FORUM FÖR HEALTH POLICY

Healthcare beyond coronavirus

More than ever before, transformation of the healthcare system is needed

BY
CATHARINA BARKMAN,
PROJECT DIRECTOR AT FORUM FOR HEALTH POLICY

HEALTHCARE BEYOND CORONAVIRUS

FOREWORD

After the acute phase of the coronavirus pandemic, we will be able to learn a lot from what has worked and where we have fallen short in healthcare and long-term care services. But we also know that there were major challenges for the Swedish healthcare system even before the coronavirus crisis.

Regional healthcare spending continues to increase. At the same time, productivity (measured as fixed price costs per DRG point in hospital care) has fallen over the last five years. A healthcare backlog is building up and waiting times, which are already long, are increasing. There is a risk that diagnoses that can prevent suffering and premature death will not be made.

The long-term discussion about renewal and innovation in the healthcare system must continue and focus more on how the resources are used and other ways of working.

What policy decisions are needed? What are the success factors for both higher quality and efficiency?

In this publication, written by Catharina Barkman, Project Director at Forum for Health Policy, we provide policy advice in a number of different areas.

Many thanks to the Forum for Health Policy's Board of Directors, members, and researchers who have contributed. We look forward to your input on how we can improve the healthcare system in Sweden.

Peter Graf

Chairman of Forum for Health Policy

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Contact: info@healthpolicy.se

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SUMMARY

The corona pandemic has caused suffering, deaths, and major economic consequences. This has put enormous pressure on healthcare systems. We see heroic measures and actions around the globe every day.

In Sweden already long waiting times for treatment increased further. Non-covid patients are either hesitant to go to the hospitals or are not a priority.

Sweden, like most countries, will emerge from the corona pandemic with a huge debt of care, both financially, lack of personnel and in the form of pent-up demand for healthcare.

Yet there are also opportunities. Some innovations are now quickly being taken up. What previously took months and years to implement can now take a few weeks. Digitization is taking great strides forward. Decisions that previously took years to investigate and decide on have only been implemented because they must be made here and now. This shows that there is an enormous potential in the healthcare staff, a potential that is not used today.

After the acute phase, much can be learned from what worked and where it broke. However, challenges were great for Swedish healthcare even before the corona crisis. When the emergency situation is over, the long-term discussion must be less about demand for more resources and more about how resources can be put to better use.

This report from the Swedish think tank Forum for Health Policy, proposes necessary measures in a number of different areas:

1. Coordination saves money and prevents suffering

- Give individuals the opportunity to choose between different providers who offer cohesive care pathways, for more seamless healthcare and long-term care.
- Create reimbursement and follow-up systems that strengthen the coordination of all the individual's healthcare and long-term care.
- Develop the information provision, IT infrastructure, and digitized service processes for healthcare based on the needs of patients and users.
- Establish more mobile healthcare teams that visit people at home.

2. Take back your time – from administration to patient meetings

- Let the medical profession do its job.
- Simplify documentation.
- Develop intelligent referral systems.

3. Clearer governance and better leadership

- Evaluate the current division of responsibilities within the healthcare system, at national, regional, and municipal level.

4. More measures to combat mental illness

- Develop a long-term strategy with specific goals and sub-goals.
- Increase the rate of development of preventive work in collaboration with social operators.
- Develop the quality and reach of healthcare.

5. Prevention for the benefit of the patient

- Create effective structures for patient involvement and person-centered healthcare and long-term care.
- More psychiatry expertise in primary care.
- Greater focus on prevention and health promotion measures.
- Develop a long-term strategy with specific goals and sub-goals.

6. Increase the pace of digitization

- Develop a political vision for modern healthcare.
- Change focus from organization to person.
- Develop and adapt the reimbursement systems.
- Use digital technology to create modern ways of working.

7. Learn from variations in healthcare

- Quality indicators for improvements must be easy to use, clear healthcare process measures, rapid indicators, and relevant to the results.
- A more powerful national interpretation of individual and individual regions' results.
- Point out a number of important quality problems nationally.
- The state, regions, and municipalities should jointly develop a standard follow-up structure to ensure that all healthcare providers report quality in a similar way.
- Patients and residents should have better opportunities to compare the quality of care given by different healthcare providers.

THE LONG-TERM SOLUTION IS NOT MORE RESOURCES

The coronavirus pandemic has caused suffering, death, and major economic consequences for society as a whole. The pressures on healthcare have been extreme. Huge efforts are made every day. Coordination, cooperation, prioritization, and, not least, the rapid creation of new ICU spaces have been impressive. Throughout the country, huge efforts are underway to care for COVID patients in hospitals and to limit infection in society. Resources are being invested in regions and municipalities. At the same time, waiting times are increasing for those patients who were already waiting for care, but for obvious reasons are being given lower priority. Planned operations are being cancelled. The coronavirus pandemic is leaving a huge healthcare backlog behind.

But in the crisis, glimpses of hope can also be seen. A powerful fostering of innovation. Things that used to take months and years to complete can now be done in a few weeks. Digitization has taken a major leap forward. New and improved collaboration. And in the midst of this extreme situation where healthcare professionals are forced to work long shifts and push themselves to the limits, many also testify to a sense of purpose and being able to devote themselves to the most important issue. According to the Swedish Higher Education Authority (UKÄ), the number of applicants increased by 34 percent compared with the previous fall semester.

After the acute phase, we will be able to learn a lot from what has worked and where we have fallen short. But we must also remember that there were major challenges for the Swedish healthcare system even before the coronavirus crisis. When the emergency situation is over, the long-term discussion must focus less on resource allocation and more on how the resources are used.

Regional healthcare spending continues to increase. Nevertheless, productivity (measured as fixed price costs per DRG point in hospital care) has fallen by 12 percent over the last five years.

The Swedish healthcare system's share of GNP is among the highest in the world. At the same time, the accessibility of Swedish healthcare is among the lowest in Europe.

And in primary care, the number of doctors per inhabitant has increased by 34 percent in the 21st century. Yet fewer Swedes are able to see a primary care physician.

This imbalance between resources and outcomes is known to decision-makers and politicians. But it is important to start with these fundamental prerequisites when drawing conclusions from the coronavirus pandemic, what it has entailed for healthcare and long-term care services and what it means for future policy-making.

One thing we already know: more resources will not resolve the major challenges facing healthcare. The coronavirus situation means that money is not available right now. We simply have to work differently.

The purpose of this report is to make suggestions for necessary measures to better manage the resources. Swedish healthcare and long-term care services need sustainable transformation.

1. COORDINATION SAVES MONEY AND PREVENTS SUFFERING

Several inquiries indicate deficiencies in coordination between the providers on whom people with major healthcare and long-term care needs rely. Studies show that patients, users, and medical professionals are dissatisfied with the coordination.[1] Lack of coordination leads to high costs and potentially lower quality of care, as well as a poorer experience and quality of life for patients and users. The challenges are not made less complicated by having three political levels: the state, 21 regions, and 290 different municipalities.

The Swedish Agency for Health and Care Services Analysis states that a lack of coordination is particularly problematic in Sweden, compared with other countries. Patients in Sweden often find that doctors do not seem to be informed about the patient's previous care.

The lack of coordination also leads to poorer healthcare/long-term care and increased costs, for example when treatments and examinations are repeated unnecessarily and patients are shunted between different providers.

In a report from 2016, the Swedish Agency for Health and Care Services Analysis stated that:

- There is a lack of knowledge of what coordination means
- Leadership and governance are lacking as regards coordination issues.
- Municipalities and county councils find it difficult to reach cooperation agreements that have any real impact for patients and users.
- Today, care plans and coordinated plans tend to be seen as fiction rather than a functioning plan for coordination.
- The primary care sector does not have the necessary resources to take on the role of coordinating care measures that is expected of it. The reasons may include primary care being given an unclear mandate and task.
- The funding system does not create sufficient incentives for coordination.
- Most reimbursement systems do not compensate specifically for coordination efforts.
- The current information structure in the IT support does not provide the right conditions for coordination.

When local and national initiatives aimed at improving coordination were studied[2], major shortcomings were also found in how to measure and follow up the effects of coordination.

In an investigation of healthcare services in Region Stockholm[3], Göran Stiernstedt proposed making a private contractor responsible for all healthcare within a specific geographical area, for example Kungsholmen in Stockholm. The point is to keep healthcare and long-term care services together. It does not matter whether it is a public or private organisation.

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[1] The Swedish Agency for Health and Care Services Analysis PM 2016:1.
[2] https://www.vardanalys.se/rapporter/fran-medel-till-mal/
[3] Mest resurser – bäst sjukvård? Göran Stiernstedt 2017.

The lack of coordination is particularly evident during the coronavirus pandemic, not least between the authorities. The debate rightly pays tribute to healthcare staff. However, staff working in care of the elderly are suspected of having inadequate procedures when there were essentially no resources for coping with the new emergency situation: no hand sanitizer, personal protective equipment, tests, or replacements for sick staff. Close contact is at the heart of long-term care. The spread became unavoidable. The ban on visitors to homes for the elderly did not come until the end of March, even though some nursing homes had already made their own decisions. This delay certainly contributed to the high infection rate in nursing homes in Stockholm.

Closer cooperation between regions and municipalities with a clear division of responsibility and support measures would have made it easier for nursing homes and home help services in the municipalities to improve conditions in a difficult situation. At the same time, there are examples of how the coronavirus pandemic has led to close collaboration between healthcare services in different parts of Sweden. Patients from Södermanland have been sent to Stockholm. Region Jönköping has received help with ICU care. As far as the healthcare backlog is concerned, different regions will have different waiting times. Here we can learn from the coronavirus pandemic and help to ensure that the necessary care is provided more quickly.

More and more evidence confirms that effective primary care with continuity reduces emergency room visits and hospitalizations, resulting in better health. At the same time, the share of resources for Swedish primary care has been relatively low compared with other European countries and has not increased in relation to somatic specialist care and hospital care over time.

Primary care is emphasized as the basis required to be able to provide integrated and person-centered health services. However, real partnerships with other stakeholders in society are also needed. After the Forum for Health Policy's training day on May 15, 2020, we received many viewpoints from the audience of patients, doctors, nurses, students, researchers, decision-makers, and others. "What we now need to work on is better cooperation between the authorities, e.g. between healthcare services/police and, above all, between somatic and psychiatric care. Something we often encounter in the emergency room." "Increase opportunities for collaboration. This applies to practical opportunities, such as networks/platforms, as well as financial opportunities, to allow all professions to devote part of their working hours to collaboration."

More powerful cooperation between regions and municipalities has been in demand for decades and is also one reason behind the investigation into Good quality, local healthcare. The government's investigator has presented fundamental principles for the healthcare of the future[4]. Proposals have been put forward to strengthen different dimensions of collaboration and create a more cohesive healthcare system. For example, the government has invested more than six billion of taxpayers' money in four development areas:

- Development of local healthcare with the focus on primary care
- Increased accessibility within children's healthcare
- Actions within the framework of Vision for eHealth 2025
- Good conditions for healthcare workers

[4]https://www.regeringen.se/rattsliga-dokument/statens-offentliga-utredningar/2020/04/sou-202019/

Good examples of effective cohesive care

Borgholm[5] has succeeded in reducing the number of inpatient cases, emergency room visits, and the total care consumption for a patient group of traditionally heavy healthcare users.
In Alaska[6], the number of emergency visits has been reduced by 40% and the number of hospital stays by 36%. At the same time, they have good clinical results and very satisfied patients as well as staff.
At Sahlgrenska University Hospital[7], the number of emergency patients has increased by 20% from 46,000 to 56,000, and the number of beds has decreased by 20% from 191 to 151. Nevertheless, the occupancy rate in January fell from 114% to 98%.
In Norrtälje[8], where healthcare and long-term care are found within the same organization, the cost per user in both home help services and homes for the elderly is much lower than average in the region.

Advice for improved coordination

Effective coordination requires real proposals for reform. There is still no reimbursement system or funding system that provides incentives for coordination. Opportunities have still not been tested (with few exceptions such as Tiohundra) for a provider, public or private, to assume full responsibility for both care of the elderly/home help services/social services, and healthcare. There is still no IT infrastructure for smooth coordination. The lack of communication between the various responsible authorities' medical record systems causes a lot of time wasting and an increased risk of incorrect treatment. There is still a lack of strong leadership to pursue reforms. Orthopedists from Karolinska University Hospital only started to make home visits in an exemplary manner when we had a pandemic crisis and elderly patients canceled visits although they were in need of follow-up. As early as 2016, over 100 people from the municipalities, regions, organizations, patient associations, companies, and politics took part in the Forum for Health Policy's workshop[9] on effective coordinated healthcare and long-term care. The recommendations resulting from the workshop are still valid:

- **Give individuals the opportunity to choose between different providers who offer cohesive care pathways for more seamless healthcare and long-term care.** Enables healthcare and long-term care providers to take overall responsibility for the regions' and municipalities' healthcare and long-term care, in addition to current structures. This can be carried out as an experiment that should be followed up and evaluated on an ongoing basis. Healthcare providers with overall responsibility can more easily organize seamless healthcare and long-term care. One example is that the patient receives a "bag" of money and can choose to

[5] https://healthpolicy.se/2019/06/07/losningen-ar-enklare-an-vi-tror/
[6] https://healthpolicy.se/2019/05/10/community-driven-healthcare/
[7] https://www.gp.se/nyheter/göteborg/nya-metoderna-minskar-trycket-på-akuten-1.22741752
[8] Utvärdering av KSON avseende resultateffektivitet RS 2019:1124
[9] http://healthpolicy.se/events/2017-2/en-effektiv-sammanhallen-vard-och-omsorg-workshop-132/

register with one of several eligible healthcare organizations (public or private), which then receives the patient's "bag" of money. The concept could be trialled in a part of the country.

- **Create reimbursement and follow-up systems that strengthen the coordination of all the individual's healthcare and long-term care needs.** The development of reimbursement systems for large cross-border functions such as healthcare and long-term care requires some form of close collaboration between the regions and municipalities. Reimbursement systems should be based on all the individual's healthcare and long-term care needs and eliminate obstacles to coordination as well as promoting innovation. The reimbursement system can, for example, reward a reduction in unnecessary re-admissions. Reimbursement systems should always be combined with robust follow-up and benchmarking of costs and quality with ongoing feedback of results to healthcare and long-term care providers. This should be transparent and be presented to the public. (Like the "Vården i siffror" tool today).
- **Develop the information provision, IT infrastructure, and digitized service processes for healthcare, based on the needs of patients and users.** It is time for greater political mobilization to accelerate the development of the "digital highways" that enable the exchange of information across providers' and authorities' boundaries. This would meet inhabitants' expectations and make things easier for staff. Contractors play an important role in the development of smart, user-friendly services. Even though there is already a national service platform and technical possibilities for third-party developers, there are still obstacles to being allowed to participate in the development of services for inhabitants.
- **Establish more mobile healthcare teams that visit people at home.** Coordination of healthcare and long-term care is needed to support patients and users. There are currently a number of different coordinator functions, such as nurse navigators in cancer care. A more extensive coordinator function consists of mobile, cross-professional teams that can coordinate the different phases of the care pathway and facilitate contacts between different providers. For example, community healthcare teams are a symptom-oriented approach for people with complex medical and long-term care needs, which can reduce readmission. The work of setting up mobile teams should be intensified and success cases should be encouraged and shared.

2. TAKE BACK YOUR TIME

– FROM ADMINISTRATION TO PATIENT MEETINGS

Administration is taking up more and more time. In a 2019[10] thesis, District Nurse Eva Anskär notes that only a third of her working hours are devoted to directly working with patients. The rest of the time is used for documentation, meetings, e-mails, etc. In the study, which included all professions, the respondents first had to indicate how much time they thought they devoted to different tasks. Time studies were then carried out where the time taken was recorded. Among other things, the results showed that 37% of staff time is spent on directly working with patients (for nurses slightly more and for doctors slightly less). All occupational groups underestimated the time required for administration. Eva Anskär points[11] out that "there is a lot of administration that staff at health centers spend an unnecessary amount of time on – time that could be used for working with patients instead."

In another study[12], 1,228 practising clinicians self-assess their working hours. The results show that doctors spend an average of 19% of their working hours on administration and documentation. However, it is important to emphasize that the survey is a self-assessment study. Several studies show an underestimation of administration when time is estimated and not recorded in time studies. The survey results in the study show that there are no staff to book patient travel and clean the cafeteria, for example. IT systems are complicated and sluggish. It is also confirmed that there are no guidelines for how doctors' working hours are to be used. The Chairman of the Swedish Medical Association, Heidi Stensmyren, is quoted in Läkartidningen[13]: "We need to get more patient time. IT systems must be greatly improved and we must have a digital infrastructure that is much more efficient and useful than it is today. We also need more technicians in healthcare who can work with us."

The "Effektiv vård"[14] investigation provides a thorough review of what is involved in administration. The investigation confirms that the healthcare system has been subject to increased administrative requirements and that frustration has increased. One example from the investigation is that scheduling should be adapted to production planning. The investigation encountered very few examples of production planning being followed by coordinated work on scheduling. "Today,

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[10] "Time flies in primary care: a study on time utilisation and perceived psychosocial work environment." Anskär, Eva. Linköping University, Department of Medicine and Health. Linköping University, Faculty of Medicine and Health Sciences. Region Östergötland, Primary care center, Vårdcentralen Mantorp. 2019

[11] Vårdfokus May 16, 2019

[12] Tid i vård ger vård i tid. McKinsey 2019

[13] Läkartidningen 30-32/2019

[14] SOU 2016:2

scheduling still seems to be largely based on available staff and not need. Scheduling that supports team-based and multi-professional ways of working is also seen as unusual."

The Vårdfokus magazine conducted a review[15] of the change in administrative staff from 2010–2017 based on statistics from SKR (formerly SKL) and found that the group of officials, administrators, and managers increased by 36%. At the same time, Sweden has more doctors than other countries, but fewer visits per doctor.

A comparative time study[16] of the working day of Swedish and English doctors found that English doctors spent a larger part of their time with patients than Swedish doctors [17] Swedish experiences are based on hospitals in Skåne. Use of time varies greatly between the two countries. In Sweden, working hours consisted mainly of working with patients and patient-related administration, 40 percent and 37 percent respectively of the total working hours. In England, relatively more time was spent on working with patients, 66 percent, and less time on administration, 15 percent. An average of 8 hours per day were spent on working with patients in England and 3.3 hours per day in Sweden. The time spent on patient-related administrative work was 2 hours in England and 3 hours in Sweden. Several interesting results emerged from the survey conducted among doctors in Skåne. Among other things, 70 percent of doctors thought that the least useful use of time consists of searching for information in patient medical records and 85 percent felt that they performed administrative tasks that another team could take over.

Several studies testify to both unnecessarily heavy bureaucracy with an increased number of administrators and an excessive administrative burden on medical professionals. The trend has gone towards higher demands for documentation and reporting. Private healthcare providers established throughout the country – publicly financed through procurement or healthcare choices – experience great frustration over the different requirements of the regions for follow-up measures. Political budget documents often set out a large number of objectives with indicators that operations must be governed by, creating extensive administration centrally as well as for local healthcare providers. Less detailed management would free up resources and reduce frustration.

The fact that Sweden's 21 regions have different healthcare choice systems, with different regulations and reimbursement, also makes it difficult to collaborate effectively across regional borders.

The question is how governmental authorities, regions, and municipalities can coordinate regulations and follow-up measures, while also reducing the requirements.

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[15] Vårdfokus magazine August 22, 2018

[16] Läkartidningen 2014, 27-28

[17] Mer tid för patienten hos läkare i England. Bengt Jeppson and Johanna Edvardsson. Läkartidningen 29-31/2014

Healthcare staff still feel that the support systems are complicated and time-consuming. The streamlining that many had expected from IT support has not taken place. One example is the regions' lack of interest in reviewing how efficiently patients are guided through the healthcare system. The patient's own evaluation of time spent and waiting is rarely taken into account. Studies and statistics about patients getting lost in the system are conspicuous by their absence. Why isn't this issue taken seriously?

While there are digital referrals, important information needed for the best possible referral is missing. In a review of the proven large number of incorrect referrals, the county council auditors for Stockholm County Council (now Region Stockholm) comment that "the issue is not prioritized" and "there can only be a substantial gain when referrers have significantly better and easily accessible support for referring patients correctly. In this review, we have not come into contact with anyone at SLL who is tasked with making the information available to referrers…"

It is hoped that new modern healthcare information systems will change this. Region Skåne is now introducing a new comprehensive digital platform, Skånes digitala vårdsystem (SDV). Framtidens Vårdinformationsmiljö (FVM) is Västra Götaland's most important digitization initiative. However, no intelligent referral systems have yet been launched. Region Stockholm has stopped its procurement due to the coronavirus pandemic.

Heroic efforts are being made in healthcare and long-term care due to the great pressure that the coronavirus pandemic puts on the healthcare system. Many doctors and nurses also testify to a certain sense of relief because their time is being used efficiently for the job they were trained for. It is important to harness this power by improving conditions and streamlining administration.

Advice for increasing patient time

- **Let the medical profession do its job** by strengthening governance and management systems that create the prerequisites for this, e.g. production planning and efficient scheduling.
- **Simplify documentation.** In collaboration with the government and municipalities, the regions should analyze and simplify documentation and follow-up, introduce the same documentation requirements throughout the country, set requirements for fewer but relevant follow-up measures, and avoid double counting.
- **Develop intelligent referral systems** that make it easier for healthcare providers and patients to follow and follow up on referrals.
- **Allow patients to acknowledge the time they have to wait**: for various messages, in the waiting room, in the operation queue, on the telephone, etc., and report this openly on each region's website.

3. CLEARER GOVERNANCE AND BETTER LEADERSHIP

Let us toy with the idea that today we are going to introduce a new healthcare system in Sweden. Would we then divide the country into 21 regions with 21 different healthcare systems and 21 different political leaders and 290 municipalities with different long-term care systems and also 290 political leaders? That is questionable. So how effectively do management and governance work in the system we have?

Prior to the coronavirus pandemic, the focus was on strengthening local healthcare. Several reports have been presented on local and cohesive healthcare. Then the whole of Sweden was thrown into a crisis that takes all strength and energy, not only from healthcare and long-term care staff.

The coronavirus pandemic has identified several deficiencies in governance. In practice, operational responsibility for emergency preparedness has been seen as unclear. The Swedish National Board of Health and Welfare, the Swedish Civil Contingencies Agency, and county administrative boards juggled responsibility for logistics for the municipalities' supply of personal protective equipment for a period of one month. It also took a whole month for the Swedish Civil Contingencies Agency and the Public Health Agency of Sweden to consider a track and trace app. And when hospital staff lacked personal protective equipment in the middle of the ongoing pandemic, they were not allowed to order from suppliers.[18] When Tarja Viitanen, charge nurse in Nyköping, tried to order aprons and face masks, among other things, she received the response that "the goods were restricted for ordinary orders and must be distributed between the regions' buffers/emergency stocks."

The Swedish Local Government Act (Kommunallagen) states that each municipality and county council must have a salaried employee who has a managerial position among the employees and that they must have instructions. However, it is not clear what the instructions should contain. In an article, Håkan Sörman, former CEO of SKL,[19] called for a clearer division of roles for leading politicians and civil servants. Today, roles are mixed up as some politicians act as CEOs and regional directors act as deputy regional councillors. A manager of a municipal company is answerable under the Swedish Companies Act (aktiebolagslagen) and is the subject of an audit. But for a manager in a municipal administration, the Swedish Local Government Act (kommunallagen) applies – and only politicians are held to account.

The above example shows ambiguities in the governance model before coronavirus and also in connection with the pandemic.

At the Forum for Health Policy's digital training day with more than 500 participants, the audience was asked about the most important improvement measures. Recurring comments included **reviewing governance and management**. Many people were critical of the fragmented system of

[18] Ekots granskning. https://sverigesradio.se/sida/artikel.aspx?programid=83&artikel=7476694
[19] Dagens Samhälle November 21, 2019

governance, controlled by 21 regions and 290 municipalities. An evaluation of the current division of responsibilities between the state, regions, and municipalities was requested.

Advice for better governance and management

- **Evaluate the current division of responsibilities within the healthcare system, at national, regional, and municipal level.** The evaluation should include a basic description of overlapping responsibilities, ambiguities in the division of responsibilities and mandates, and define specific problem areas.

4. BETTER MEASURES TO COMBAT MENTAL ILLNESS

Mental illness, with problems such as anxiety and sleep problems, has increased significantly in the last twenty years. Psychiatric diagnoses have been the most common cause of sick leave in Sweden since 2014. More than one million Swedes take antidepressants. While serious psychiatric diseases and diagnoses have not increased, the question is whether the healthcare system uses all the latest knowledge to treat severe conditions. Increased mental illness means suffering for individuals and major costs for society.

Stress and fatigue are common reasons for sick leave, at high costs to employers. Long-term sick leave is also associated with high costs for rehabilitation and work adaptation, etc. The lack of access to psychologists, psychotherapists, and counselors, among other things, means that many employers pay for private health insurance. Today, approximately 680,000 people in Sweden have private health insurance.

There is a great need for preventive measures, healthcare, and rehabilitation. The healthcare system is not able to keep up, and the waiting lists are often long. The same applies to the waiting list for psychologists and similar professionals for our young people. Recently, 28 operations managers, medical superintendents, and medical directors solely from Child Psychiatry, testified that it is not possible to rely on Child and Adolescent Psychiatry being able to cope with the large increase in mental illness among children and young people.[20] At the same time, other comparisons show that physicians in Child and Adolescent Psychiatry do not see more than 1.5 patients per day. [21]

The final report of the Swedish national coordinator for the development and coordination of mental health initiatives[22] states that "national governance has been characterized by short-sightedness and project management. The effects of the next SEK 13 billion invested in improving living conditions for people with mental illness, in whom more than SEK 10 billion have been invested in the last 10 years, are unclear".

With new ways of working, psychiatry can reach even more people. According to consistent scientific evidence,[23] online CBT (cognitive behavioral therapy), which has been offered in Stockholm since 2007, can have an equivalent effect to standard CBT while saving valuable treatment time. At least four times more patients can receive help with online CBT compared with CBT through a physical meeting in terms of effective treatment time.

Including people with personal experience of mental illness increases the likelihood of the healthcare system being designed and developed based on patients' real needs. One example is the user

[20] SvD 20190322
[21] Psykiatrin i siffror 2019. SKR.
[22] SOU 2018:90
[23] Läkartidningen. 2017;114:D77R

influence coordinators (BISAM) in psychiatry in Region Stockholm, whose remit includes listening to patients' needs. This can include everything from better phone support or increased opportunities for activities to more inclusive healthcare planning.

There are a number of initiatives for improving psychiatric care in Sweden, but the challenge is so great that capacity is also needed outside of the healthcare system. This is particularly important in view of the lack of psychiatrists, psychologists, counselors, and therapists. An important, but perhaps underestimated, focus in Sweden is to involve civil society to a greater extent.

Internationally, there is an ongoing discussion about giving people specific training in order to be able to identify, intercept, and support people who experience varying degrees of mental illness. Mental health workers are more common in low-income countries, but are also increasingly used in rich countries such as the USA, England, and Australia.

The International Initiative for Mental Health Leadership is an international and cross-sectoral network for mental health leaders. In 2018, 400 leaders from 24 countries from different sectors involved in mental health gathered in Stockholm. They confirmed that the research situation is good for finding practical solutions for system coordination in policy and practice. Yet this does not dominate the way the healthcare system works today. They agreed unanimously that the most significant barriers to successfully dealing with mental illness are:

- inadequate structures and processes for cross-sectoral management and governance
- inadequate political attention
- inefficient resource allocation
- stigma and negative attitudes to mental illness

In Sweden, there is a lack of psychology expertise in primary care. The treatment offered is primarily medical. The range of cost-effective and individualized models for psychological support and treatment is too limited in relation to the growing needs.

Many people also request greater availability of psychological support. Lead times are perceived as long. In the case of mental illness, early treatment increases the chance of recovery. Psychiatry can and should reach more people with new ways of working and digital support, which can also free up resources.

Costs of mental illness

Calculations (SOU 2018:90) show that the costs to society of mental illness directly and indirectly amount to almost 5 percent of Sweden's gross national product (GNP). Apart from suffering for the individual, the increase in mental illness means major costs for society. Stress and fatigue are common reasons for sick leave, at high costs to employers, especially for the first two weeks. Long-

term sick leave is also associated with high costs for rehabilitation and adaptation, etc. Improving mental health would bring about significant socioeconomic savings.

Advice for reducing mental illness

The Health Policy Forum organised a major workshop on the topic of mental illness in 2019 with politicians, officials, patients, psychiatrists, psychologists, counselors, and other healthcare professionals, as well as representatives from companies and researchers. There was a broad consensus on the need for new thinking, concrete proposals, and follow-up to reverse the trend. Three overall recommendations were highlighted

- **Develop a long-term strategy with specific goals and sub-goals.** To reverse the trend towards mental illness in Sweden, an integral group and innovative approach are needed. A long-term strategy with clear goals that can be monitored can stimulate innovation in different areas. Early interventions, digital aids, complementary training, patient involvement, and collaboration with civil society organizations are just a few examples
- **Create reimbursement and follow-up systems that promote health and prevention**
  Healthcare reimbursement systems should include prevention and health and be based on the individual's entire care pathway. This may involve rewarding a reduction in unnecessary re-admissions, for example. At the same time, it is of great importance that reimbursement systems also promote higher accessibility.
- **Increase the rate of development of preventive work in collaboration with social operators.**
  Human suffering and high costs to society can be prevented if more focus is placed on prevention and health promotion measures. More providers in society should, for example, encourage increased physical activity, which has a documented effect on depression, etc.
  Not only healthcare services, but also other operators in society should work more actively to prevent mental illness, such as schools, employers, and organizations in local and civil society.
  A holistic approach and individualized needs require real cooperation between different professionals and responsible authorities.
- **Develop the quality and reach of healthcare.** Functioning structures for patient involvement create the conditions for more needs-driven development and smoother healthcare processes.

5. PREVENTION FOR THE BENEFIT OF THE PATIENT

A major challenge in healthcare systems is the increase in chronic diseases, which in many cases can be prevented. Various providers can contribute to health-promoting processes, but healthcare plays a central role. Primary and secondary prevention is a prerequisite for meeting the challenges of the future. Effective prevention improves health but also saves money. Several reports show the importance of preventive measures.

One study[24] shows a strong desire in the population to improve health with preventive measures. More than half of respondents state that they would look to the healthcare system to improve their health, but at the same time have the perception that the healthcare system lacks suitable preventive processes. The survey also shows that respondents are positive about monitoring their disease. They also say they are willing to share their personal health data with the healthcare system.

Calculations from a government inquiry[25] show that the costs to society of mental illness amount to approximately SEK 140 billion annually. If an increased focus on preventive work can reduce the incidence by only five percent, SEK 7 billion could be saved every year solely in the area of mental illness. There are also indirect costs, which are often greater, e.g. sick leave, production loss, etc. In one article, the Swedish Rheumatism Association[26] writes that the costs of rheumatic diseases are close to SEK 40 billion per year, the majority of which relate to production loss and sick leave costs.

In a blog article[27] for the Forum for Health Policy, Professor Lars Weinehall describes Västerbotten County's work on the prevention of heart attacks and strokes. By the 1980s, the northern counties had dramatically increased mortality rates for cardiovascular diseases. The introduction of health surveys in 1985 and individual health dialogs produced good results with a change in living habits. An article published in the British Medical Journal in 2015 showed that Västerbotten County, which in 1985 was the worst, now had 10% lower total mortality rates for the age group 40–74 years compared with the rest of Sweden.

Digitization is creating completely new conditions for prevention and preventive measures. With access to DNA, clinical values, and lifestyle habits, there is a dual opportunity to identify the risk of ill-health in specific individuals and to support changes in lifestyle habits and/or treatment. This paves the way for individually-oriented preventive work that can reduce the incidence of cardiovascular diseases, diabetes, and mental illness. Preventive measures, in the form of both primary and secondary prevention, can and should become the health revolution of our time.

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[24] Från sjukvård till hälsovård. June 2019. PWC et al.
[25] SOU 2018:90
[26] Lotta Håkansson's blog for the Forum for Health Policy
[27] http://healthpolicy.se/2017/04/27/inte-det-smartaste-vagvalet/

Reimbursement systems are an important part of healthcare governance. The focus is usually on healthcare. This may involve payment per procedure or operation performed. Quality measures are included, but are usually linked to medical outcomes. Reimbursement systems should focus more on health and prevention. Reimbursement systems should be based on the individual's entire care pathway and remove thresholds for preventive measures, especially for people with chronic diseases. Reimbursement systems can, for example, reward reductions in unnecessary re-admissions.

Effective prevention is based on the patient. Each patient has unique knowledge of herself and her needs, expectations, and resources. Prevention is only successful with the patient's active involvement. Healthcare is safer and better if patients are well informed, actively participate in their care, and can influence healthcare based on their role.[28]

In Sweden, the patient's rights and position are prescribed by law under the Swedish Patient Act (Patientlagen), which came into force on June the 1, 2015. The act promotes the integrity, autonomy, and participation of the patient. However, the act has not had a significant impact. A report[29] from the Swedish Agency for Health and Care Services Analysis shows that the patient's position is still weak and has actually weakened over time in areas relating to accessibility, information, and participation.

[28] The patient is part of the team. The Swedish National Board of Health and Welfare 2019

[29] Lag utan genomslag. Utvärdering av patientlagen 2014-2017. The Swedish Agency for Health and Care Services Analysis. 2017.

Prevention that frees up resources

Effective prevention and active patient participation improve health and save money. Several reports show the importance of preventive measures. One example is rheumatic diseases, which cost society almost SEK 40 billion a year. Most of the costs consist of production loss and sick leave. Better primary and secondary prevention improves health and frees up resources for society.

The Swedish Patient Parliament (Patientriksdagen), which is a meeting place for patients and decision-makers to discuss the position of patients. A number of different patient associations participate and give their views on how to strengthen patient participation. The most recent patient parliament[30] highlighted the following:

- Integrate the health plan into medical records
- Patient education should be defined and structured
- All healthcare training courses should include training in the Swedish Patient Act
- Digitization must be based on the patient
- The healthcare system must be more person-centered
- The healthcare system must be better at taking care of chronically ill people
- The role of care coordinator should be introduced, considering the top to bottom organization that exists in healthcare today
- Stronger and clearer complaints system – patient committees are currently underutilized

Advice for improving prevention

- **Functioning structures for patient participation and person-centered healthcare and long-term care** create the conditions for more needs-driven development with a focus on prevention.
- **More psychology expertise in primary care** can provide timely support and therefore reduce suffering as well as costs.
- **Greater focus on prevention and health promotion measures.** More operators in society (schools, employers, etc.) should, for example, encourage increased physical activity.
- **Develop a long-term strategy with specific goals and sub-goals.** Investing in prevention requires a holistic approach and innovation, which a long-term strategy can stimulate. Early interventions, digital aids, patient involvement, and collaboration with civil society organizations are just a few examples.

[30] Patientriksdagen. Report 2019.

6. INCREASE THE PACE OF DIGITIZATION

We are awash with information about the spread of coronavirus and vital knowledge about how to behave in order to protect high risk groups. At the same time, the crisis requires us to use digital tools in healthcare and long-term care to a much greater extent than before, here and now. If possible, staff cannot and should not be close to patients. Patients do not want to and should not be physically close to staff, considering the risks of contagion. Now, the digital transformation in healthcare is exploding.

Online healthcare is just one of several digital tools that are now being used to a greater extent. Digitization in general provides major opportunities for quality and efficiency improvements in healthcare. Several studies show reduced costs with relatively simple measures. This may involve administrative support, diagnostic support, medical records, etc.

New technology in the home, for example, facilitates self-care for people with chronic diseases and creates a higher quality of life, as well as freeing up resources by reducing hospital admissions. New technology provides the conditions for more equal care, including digital decision support. AI-based diagnosis and decision support sometimes has better accuracy than even the most experienced physicians, despite the fact that the development of this support is only in its infancy.

Using analytical instruments, medical history, and general examination, healthcare professionals today assess what is needed to help the individual. In the past, it was a few, obtuse parameters that formed the basis on which patients' conditions could be assessed, while today's technology offers significantly greater opportunities.

Thanks to increased digitization, the healthcare system can also make greater use of the patient's own assessment of their condition before an appointment. In the past, where too much time was taken for healthcare staff to assess and document information, this is now done using decision support and automatic documentation. This procedure is used by online doctors who automatically ask questions while we wait to be contacted. There are also unique initiatives in certain patient groups that assess their pain or symptoms prior to an appointment at the healthcare center.

Documentation has previously been a bottleneck, where it has either been missed out, delayed, or documented twice. With increased digitization comes increased automation, which will not only save time but also improve integrity, where there was previously a risk that staff documented only their interpretations. Increased standardization of nomenclature simplifies the handling and comparison of data and information – bad handwriting is also avoided.

Sweden is the country in the world where citizens have the best access to the internet at home, as well as experience in the use of smartphones and wireless connections. Sweden also has a good

infrastructure for handling information and data, as well as legislation that enables us to handle it safely. The conditions here are phenomenal. With an increased ability to share data between regions and municipalities, as well as the ability to combine data from different sources, Sweden could be at the forefront – not least in our capacity to treat or keep our citizens in good or better health with greater precision.

Several studies show great opportunities for quality and efficiency improvements with the help of digitization. One study[31] shows opportunities for reducing healthcare unit costs by up to 25% over a 10-year period, by systematically applying digital technology in 14 areas.

Another report[32] on digitization in municipalities reviews seven municipal services. The study calculates the efficiency potential based on the proportion of people who use digital services instead of manual/analog services, the digital uptake. The annual savings potential is extensive in all municipality types studied. The report also shows that there are significant savings opportunities, even if only one in 10 people uses the four e-services within the home help service.

There is still no incentive in the healthcare system in the form of technology-neutral reimbursement systems that encourage the development of work processes in digital and physical care. The regions' reimbursement models are not in line with developments. A common technical platform that works for the whole of Sweden needs to be made more easily accessible between regions, municipalities, private and public healthcare providers.

Today, legislation and regulations often constitute an obstacle to innovation and patient and user-adapted healthcare and long-term care. In order to exploit the full potential of digitization, regulations and legislation must change focus from organization to individual, promote compatible systems and enable collaboration across all boundaries (between responsible authorities, between private and public healthcare providers, and between digital and physical healthcare).

The cost of the coronavirus crisis to society is huge. But the crisis is also accelerating the use of existing digital tools and innovation of new ones, which is necessary for the healthcare system regardless of the pandemic. When the Forum for Health Policy organizes workshops on the theme of digitization in healthcare with representatives from public and private healthcare providers, patients, employees, researchers, and politicians, a broad consensus emerges. There is a great need to meet the challenges of the future with the help of new technology.

Swedish society now shows that quick decisions can be made when it really matters. Something good can come out of this very serious crisis. Strong, supportive, innovative partnerships enable the rapid digital transformation we needed before the coronavirus crisis and that we now need even more.

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[31] Värdet av digital teknik i den svenska vården. McKinsey. June 2016

[32] When will the digitization of municipal services be cost-effective? The Swedish National Digitalisation Council, RISE, Stelcon, February 2019

Benefits of digitization

Digitization offers great opportunities for quality and efficiency improvements in healthcare. Several studies show reduced costs with relatively simple measures. This may involve administrative support, simple follow-up, diagnostic support, medical records, etc.

Advice for accelerating the pace of digitization

- **Develop a political vision for modern healthcare.** A political forward-looking vision is needed, where digital tools and healthcare appointments are a natural and integrated part of healthcare. Develop a common technical platform that works for the whole of Sweden, is compatible between regions, municipalities, private and public healthcare providers, and is easy to use.
- **Change focus from organization to person.** Consider the needs of the individual instead of the organization. By actively and responsibly listening to and creating solutions together with residents, patients, and users, development can be governed by the individual's resources, opportunities, and needs.
- **Develop and adapt the reimbursement systems.** Create technology-neutral reimbursement systems with a focus on results. Digitization of healthcare provides great opportunities, but also requires adaptation of the management system. The regions' reimbursement models are out of step with developments. Incentives are needed for healthcare providers to give cohesive and preventative care, across the boundaries of responsible authorities, and across digital and physical boundaries, without encouraging overutilization.
- **Use digital technology to create modern ways of working.** Digital technology is used to create modern ways of working. A variety of digital technology support allows healthcare professionals' skills to be better utilized, increasing the attractiveness of the profession.
- **Modernize legislation.** Create a clear, principled regulatory framework without micro-management and trust in the users. In order to exploit the potential of digitization in healthcare and long-term care, regulations and legislation must change focus from organizations to individuals, enable collaboration across all boundaries (between responsible authorities, private and public healthcare providers, and digital and physical healthcare), and promote compatible systems. Today, the regulatory framework often constitutes an obstacle to innovation as well as to patient and user-adapted healthcare and long-term care.

7. LEARN FROM VARIATIONS IN HEALTHCARE

Increased knowledge of healthcare and long-term care is a prerequisite for better policy decisions and new innovations. Variations in healthcare outcomes pose a challenge for decision-makers, practitioners, and researchers to analyze. This applies to healthcare needs, which differ between individuals, and how healthcare is provided.

Quality management should be seen as part of the efficiency improvements in healthcare. Getting things right from the start not only prevents suffering for the patient, but also reduces operation costs, for example if fewer reoperations are required. Nordic comparisons (Rehnberg 2016) and experiences from Capio St Göran Hospital show that we could get significantly more healthcare for the tax money spent at Swedish emergency hospitals.

Sweden has a long tradition of collecting and presenting data, and almost unique data sources that highlight variations in healthcare. Annual reports are presented from national quality records, indicator-based evaluation reports from the Swedish National Board of Health and Welfare, quality and cost data from SKR, including "Öppna jämförelser" (Open comparisons) and "Vården i siffror" (Healthcare in figures). The quality records have led to significant improvements in healthcare results.

In a blog post on the Forum for Health Policy, in his thesis Johan Mesterton shows that there are major differences in c-section frequency and health outcomes between different Swedish maternity hospitals after case-mix adjustment. If all hospitals performed as well as the 20% that performed best for the respective quality indicators, it would have been possible to avoid 2,200 cesareans, 900 serious ruptures, 1,500 infections, and 2,700 severe hemorrhages during the period studied, the years 2011 and 2012.[33]

Another thesis, from Medical Management at Karolinska Institutet, shows the benefits of healthcare outside the system of top to bottom organization. The cost of healthcare at a Swedish HND centre for multi-morbid patients with heart and kidney disease as well as diabetes was approximately SEK 50,000 lower per patient per year compared with healthcare for heart and kidney disease and diabetes in traditional healthcare.[34]

In the annual report from SKR, "Vården i siffror" (Healthcare in figures), some regions, hospitals, and clinics perform significantly better than others in terms of better accessibility, treatment results, patient satisfaction, etc. Why?

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[33] Omotiverade skillnader i svensk förlossningsvård. Johan Mesterton. Blog for Forum for Health Policy

[34] Counting what counts: time-driven activity-based costing in health care. Georg Keel. Karolinska Institutet 2020

An important policy issue is not whether to publish quality comparisons, but how regional and national work on quality measurement and publication of data should be organized to provide as much benefit as possible in terms of development and improvement. Some quality measurement is done to support improvement that focuses on the unit's own development over time. Measuring quality to support evaluation instead emphasizes fair comparisons between units or healthcare systems.

Overall, there is a very large number of indicators and together with other relevant comparative figures (healthcare consumption, cost data, average lengths of hospitalization, analyses of medicinal products), the number increases further. There are large amounts of potentially meaningful information about quality and efficiency. From both a regional and national perspective, it is important to increase the usefulness of this information.

Advice for better evaluation

- **Quality indicators for improvements** must be easy to use, clear healthcare process measures, rapid indicators, and relevant to the results.
- **A more powerful national interpretation** of individual and individual regions' results is needed and would mean saving labour and simplification for the regions. Both national and regional governance are facilitated by better evidence of what works and what does not. A competent organization for external and authoritative assessment could evaluate and challenge the regions constructively.
- **Point out a number of important quality problems nationally.** However, accessibility has previously been highlighted without analyses of why certain regions or hospitals had better or worse accessibility. These areas should be seen as high priority quality deficiencies, but backed up by health and socioeconomic analyses so that broader assessments of health and other benefits are also reflected.
- **The state, regions, and municipalities should jointly develop a standard follow-up structure** to ensure all healthcare providers report quality in a similar way. This should include clinical outcome measures (e.g. readmission, post-surgery infections, etc.), waiting times, patient experience of care, information, participation, etc. Healthcare providers, regions, and municipalities can use the metrics to improve governance.
- **Patients and residents should have better opportunities to compare** the quality of healthcare given by different providers. There are currently a number of different measures available, but it is still difficult to find your way among the many different measures in different places.

CONCLUSION

The coronavirus pandemic has caused suffering, death, and major economic consequences for society as a whole. The pressures on healthcare have been extreme. Huge efforts are made every day.

Resources are being invested in the regions and municipalities. At the same time, waiting times are increasing for those patients who were already waiting for care, but for obvious reasons are being given lower priority. We will come out of the coronavirus pandemic with an enormous healthcare backlog, financially, personally, and in the form of a huge backlog of care needs.

But there are also glimpses of hope. A powerful fostering of innovation. Things that used to take months and years to complete can now be done in a few weeks. Digitization has taken a major leap forward. Decisions that previously took years to investigate and resolve have been taken because they must be taken here and now. This shows that there is tremendous potential in our healthcare staff, a potential that is currently not being utilized.

After the acute phase, we will be able to learn a lot from what has worked and where we have fallen short. But we must also remember that there were major challenges for the Swedish healthcare system even before the coronavirus crisis. When the emergency situation is over, the long-term discussion must focus less on resource allocation and more on how the resources are used.

This report makes suggestions for necessary actions in a number of different areas:

1. Coordination saves money and prevents suffering

- Give individuals the opportunity to choose between different providers who offer cohesive care pathways, for more seamless healthcare and long-term care.
- Create reimbursement and follow-up systems that strengthen the coordination of all the individual's healthcare and long-term care.
- Develop the information provision, IT infrastructure, and digitized service processes for healthcare based on the needs of patients and users.
- Establish more mobile healthcare teams that visit people at home.

2. Take back your time – from administration to patient meetings

- Let the medical profession do its job.
- Simplify documentation.
- Develop intelligent referral systems.

3. Clearer governance and better leadership

- Evaluate the current division of responsibilities within the healthcare system, at national, regional, and municipal level.

4. More measures to combat mental illness

- Develop a long-term strategy with specific goals and sub-goals.
- Increase the rate of development of preventive work in collaboration with social operators.
- Develop the quality and reach of healthcare.

5. Prevention for the benefit of the patient

- Create effective structures for patient involvement and person-centered healthcare and long-term care.
- More psychiatry expertise in primary care.
- Greater focus on prevention and health promotion measures.
- Develop a long-term strategy with specific goals and sub-goals.

6. Increase the pace of digitization

- Develop a political vision for modern healthcare.
- Change focus from organization to person.
- Develop and adapt the reimbursement systems.
- Use digital technology to create modern ways of working.

7. Learn from variations in healthcare

- Quality indicators for improvements must be easy to use, clear healthcare process measures, rapid indicators, and relevant to the results.
- A more powerful national interpretation of individual and individual regions' results.
- Point out a number of important quality problems nationally.
- The state, regions, and municipalities should jointly develop a standard follow-up structure to ensure that all healthcare providers report quality in a similar way.
- Patients and residents should have better opportunities to compare the quality of care given by different healthcare providers.

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By Catharina Barkman,
Project Director at Forum for Health

Translation: SAS Institute

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Carmona
Länsförsäkringar
Stockholms sjukhem
SAS Institute

Contact: info@healthpolicy.se

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