Knut Rexed
2015-05-10

Next Step in European Health Policies

1   Introduction

Health services are vital activities in any country; not just from a humanitarian but also from a social and an economic perspective. As such they are dealt with in one way or another in all levels in the society; from the individual to the global. This short note is written for a workshop that will discuss the effect of European health policy on the Swedish health services. Its perspective is that of management and governance, and not that of medicine.

The note only gives a summary orientation of the different issues and polices involved. A key point is a review of the perceived challenges facing Swedish policy makers and managers in this field. This is then contrasted with the European Union's health policy and its corresponding action plan.

2   General aspects of health systems

Context and path dependency

Each member state of the European Union has its own historical, constitutional, cultural, political, economic and administrative context. The challenges may have been the same, but the options available to a country have depended on its national context, and its responses and solutions have therefore been different. Administrative scientists and analysts talk about path dependency.

This is as true for health services as for any other sector of public services. But the populations in the member states are affected by the same health problems and the available measure are contained in a shared knowledge base. The context and path dependence is thus not a barrier towards finding common solutions, it's merely generating an inertia that may delay progress but which can be overcome.

The nature of health services

The World Health Organisation (WHO) has defined a well-functioning health system as a system that responds in a balanced way to a population's needs and expectations by:

- improving the health status of individuals, families and communities
- defending the population against what threatens its health
- protecting people against the financial consequences of ill-health
- providing equitable access to people-centred care
- making it possible for people to participate in decisions affecting their health and health system.

The WHO has also stated that a well-functioning health system requires

- a robust financing mechanism;
- a well-trained and adequately-paid workforce;
- reliable information on which to base decisions and policies; and
- well maintained health facilities and logistics to deliver quality medicines and technologies.

The concept of eHealth is used in different contexts with different significance. Sometimes it only concerns digital front-office services linking care seekers and care providers. At other times it designates the entire digital information system of the health services; that is both front and back office functions and core operational functions.

The most important aspect of health services is that they are based on and immersed in a dynamic and constantly evolving global knowledge management system. Knowledge gained around the world – whether through formal research or through clinical observations and experiences is systematised, published and made available for health services around the world. Health service providers need to establish and operate their own knowledge management systems to ensure that they can follow and benefit from the evolution of medical knowledge. The digitalisation of these systems opens up vast possibilities but also threatens old structures.

The ever growing knowledge mass drives specialization into a steadily increasing number of specialities and subspecialties. Specialists need to be able to concentrate on cases where their specialised skills and knowledges are relevant, and this drives a need for larger case catchment areas. Health services thus range from fields with mature knowledge bases where diagnoses and treatments are relatively standardised to fields at the knowledge frontier where the medical professsions faces a genuine uncertainty about causes and appropriate treatments.

The environment in which health services operate is open, dynamic, intensive, heterogeneous and knowledge-intense. Administrative research indicates that the optimal way of managing such organisations is a *professional bureaucracy*. This doesn't mean that the owner can abdicate, but it means that these organisations have to be governed in cooperation with the concerned professions.

Value creation in health services

The value-creating core of the health services is the meeting between the patient and the health service professional. The main driver of value is the knowledge and competence of the professsional that meets the person seeking help, and his or hers ability to make a correct assessment of the health problem or problems – if any – of the person seeking help.

The constructive role of the political governance and management of the health system and its institutions is to promote an optimal setting for that meeting. This involves providing and allocating financial and physical resources as well as assessing and amending organisations, structures and processes. Two processes that have always been present but that have acquired a new urgency in the digital age are the information system and the knowledge management system.

3   The Swedish health service system

Introduction

Swedish local and regional governments are subordinated to the national parliament but not to the national government. They have constitutional guarantees for self-governance in their discharge of their responsibilities, and for their right to tax their own citizens. The extent of their

responsibilities is determined by parliamentary law, and the parliament has authorized the national government to regulate specific aspects of services entrusted to the local and regional governments, and approved a range of economic incentives intended to promote efficiency and reforms in selected areas.

The main responsibility for health services is entrusted to the regional governments. Larger regions have been created in south and west Sweden, but the remaining 19 regional governments still reflect a territorial organization set up in the first half of the 17th century. The main responsibility for the social services is entrusted to local government. Consequently, regional and local governments have to find adequate structures and processes targeted at i.a. old persons with concomitant needs of social and medical services.

The regional governments have been designated as health service principals[1] with a responsibility for all medical services within their region. Sweden has always had an element of private practitioners in specialized open care, and a small number of private hospitals outside the publicly financed hospital system. During the last decade the primary care has been opened up for the establishment of private providers of health services within the publicly financed system, as well as within selected specialized health services.

There are seven large hospitals that are linked to medical faculties at universities. These provide specialized medical services not only for their own region but also on a contract-basis for larger region groups and for other customers.

The formal goals

The goals of the Swedish health services have been enshrined in parliamentary law as *a good health and equal conditions for health care for the whole population*. The law then goes on to break this down into subgoals and required conditions.

The actual implementation is devolved to the health service principals. The goals set by the principals vary across regions, and may be reformulated when the political composition of the regional assemble changes. One example is the goals set for 2012 – 2017 for the principal in the Uppsala region. These begin by stating that the principal shall provide accessible and safe health care of the highest quality. They go on to state i.a. that the care should be characterised by dignity, quality and safety; that health economic assessments should be used more often, that waiting times should be reduced, that care seekers should be given more choices, and that specialised health services should more often be provided outside the region's hospitals.

4   The perceived challenges

The challenges meeting a health service principal

The deliberations in regional government assemblies and governing boards across the country are dominated by the same range of substantial challenges.

The foremost of these is the need to control and contain the evolution of the costs for meeting the demand for health services. Most – if not all – of the large highly specialized hospitals are year after year drawing over their approved budgets. There are a number of generic factors driving the evolution of costs that are beyond the principals' control. Demand is for example driven both by the demographic trend towards larger groups of citizens in old and very old ages, and by rising expectations of citizens of better access and higher quality. Supply is driven by medical re-

---

[1] "Sjukvårdshuvudmän"

search and development creating new methods and new capacities for treatment, including new and expensive medicines.

There is an apparent risk that the economic concerns crowd out other concerns. There are a number of interrelated areas where the principals face challenges that they need and should address in an appropriate way.

The growing presence of commercial and non-governmental providers of health services within the publicly financed health service system is one such challenge. Principals need to distinguish and separate system governance setting the rules of the game for all providers from the management of their own service provision units. This growing presence also means that the principals' service provision is more exposed to competition that before. New national and European legislation entitling citizens to reimbursement of costs for health services received outside their home region have the same effect.

Another is the need to recruit, train and retain a sufficient number of competent employees. All regional governments have difficulties when it comes to nurses but also in some cases to doctors. There is also a need to renew and streamline internal processes within the hospitals that can only be met by better management and scheduling; changes that affect the doctors' work in ways that many of them find negative. And there is a need to improve the interaction between primary and specialized care to ensure that medical needs are dealt with at an appropriate level, and to improve the system for caring of old persons with multiple health and social problems.

The ongoing technological revolution affects the health services at least as much as other activeties in the society. The primary phase of the digitalisation is more and less over, but it has left the health services with a multitude of applications and systems with different program logics, differrent user interfaces, and too often with outdated program architectures. Principals need to fuse these into coherent health information systems with high levels of usability, security and interacttion. The main attention has so far been given to the medical journals, which have been the aide memoires of individual health professions and that need to be transformed into a structured database servicing any health service provider as well as providing inputs for a modern knowledge management system.

The challenges meeting the national health service governance

The main trend during the late 20th century was the transfer of all public health services from the state to the regional governments. In Uppsala for example, the Academic Hospital was transferred in 1983 and the Psychiatric Hospital in 1988. Performance-related state subsidies to primary and regional governments were replaced by needs-related contributions during the 1990s.

The State retained its regulatory and supervisory functions. Medical standards are set by professsional boards appointed by a State authority. Health professionals are certified by a State agency, and their certifications withdrawn in cases of mal-conduct. State agencies are surveying and evaluating the health services provided by principals. New pharmaceutical products are approved for sale and use in Sweden by another State agency. Yet another State agency decides which pharmaceuticals that is to be covered by the medical insurance system.

In the early 2000s, the national government again became more involved in how health services are provided. One driving force was a perceived need to ensure cost-efficiency. Another was more vocal demands for 'equal access to health services' that challenged the operating autonomy of the health service principals. A number of performance related incentives were introduced. The most debated of these is based on how long the waiting times are at emergency wards and for specialised care. These may contradict the medical ethic that priority should be based on professional assessments and not on a first come – first served rule.

One salient step was the designation of national service providers for some advanced and highly specialised medical treatments. These were treatments, such as for example heart transplants and very severe burns, where the annual number of cases in Sweden is so small that only one or a few of the major hospitals could build and maintain this type of competence.

Centre-right cabinets promoted so called 'citizen's choice'-systems which entailed allowing commercial service providers to provide public services. Any assessment of these systems is likely to be challenged by their political proponents or opponents, but it seems safe to say that it has been less problematic in the primary health care than in the school system or in the provision of specialised care.

The last decade has also seen a substantial strengthening of the national government's role and activities when it comes to modern information systems. It is not enough, when seen in a national perspective, that each health service principal creates its own coherent health information system. These have to be designed and operated in such a way that they form a coherent *national* health information system. A number of initiatives have been taken in cooperation with the Swedish Association of Local and Regional Governments, including the evolution of national quality registers and publicly available comparisons of performance and results. Focus during the years to come will evidently be on legal, semantic and technical interoperability.

The recent years have seen a build-up of a stronger national organisational capacity with a new State agency for eHealth, an application provider owned by the Association of Local and Regional Governments, and a modernisation of the regulatory framework. A coordinator appointed by the national government is expected to present a report later this year calling for the State to assume a more visible responsibility for the necessary network functions. The ubiquitous recruitment problems indicate that the national government should probably also assume more responsibility for assuring an adequate supply of health professionals.

4   The European Union and its health policies

Introductory comments

The Treaty on European Union states that a high level of human health protection is regarded as essential, and that it should be a secondary goal in the definition and implementation of all community policies and activities. Community action shall complement national policies and be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health.

The Commission's White Paper *Together for Health* listed a number of areas where Union action adds value to member states' actions. These include work on food safety and nutrition, the safety of medical products, tackling smoking, legislation on blood, tissues and cells, and organs, water and air quality, and the launch of a number of health-related agencies. The White Paper also points out the ageing of populations, major threats to health and new technologies as major challenges for the member states that might benefit from action at the Union level.

The European Union's legislative mandate

The European Union has no general legislative mandate. Its ability to take binding decisions – directives and regulations – is limited to areas enumerated in the Treaty on European Union.

There is however an area where the European Union has a legislative mandate and where decisions are taken that affect health policy and health services, namely the free movement of persons, services, goods and capital across the member states. This means that a number of product

and service standards – including pharmaceutics - have to be agreed at the union level if they are to be effective. The European Union can also act in issues concerning validation of educational achievements. The union has also been able to adopt legislation on entitlements intended to facilitate cross-border health services.

The European Union's soft coordination

The member states have developed a soft form of coordination that is based on moral and political commitments, combined with monitoring achievements and issuing non-binding recommendations. The cornerstone of this form of coordination is an adequate and appropriate monitoring of the developments in the members states.

The Commission has therefore proposed the creation of a system of European Community Health Indicators, with common mechanisms for collection of comparable health data at all levels. It has also proposed that the mechanisms for surveillance and response to health threats be strengthened. The European Union can also fund research and development projects that can facilitate and promote an adequate development in the member states.

It can actually be argued that the soft mandate is more important for the Union's long-term development than the legislative. The dialogue between representatives of member countries at different levels and in different fora will over time lead to a convergence of values, perceptions and ideas and create the necessary foundations for joint political actions.

The European Commission's Action Plan

The action plan contains fours actionable policy lines; (i) Achieve wider interoperability in eHealth Services; (ii) Supporting research, development, innovation and competitiveness in eHealth; **(iii)** Facilitating uptake and ensuring wider deployment of eHealth; and (iv) promoting policy dialogue and international cooperation on eHealth at global level.

The salient policy line is the first one; that is the one on interoperability. It will involve semantic, legal and organizational aspects and may affect the national structures and processes directly. Legal linguistics has long been a cornerstone for European Union action in different fields. The Action has already been taken along the line with regulation on cross-border health services.

The Commission has signalled that it intends to take initiatives concerning the interoperability of electronic health records, and is presently reviewing the European Union's general legal framework on the protection of personal data.

5.   And whither then?

How will the health policies of the European Union affect the Swedish health services? And how would appropriate and efficient future EU health policies look like?

There are in my opinion two salient fundaments for this discussion. One is the *subsidiarity principle.* Decisions should not be taken at a higher level than necessary, taking the need for effectiveness and efficiency into account. It also means that decisions should be taken at higher level when this appropriate and necessary for effect and efficiency. The second is the *common market.* This is the main European project, and it's far from completed. It does not only entail enforcing the free mobility, but also creating the institutions and framework necessary for adequate and appropriately functioning services.

There are some issues which – although important in themselves – can be moved to the sidelines. One is the high level political goals adopted by the European Union as part of its health policies. These are relatively non-controversial in the Swedish context, and they already correspond to goals adopted in Sweden.

Another is the challenges meeting the health service principals. These are such that they can hardly met by national decisions, and even less by European. The national government could of course give relief from the financial stresses by increasing the state contributions, but such relief would only be temporary. Instead, the challenges are basically *management* challenges, and neither the national government nor the European Union could be likely to appoint better managers than a regional assembly that bears the financial responsibility and that can be held to account by the region's citizens. Many of the challenges meeting the national government are also such that they have to be met by national decisions.

A third and a fourth is European support to developing digital services and to resource and development in the health field. These can be seen more as support to the growth and competitiveness of European industries than to the health services, given the relatively efficient global dissemination of new knowledge and technology within the health sector.

What remains is primarily the promotion of a common market for health services, and the creation of the common institutions and frameworks that are necessary for its functioning. I will highlight the three challenges that I believe are most important.

The first is the need to develop and managed a coherent European *health information system*. This has already been included by the European Commission in its Action Plan for eHealth 2012 – 2020. As cross-border health services continues to expand, it becomes essential to achieve legal, semantic and technical interoperability across the member states of the European Union, just as it is essential to achieve legal, semantic and technical interoperability across the Swedish regions health service principals and providers. And just as regional health service principals have to subordinate their efforts to the appearing national system; the national government will have to subordinate its efforts to the European system that has to come.

The second is the need for a European framework for *competency recognition and supply*. It is already evident that health professionals are geographically mobile, primarily because of the global nature of the professional knowledge and competences. The European Union will need to evolve European professional authorisations, or at least a system for mutual recognition of national authorisations. The European Union will also have to assess the total supply of various health professionals within the Union and to take action if and when it is inadequate.

The third concerns the *protection against infections* during hospital care. Today, the lack of information on the standards and presence of infectious diseases in other European hospitals means either that hospitals have to take unknown risks, or that all patients that have been operated on in another European have to be treated in high-risk wards with extra costs that might have been avoidable.