

Good quality, local health care – A primary care reform (SOU 2018:39)

Summary

Background

The Government decided on 2 March 2017 to appoint an inquiry chair with the remit of supporting county councils/regions, relevant government agencies and organisations in the coordinated development of a modern, equitable, accessible and effective health care, focusing on primary care, on the basis of an in-depth analysis of the proposals in the report *Effective health care* (SOU 2016:2). The Inquiry chose the name *Coordinated development for good quality, local health care* (S 2017:01).

In June 2017 the Inquiry presented its first interim report *Good quality, local health care – a joint roadmap and vision*. At the end of May 2018 the Riksdag (Swedish Parliament) is expected to make its decision on Government Bill 2017/18:83, *Governing principles in health care and an enhanced health care guarantee* on the basis of the proposals presented in that interim report.

Historically, the Swedish health care system has been dominated by investments in emergency care hospitals and specialist care other than primary care. In international comparisons, Swedish health care shows good outcomes regarding medical quality, but does less well in comparisons regarding continuity, patient participation and accessibility. There is an awareness that resources are limited and that it is important to make health care interventions as effective as possible. If we are to maintain or increase the quality of health care and address demographic changes while keeping costs under control, health and social care cannot be organised as it is at present. Changes

to its structure and how it is organised are required both to increase quality and patient participation and to improve access and ensure more effective use of resources.

Primary care plays a central role in the health care system. Research shows that stronger primary care is in a good position to contribute to equitable health throughout the population.

One central strategy for fulfilling the 2030 Agenda for sustainable development and a core priority of the World Health Organisation (WHO) is work to achieve Universal Health Coverage (UHC) around the world. WHO maintains that, for this objective to be achievable, a shift is also required from current health systems largely built up around diseases and institutions to a system designed for people. On this basis WHO advocates an integrated people-centred approach in developing our health services and systems. WHO emphasises specifically that such an approach is crucial in ensuring that marginalised/vulnerable groups are also reached and that no one is left behind. Primary care is emphasised clearly as the base needed to be able to provide integrated people-centred health services in the way desired.

If Sweden is to live up to the sustainable development goals regarding both health and the overarching goal of sustainable development, action is required at all levels of society to establish a modern, equitable, accessible and effective health system. To be able to meet the new needs that follow from changes in demographic and epidemiological conditions, and the great need for broad and intensified preventive action, such a health system must have a strong front line/primary care as its base. The Inquiry therefore makes the assessment that our remit should also be viewed as a central part of work to make it possible to achieve the sustainable development goals in Sweden.

In Sweden, too, primary care is the part of health care that is best placed to address individuals' overall health care needs. This is why patients are expected to turn to primary care in the first instance for an assessment. However, a large proportion of patients currently turn to other levels of care, e.g. emergency departments, partly because of the limited possibility of obtaining a primary care appointment quickly enough. The lack of continuity and the absence of well-functioning long-term relationships mean that it is not obvious for people to turn to that level with their everyday health

care needs, as it is in many other countries and health care systems. This also has an adverse effect on preventive work, which is generally best delivered close to people and in interaction with local civil society. Avoidable hospital care, or emergency care, results in high costs and a risk of adverse events, in addition to non-optimal care for the patient.

The Swedish health care system must therefore be reformed so that more resources are steered to the parts of the system with good prospects of offering proximity to patients and of handling complexity in diseases and preventive work. A reinforcement of primary care is necessary; this applies both to the part that is a regional/county council responsibility and to the part that is a municipal responsibility. It is particularly important to improve care for those with the greater needs.

Starting points

According to its terms of reference the Inquiry is to start from the proposals in the report *Effective health care*. The Inquiry has also chosen to give particular attention to fostering the transition to people-centred health and social care. The proposals in *Effective health care* addressed a number of different aspects and targeted a number of different actors and levels in health care. According to its terms of reference, this Inquiry is to take particular account of the following proposals:

- changes to fundamental governing principles for the organisation of care;
- the possibility of providing inpatient care outside of health care institutions;
- a nationally formulated mission for primary care;
- a clearer emergency care mission for primary care;
- a profession-neutral health care guarantee and an amended time limit for medical assessments; and
- the transfer of resources from hospital care to primary care.

According to its supplementary terms of reference, the Inquiry is also to

- analyse the appropriateness of the division into outpatient care and inpatient care in relation to the other proposals made by the Inquiry and to set out the potential consequences of changing or removing these terms; and
- investigate and present proposals about how to facilitate collaboration between primary care and municipal health and social care and about what the interface between these services should be like.

Since *Effective health care* was presented in January 2016 and since the Inquiry's first interim report was delivered to the Government in June 2017, various administrative levels, organisations and services around Sweden have continued to work along the lines of the analysis and proposals in *Effective health care* and this Inquiry's first interim report *Good quality, local health care – a joint roadmap and vision*. Other decisions with a fundamental impact on the structure of Swedish health care have also been made, such as the decision on the organisation of highly specialised health care and the responsible authorities' unified structure for knowledge management.

In both its analysis and its proposals this interim report focuses on primary care and how to strengthen it. It contains both legislative proposals and examples of success factors in work to strengthen primary care, which are intended as inspiration for the responsible authorities, i.e. county councils/regions and municipalities. A restructuring of the health care system has begun. Taken together, the proposals made by the Inquiry in this report form the basis for a reform of primary care.

Introductory chapters of the report

This interim report begins an account of the Inquiry's remit and way of working, the Inquiry's view of the need for change and international starting points. The need for transition is located in a context of ongoing changes and Sweden's commitment to the 2030 Agenda. We give a demographic description of the Swedish

conditions underlying the need for a major change of the health care system.

Then comes a section that, from an international perspective, both describes the term primary care and gives examples of a number of health care systems often emphasised as being of interest for Sweden, not least in our Nordic neighbours.

This is followed by an overview, in a way similar to the Inquiry's first interim report, of national work linked directly or indirectly to the proposals in *Effective health care* and/or to our remit. This overview focuses on developments since we presented our first interim report.

Then comes a section of descriptive texts and analyses of the present situation as background to the Inquiry's proposals. We describe the current situation regarding the regulation and organisation of health care in Sweden, focusing on primary care. We illustrate the confusion that still exists today about the term Swedish primary care, which has become synonymous, in many contexts, with the activities traditionally conducted at a health care or health centre (Sw: vårdcentral eller hälsocentral). As used in the legislation, the term primary care is broader than that, and covers health and social care that is the responsibility of the county council/region and the municipality.

In subsequent sections a corresponding description is given of the current situation concerning the regulation and handling of certain issues related to appropriate administrative procedures.

The closing part of the background chapters provides a brief introduction to the Inquiry's supplementary remit concerning collaboration between the responsible authorities and the new Act on collaboration on discharges from inpatient care.

Summary of the Inquiry's proposals

Vision and road map

The Inquiry proposes deepening the common road map and vision¹ for the restructuring of the health care system. This is done through

¹ Originally presented by the inquiry in its first interim report.

a clarification regarding a people-centred way of working and clearer inclusion of municipal services. Patient participation is emphasised. It is made clearer that primary care is the hub of health and social care and interacts with other interventions from other specialist care in and outside hospitals and with other municipal health and social care. The road map also clarifies the people-centred way of working and highlights the staff perspective. Workforce planning and development is emphasised, as is digitisation linked to the Vision for e-Health 2025. Regional and local analyses and decisions in county councils/regions and municipalities are highlighted as essential to the implementation of the transition.

To follow the transition in accordance with the proposed road map, the Inquiry proposes following four metrics at set intervals. These metrics are intended to provide input for discussion and dialogue between and together with various relevant actors in the system.

The Inquiry also proposes national consultations for implementation of the road map on three occasions up until 2027. These consultations should bring together representatives of both the local level and the regional and central government levels to make a joint check of the status of the transition and, when required, propose adjustments of the direction of the road map. It is proposed that the Swedish Agency for Health and Care Services Analysis follow the transition to good quality, local health care at a general level and provide supporting information for these joint dialogues.

Need for more possibilities of follow-up at aggregated level

The Inquiry proposes that county councils/regions report data from providers in primary care to a national database.

The Inquiry's assessment is that, at present, there is in Sweden, as in many other countries, a lack of national monitoring and follow-up of primary care at aggregated level, based on common standards. This means that there is a great lack of solid supporting information for statistics and research in the area, as well as for systematically monitoring, following up and evaluating most health care provided in Sweden today and assuring its quality at the aggregated level. This type of aggregated data is essential in order to follow and evaluate

the transition to good quality, local health care in an appropriate way.

Nationally formulated mission for primary care

A modernisation of the mission of primary care in the Health and Medical Services Act is proposed. The Inquiry proposes that primary care should be defined as ensuring the medical assessment and treatment, preventive work, nursing care and rehabilitation that do not, for reasons of quality and efficiency, require other medical or special technical resources or other special expertise. The purpose of this amendment is to clearly mark that primary care is the first level of health care, and that is the level to which people should turn in the first place with their health care needs.

The Inquiry also presents proposals that are intended to clarify the mission of primary care and create conditions for strong and equitable primary care throughout Sweden. The Inquiry proposes regulating the fundamental mission of primary care in an ordinance, i.e. a statute issued by the Government. The reasons for the Inquiry's proposal of regulating the mission of primary care in an ordinance, and not in an act of law, are set out. The Inquiry also presents a proposal for the wording of such an ordinance. We propose that the Health and Medical Service Ordinance should provide that primary care shall supply the competences in health services needed to be responsible for the fundamental mission of primary care. The necessary competences can be available within the framework of one or more health care choices in the systems of health care choice in county councils/regions. Access is a challenge in primary care today. We make clear in our proposals that primary care has to be responsible for urgent health care that falls within the mission of primary care. Primary care has to be organised to provide very good access regarding the interventions covered by its mission.

Our proposal also gives visibility to the mission of primary care to coordinate the patient's contacts with other parts of health care in cases where primary care is involved in care of the patient. Education, training and research are of crucial importance for good and sustainable health care. We therefore propose making clear that research has to be conducted in primary care. We also make the

assessment that county councils/regions should require providers in primary care to contribute to the arrangement of education and training in both the first and the second cycle of higher education. Preventive measures are a key to the health care of the future. Our proposal is that the fundamental mission of primary care should state that primary care has to provide preventive measures based on the needs of both the population and the individual patient. Primary care should also provide rehabilitation measures.

The Inquiry sees a need to clarify the special status of the health care choices in primary care² that are based on the generalist competence of, for example, specialists in general medicine and district nurses, and that act as the hub of the primary care carried out with the county council/region as the responsible authority. This should be called *Health care choice, primary care*. The county council/region should organise its *Health care choice, primary care* so that providers, either separately or in collaboration with others, specifically provide the competences and health care services required to fulfil the fundamental mission of primary care.

On the basis of the Inquiry's many dialogues around the country, a number of good examples are also presented of success factors in efforts to strengthen primary care; these are intended as inspiration as to how responsible authorities can organise primary care.

Continuity in primary care

The Inquiry makes the assessment that the importance of well-functioning and sustainable relationships in Swedish health care has long been underestimated. Continuity in the relationship between the patient and health care staff and between different professions and different health care contacts is of central importance for both the quality of care and the patient's experience, as well for the work environment of staff and the effectiveness of health care. The Inquiry illustrates the fact that there is no contradiction between the functions of registered health care contact [*sw: fast vårdkontakt*] and registered general practitioner in primary care [*sw: fast läkarkontakt i primärvården*].

² Primary care is the only area in Swedish health and social care where county councils/regions are required to introduce systems of health care choice.

The Inquiry proposes a clarification of a patient's possibility of having access to and choosing a general practitioner to register with in primary care with the provider in the *Health care choice, primary care* chosen by the patient. The Inquiry sees it as crucial for people's continued confidence in the work of primary care that this service is run with quality requirements that are at least as high as they are today. A mission as broad as the one that primary care has makes special requirements on the expertise of those working there. The Inquiry therefore proposes introducing a requirement that a registered general practitioner in primary care has to be a specialist in general medicine, a specialist in geriatrics or in paediatrics and adolescent health or have some other equivalent competence or be a doctor in specialist training in general medicine.

High patient safety requires a good work environment. This is why it is important to ensure that a person who has the function of a registered general practitioner in primary care is able to perform this task safely. The Inquiry therefore proposes permitting the National Board of Health and Welfare to issue the regulations on patient responsibility for doctors functioning as registered general practitioners needed to guarantee good and safe health care.

The Inquiry also makes the assessment that there is a need to review the possibility of limiting the number of patients listed with providers in a system of health care choice. There is also a need to review the possibility of limiting the number of times each year a patient can choose to change their provider in *Health care choice, primary care*. This should be done in the context of the ongoing inquiry "Governance for more equitable health care", whose remit includes reviewing the Act on Systems of Choice in the Public Sector (SFS 2008:962).

To ensure the supply of specialists in general medicine needed to meet the objective of offering a registered general practitioner in primary care for the whole of the population, the Inquiry proposes that central government should stimulate adequate access to general practitioners in primary care during a transitional period by financing 1250 specialist posts in general medicine in the period 2019–2027.

Appropriate administrative procedures

On certificates

The Inquiry makes the assessment that there may be reason to review whether more profession-neutral regulation is possible at ordinance level in certain cases. Municipalities should review the extent to which requirements of competence for the issuing of certificates in local implementing regulations can be made more profession-neutral.

The Inquiry makes that assessment that managers of health care operations should ensure that there are clear guidelines for handing certificates. The Government should commission the relevant agencies to review whether their requirements for certificates are appropriate and to take the measures necessary to facilitate the handling of certificates in health care. Municipalities should review their need of certificates from health care.

Finally, the Inquiry makes the assessment that county councils/regions and municipalities should coordinate their handling of certificates so as to establish good and equitable handling of certificates throughout the country.

On signature requirements

The Inquiry proposes that an entry in a patient record should be signed by the person responsible for the information unless this is unnecessary or there is an exceptional obstacle to doing so. The Government or the agency designated by the Government – the National Board of Health and Welfare is appropriate – should issue regulations on when signatures are not needed, as is the case today.

The Inquiry makes the assessment that, as a whole, the signature requirement does not cause an unnecessary administrative burden, but that care providers should decide when signatures are not needed in accordance with the regulations of the National Board of Health and Welfare. It is part of the responsibility of managers of health care operations to ensure that there are clear procedures for signatures that are adapted to their own service. In its regulations and guidance the National Board of Health and Welfare should make

a clearer distinction between the signing of patient records and verification measures taken.

Entry into force

The Inquiry proposes that the all legislative amendments proposed should enter into force on 1 July 2020.

Further work of the Inquiry

The Inquiry wishes to point out that even though this interim report focuses to a great extent on the design of a reform of primary care, the full remit of the Inquiry covers more than primary care. This is partly reflected in this interim report, and is underlined particularly in the parts that deal with the way ahead and the issues that will be handled in the Inquiry's final report.

The scope of the Inquiry's remit is a particular challenge, since it is not possible to describe all of the areas of issues on one and the same occasion. It is therefore unavoidable that certain actors and stakeholders will feel that their issue or area has not been given sufficient attention in this interim report. The Inquiry fully understands this. This is not to say in any way that the issues that the Inquiry intends to revert to in its final report are of less importance. A selection of these areas of issues are collaboration between municipalities and county councils, further elaboration of the role of health care in preventive work, research, development, education and training and further redistribution of resources, especially in relation to the Inquiry's remit to analyse the appropriateness of the definitions of outpatient and inpatient care. All of these areas are, of course, of very great importance for the design of the future system. These areas are being handled in the work of the Inquiry in parallel with work on the present interim report in terms of the gathering of material, analyses and ongoing dialogue with all the actors that the Inquiry meets in its ongoing activities.

The Inquiry will also continue to follow the development of processes and projects of particular interest to the remit of the Inquiry, such as the further development of highly specialised care;

the development of pre-hospital care, the missions and initiatives of various actors concerning staffing and skills planning and development regarding the various professions in health care; work on Vision e-Health 2025; the intensive ongoing work on the transition to local care in all authorities responsible for health care around the country; and further work on free-of-charge primary care in the County Council of Sörmland.

Confidence and trust

The health care of the future is probably to be found in the possibility of well-functioning collaboration between different actors involved. Success factors appear to be working in networks, rather than traditional line structures. Working in partnership with those health care is for, rather than in hierarchically designed systems. A change to people-centred health care. Good quality and equitable health care, based on the ethical platform for setting priorities adopted by the Swedish Parliament.

We refer back to the discussion in the Inquiry's first interim report on the importance of trust. It remains clear in our dialogues that health care in Sweden is characterised by a lack of trust between different actors and organisational levels, and that this risks having an adverse effect on work for change. Our hope is that the dialogue that the Inquiry has been involved in initiating and running will contribute – along with other ongoing initiatives such as the work of the Delegation for Trust-Based Public Management, joint projects between county councils/regions, greater collaboration between regions/county councils and municipalities in different parts of the country – to a more trusting climate between different actors.

Encouragingly, the Inquiry is able to identify more agreement in certain areas than in the initial phase of the Inquiry. More and more actors are highlighting the need to reinforce primary care and the reasons why this must be done. The need for greater continuity and the importance of well-functioning relationships for good quality and safe health care is being emphasised by more and more actors. There appears to be increasing understanding that there is no contradiction between people-centred health care and a structured

knowledge-based way of working – that they are, on the contrary, mutually dependent on one another. The understanding that for things to really happen staff in health and social care must be involved in work on change is highlighted more often than before. The insight that the need to make wise use of all the competences in health and social care with the aid of interprofessional learning and ways of working and the understanding of the need for training in these ways of working seem to be spreading,

The Inquiry sees trusting dialogues, with space for dynamic exchanges of opinions, and perseverance at all levels of the system as essential for the constructive development of health care in Sweden. A development of people-centred, good quality, local health care; high-quality and cost-efficient health and social care; and also health and social care capable of being an attractive employer now and in the future.