkats negativt av erfarenheten av privata sjukvårdsförsäkringen.

Slutsatser

Det övergripande syftet med denna avhandling var att undersöka om privata sjukvårdsförsäkringar i Sverige påverkar legitimiteten för det offentliga hälso- och sjukvårdssystemet. Med utgångspunkt i teorier om universalism och legitimitet föreslogs två dimensioner som viktiga för att upprätthålla det offentliga hälso- och sjukvårdssystemets legitimitet. Resultaten i denna avhandling antyder att den första dimensionen, det vill säga viljan att betala skatt till det offentliga hälso- och sjukvårdssystemet, inte verkar ha påverkats av den ökade tillgången till privata sjukvårdsförsäkringar i Sverige. Än så länge ses privata sjukvårdsförsäkringar främst som ett komplement, en förmån vid sidan av den offentligt finansierade hälso- och sjukvården, vilket fortsatt anses vara den primära källan till sjukvård i Sverige.

Gällande den andra dimensionen; vikten av att kvalitén på den offentliga sjukvårdens tjänster uppfattas som tillfredsställande, var resultaten något mer blandade. Tillgänglighet och bemötande ansågs sämre inom den offentliga sjukvården i jämförelse med den försäkringsfinansierade sjukvården. Den medicinska kvaliteten inom den offentliga sektorn ansågs dock vara hög, särskilt inom den specialiserade sjukhusvården. Resultaten pekar således mot en något sänkt nöjdhet med det offentliga systemet. Sammantaget tycks legitimiteten för den offentliga hälso- och sjukvården i Sverige vara ganska motståndskraftig mot påverkan från privata sjukvårdsförsäkringar. Att både tillgänglighet och bemötande ansågs sämre inom den offentliga sjukvården kan dock, i förlängningen, undergräva legitimiteten i det offentliga systemet.

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