EU IN SWEDISH HEALTHCARE – GAME-CHANGER, PART OF THE PROCESS OR JUST BUMPS ON THE ROAD?

A discussion-paper to Forum for Health Policy 2015-05-19, Sören Berg

Introduction

This paper starts with a sketchy picture of Swedish healthcare. In an equally sketchy way it presents a few cases where EU-policy has, or has not, been visible in practical healthcare, and from there discuss opportunities and threats in an intensified EU-involvement.

Can EU-policy help us rethink on challenges and/or solutions? Can it help us to handle our problems? Or does it only provide bumps on the road that we would travel anyway?

It is important to note that this paper is meant to contribute to a discussion, not to present final conclusions or suggestions.

The state of Swedish Healthcare

In perspective of the patient

Many swedes would summarize that Swedish healthcare provides good medical outcomes with fairly equal access and fairly equal conditions. The waiting-time-problem is not as big as it was some years ago.

Primary care can often not offer the continuity and attention that patients want. Shortage of hospital beds causes problems with moving around. Many of the visible problems are connected to lack of coordination in care for patients with multiple and/or complex needs.

In perspective of the healthcare-professional

Many healthcare-professionals take pride in their medical results, and in most cases this pride has good reasons. The principles of public funding are widely supported, and make it easy to treat patients without regard to their economical conditions.

Lack of resources is an often discussed problem. Shortage of hospital-nurses makes hospital-beds unusable. As a relatively low percentage of doctors work in primary care, it is hard for primary care to live up to expectations.

The system for decision-making is complicated; 21 county councils/regions, national agencies that are not always coordinated and the SALAR/SKL which in many cases seem to be a national agency.

In perspective of the policymaker

As in many other countries, healthcare-costs are growing faster than funding. This makes cost an always central issue with many perspectives; meeting the needs of an ageing population,

providing up-to-date treatments, giving good service, taking place in international research and development and still keeping the general public funding.

Structural issues, such as physical-, organizational- and IT-infrastructure takes a lot of attention.

Step by step issues are moved from regional to national level. Highly specialized care is slowly centralized. Common structures are built for information to patients, for general IT, for knowledge-management, for priority-setting etc. In most cases, this is not a simple process of a strong national level taking more power, but rather a result of regional decision makers realizing that many issues are easier to deal with in national cooperation.

Above this, there are public health issues common for most EU-member states: Tobacco, Alcohol, Illegal drugs, Obesity etc. European action and legislation is very important.

In perspective of science and innovation

A couple of decades ago, Sweden had an extremely strong position in medical science, especially in the drug-sector. Many conditions, such as massive efforts in other parts of the world, make it unrealistic to come back to that position. Still, Swedish medical science could be more successful than today, and several initiatives are taken.

In practical healthcare it can be discussed what it means that Sweden in the 90-ies was a very early adaptor when it came to new drugs, and that we today are much more cautious. This is a question with aspects of safety, innovation, economy and more.

Antimicrobial resistance provides an extraordinary challenge, where Sweden has a leading position and a lot remains to be done.

EU as part of a broad internationalization

Medicine as science and clinical practice in high-level-facilities is getting more and more international. Many EU-initiatives can be seen as a part of this wider internationalization.

When it comes to science and knowledge-management, USA is still leading in many ways. EU:s systems for legislation and cooperation are very important, and many EU member-states have important centers for research, development and innovation, but in these areas EU is not always the primary node for Swedish international relations in healthcare.

Some EU-interventions

The working time directive

The EU working-time directive (2003/88/EC) caused a lot of stress in many county councils/regions. The limitations of length of work-sessions, and that time on call should be included, made some hospitals afraid that it would not be possible to keep a wide range of specialists available for work in emergency-rooms.

The directive also put focus on an old tension between hospital managers and doctors, on if to make 24-hour-shedules for doctors or if to develop the on-call-systems.

In this case, EU-policy had obvious impact on the domestic process. But maybe the outcome was not dramatically different from what had happened anyway. Parallel discussions on patient safety were also driving for more limited work-sessions. And there are still tensions on 24-hour schedules vs. on-call-systems.

Cross-border Healthcare

Different aspects on cross-border healthcare have from time to time been intensively discussed in different circles. Some groups of patients argue strongly for the possibility to get more efficient treatments than those available in Sweden. Some people look at this as a principal issue, the right to choose, and a potential driver for competition and improvement. Others see risks of undermining the public funding by letting small groups of patients open up for expensive treatments that should not be prioritized within a limited budget.

Today the issue has been accentuated by the new Swedish national patient-law that gives every patient right to get ambulatory treatment anywhere in the country. Treatment should be paid by the patient's residential county, but conditions should be the same as for a citizen living in the treating county. Theoretically this eliminates the possibility for county councils/regions to prioritize in ambulatory care. Theoretically it also gives treating counties an opening to expand services without concern of their own budget – external patients bring "fresh" money.

Practically this is a marginal issue. The numbers of moving patients are small, both cross-border and cross-county. Practical concerns and difficulties can limit the interest of moving around. But things may change.

The Swedish LSS-system gave persons with disabilities and need for personal assistance substantial economic support and power to hire helpers of their own choice. It has led to important improvements, but also to financial burdens on national and local level. Some companies that provide services today also give their customers legal advice on how to demand more support. In summary; a system with many upsides, but also with challenges that could have been better foreseen.

The relatively new tax-reduction system for services in households, RUT, has opened for private persons to buy cleaning and other home services at a reduced price. If you need only small amounts of service, the price can be approximately the same as if you would get the same support from the municipality. The difference is that you have full freedom to choose provider and what should be done. Initially the system had a very limited number of users, but after some time there has been a substantial expansion. Elderly people with limited needs may start using this way of getting support instead of using the municipal system – as the system was introduced from a financial and job-creating perspective rather than from a social, there is not much knowledge and discussion on these possible shifts.

Patient-reported adverse effects of drugs

The European Medicines Agency has now published a short, easy to understand, information on how patients can themselves report adverse effects of drug treatments. It I published in all EU-languages, with the same content and layout.

As far as I have seen, this information is not well spread in Sweden. And if you follow the Swedish contact-information, you come to a web-site which – in my opinion – is not very user-friendly. The underlying message seems to be that you should discuss these issues with your doctor rather than making reports of your own.

Rare diseases

Rare diseases form a cluster of issues that needs to be handled on international level, basically because the number of patients are small and cooperation and concentration is a necessary condition for knowledge to grow.

Making the parallel with other kinds of cross-border care, it is also necessary to consider the financial aspects: It is more economical to find and use effective treatments, but there can also be questions on prioritization both in research and clinical practice. Many of these diseases occur at early age, and these patients parents have especially good reasons to move around, and often the energy to also do it.

Reflections

The impact of EU-policy is a result both of what is done on EU-level, and of how we participate and react on national level.

My impression is that EU-policy in most cases is an integrated part of the national process, as intended. But in some cases, for good or bad, EU policy can also challenge our ways of looking at both problems and solutions. I think that issues affecting public funding and concerning patient-perspective are two complexes where EU-policy can have such game-changing impact.

The issue of public funding has been discussed in many scientific and political fora's during many years. Combining open societies with general welfare systems is not easy. At the same time, equality in healthcare may be an extra important symbol of togetherness in changing multicultural countries. I am not capable to give new insights on these issues in this paper, but I think that it would be fruitful to lift and more explicitly discuss them in direct connection with the practical efforts to open up cross border mobility.

When it comes to patient centeredness, I think EU-policy can be an important driver. Almost everyone would agree that healthcare should be patient-oriented, but it is easy to be blind for domestic traditional thinking. For instance, it is common to discuss how patients could be more involved in their care, instead of asking patients how much, and what kind of, involvement of professional care patients want in their life. The EU-initiative to encourage patients to report adverse effects of drugs could be used as a mind-changer: A patient should of course discuss hers or his experience with the prescribing doctor, but after that the genuine patient-evaluation could and should be given primary attention.

For many of our other challenges, I think further improvements in exchange of data, knowledge and ideas are important. This exchange cannot be limited to EU, but EU is especially important as our countries have many factors in common and we can use and cultivate already existing networks. The importance of comparable data should not be underestimated.