

Good quality, local health care

A reform for a sustainable health care system
(SOU 2020:19)

Summary (SOU 2020:19)

About the report

The Government decided on 2 March 2017 to appoint an Inquiry Chair with the remit of supporting regions, relevant government agencies and organisations in the coordinated development of 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*.

In June 2017, the Inquiry presented its first interim report, *Good quality, local health care – a joint road map and vision* (SOU 2017:53). At the end of May 2018, the Riksdag (Swedish Parliament) made 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.

In June 2018, the Inquiry presented its second interim report, *Good quality, local health care – a primary care reform* (SOU 2018:39). The proposals are currently being prepared by the Government Offices of Sweden. A Government Bill on a primary care reform will be announced by the Government in spring 2020.

In June 2019, the Inquiry submitted its third interim report *Good quality, local health care. A joint effort* (SOU 2019:29). In line with the terms of reference of the Inquiry, the report contained an account of the focus of the work and its progress. That third interim report contained an analysis of and background to the areas on which the Inquiry is submitting proposals in this main report. The third report should therefore be read alongside the proposals sections of this report.

The proposals in this report, combined with all the proposals in the Inquiry's previous reports, contribute towards a reform aimed at creating a health care system that is sustainable across all aspects: social, environmental and economic. We judge that our proposals are steps on the road towards developing a modern, equitable, accessible and effective health care system founded on strong and adequately resourced primary care. A health care system with both a heart and a brain. A high-quality, sustainable health care system in which patients and their relatives feel involved and secure, in which taxpayers trust, and for which employees choose to work.

Form and content of the report

The chapters of the report are summarised below with a focus on the assessments made and proposals submitted. The chapters that do not include explicit assessments, and proposals are summarised very briefly. Chapters 1 and 11 contain proposals for and comments on legislation and are not summarised in greater detail here. They should instead be read alongside the relevant chapter on the proposals.

Chapter 2. The Inquiry's remit, working methods and starting points

This chapter sets out the starting points underlying the report and outlines its structure. We describe the aspects on which we have submitted proposals in previous reports and set out a number of limitations to our remit. We also describe how we fulfilled our remit of developing our proposals in broad dialogue with all actors involved. The chapter provides a picture of the current status of the transition to integrated¹ care and reports on the milestones already decided in the road map, as well as remaining milestones awaiting decisions. We conclude by presenting our picture of some of the impacts the transformation in progress can be expected to have for patients and the population in general.

¹ During the years that our Inquiry has been working, the term "integrated care" has become more and more rooted in the international health policy debate. Today we find that this term essentially captures what is inherent in the Inquiry's Swedish term "God och nära vård" (whereas our first translations used the more literal expression "good quality, local health care").

Chapter 3. Success factors and obstacles

In this chapter we outline some important success factors and the obstacles faced in the transition to integrated health care. Aspects highlighted include person-centred care and the involvement of local residents and patients, relatives and employees. There is an emphasis on interprofessional learning and a salutogenic approach. Skills supply, logistics and infrastructure are highlighted, as are research and teaching, and digitalisation based on the needs of patients and units.

Obstacles such as a lack of perseverance, a lack of a holistic approach, different interpretations of regulations and economic challenges, including extensive investments in buildings, are reflected. Once more, the lack of aggregated data at primary care level is emphasised; the need to highlight the importance of leadership is pointed out. Light is shed on the risk of designing systems that reduce accessibility and so become exclusive, rather than inclusive, of groups with the greatest needs or limited agency in acting on their own care needs.

Chapter 4. Collaborative structures for health care

We have been tasked with investigating and submitting proposals for how collaboration between primary care and municipal health care and social care services can be facilitated, what the interface between these services should look like, and with exploring how it can be made easier to coordinate health interventions for patients and users of different ages with extensive and complex health care needs. We are also tasked with reviewing existing legislation on statutory health care plans.

The fact that health care is a responsibility shared between regions and municipalities also means that there is a shared responsibility to clearly describe and build a joined-up health care system that makes sense to patients and employees alike. This is an important task that demands close collaboration to enable good working environments for health care staff and put in place a health care system that the population, patients and their relatives can understand.

In this chapter we make a number of proposals to improve collaboration in the best interests of patients and users. *We propose*

that the term “home care” (Sw: *hemsjukvård*) be replaced with the term “health care in the home” (Sw: *hälso- och sjukvård i hemmet*) to make it clear that health care provided in the patient’s home stands on an equal footing with other health care, the only difference being the place where the health care is provided. This proposal makes it clear that the issue is one of health care, with the same quality requirements, need for adequate resourcing and skills requirements as other health care.

We make the *assessment* that the health care that the municipalities are responsible for providing constitutes primary care, but that municipally employed health care staff can be involved in health care that the region is responsible for providing. This clarification does not seek to transfer any new health care responsibility to the municipalities. However, it seeks to facilitate person-centred care across provider boundaries, to benefit those with the greatest and most complex needs for interventions on the part of both providers.

The Inquiry further *proposes* that given the increased undertakings incumbent upon the municipalities as health care providers since the legislation in question was drawn up, collaboration between providers must be strengthened. To make the collaboration requirements clear, the regions’ and municipalities’ particular responsibility to work together in planning and developing health care must be clearly set out in legislation.

The Inquiry judges that there is a need for stronger collaboration at primary care level to ensure that the patient receives joined-up health care irrespective of the provider. We therefore *propose* that a new provision in the Swedish Health and Medical Services Act (HSL) oblige regions and municipalities to draw up a joint plan for health care at the shared care level of primary care in the county. This proposal is not intended to regulate the content and timescale of such a county-wide plan in detail. Rather, its intention is to ensure joined-up, long-term planning on the joint commitment of primary care, suggesting that the plan may cover strategic questions such as skills supply, premises issues and service points.

The Inquiry further outlines the way that applicable legislation on collaboration in health care is relatively well regulated at macro (region/municipality) level and micro (individual) level in the system, but is largely lacking at meso (health care provision) level.

Currently, provisions that cover the level where health care is provided, and thus how the overarching mandate is to be performed such that the legal requirements at micro level can subsequently be applied are not regulated sufficiently clearly. Therefore, the Inquiry *proposes* that it be regulated by law that where health care is provided, the conditions for collaboration needed to ensure that good health care can be provided are in place. Clearly stating in HSL that good care requires that conditions for collaboration are in place in the same way as it requires staff, premises and equipment would make clear what a joined-up health care system demands, also at the level where health care is provided.

The obligation of the health care service to plan interventions for an individual patient has been expressed by different planning tools, etc., a number of which are regulated by law. Many different actors with whom we have been in dialogue have highlighted that in designing health care, and in particular in work on the ground, people are unclear about which planning tool is to be used for a specific intervention and which planning tools are available. The Inquiry therefore proposes that the regulation of individual plans in HSL and the Social Services Act (SoL) be harmonised with regulation under the Act on collaboration on discharges from inpatient care (LUS) such that municipal health care is involved throughout the process, not only when the individual plan is set up when a patient leaves inpatient care. Furthermore, patients that do not receive social services but have a need for support in coordinating care processes that incorporate several different care providers will be covered by the opportunity to receive an individual plan.

Regarding the individual plan, the Inquiry further *proposes* that it be regulated in HSL and SoL that the individual's wishes to have an individual plan drawn up are to be taken into account.

Furthermore, we *make the assessment* that a permanent care contact (sw: *fast vårdkontakt*) is to be responsible for ensuring that the individual plan is relevant and updated. Coordination for the individual patient will draw on the individual plan to meet the patient's needs for security, continuity and safety.

We also *propose* that the individual plan should state the aim of the interventions for the individual. The aim is to be worded from the individual's perspective, and should be stated in the short and

the long term, which enables the plans to be applied based on different perspectives; partly for planning support interventions that are to be provided for a longer period and affect much of the individual's living situation, and partly for interventions that need to be put in place immediately to resolve a temporary situation. Sometimes the individual may need support and motivation to put their needs and wishes into words. It is important that health care representatives are sensitive and actively ask about needs in different areas.

Finally, regarding the individual plan, the Inquiry *proposes* that it must include which preventive and rehabilitative measures are needed. Strengthening the requirements on the content of the individual plan regarding health-promotion interventions, combined with the proposal that more patients gain an opportunity to receive an individual plan, is a way to ensure that initiatives to promote health and prevent relapse are planned and followed up for more patients than is currently the case. As previously described in earlier interim reports, the Inquiry judges that a focus on how we can improve health, and not merely treat illness, is crucial to Sweden being able to meet the health challenges of the future and the population's care needs in years to come. Preventing or postponing patients developing acute or chronic illness, reducing the risk of relapse and creating or recreating functional capacity, means that human suffering can be avoided and the limited shared resources can be used more efficiently.

Chapter 5. Patient support for joined-up health care

Person-centred care requires collaboration on equal terms between the patient and health care staff. Enabling this requires that both parties have access to the same information and that there is an opportunity to jointly create the activities that are to be carried out. The Inquiry has been tasked with reviewing existing legislation on care plans and considering statutory regulation that requires patient contracts in the form of an overarching care plan covering all the elements of the patient's care irrespective of the actor or the provider. We have also been tasked with clarifying how the patient

contract should relate to coordinated individual plans (sw: *samordnad individuell plan*), commonly known as SIP.

Work on patient contracts has been in progress over a long period. Back in autumn 2016, the Government announced a pilot, which was carried out in three regions. Since 2018, patient contracts have been part of agreements between the Government and the Swedish Association of Local Authorities and Regions (SALAR). In the implementation work, the patient contract is described as having several parts: an agreement between the health care service and the patient containing information and contact details of permanent care contact(s), a joined-up plan and the appointments in the plan being booked in consultation with the patient.

The Inquiry *proposes* that it be laid down in the Patient Act (PL) that every patient is to have the opportunity to have a patient contract that cohesively presents the patient's individual plan, with the activities and interventions planned, based on the patient's individual needs and preferences. It must also state the name(s) of the patient's permanent care contact(s).

It must be possible to tailor how the patient contract is provided to the recipient, and it must be available in different forms, e.g. digitally, orally or in writing, to ensure that all patients have the same opportunities to benefit from the content. According to our proposals, a patient contract will be provided when a patient requests one. The region or municipality as the health care provider is then responsible for providing one. The patient's permanent care contact is then responsible for ensuring that a contract is drawn up, consisting of the patient's joined-up plan, booked appointments and contact details of the patient's permanent care contact(s).

Chapter 6. Activities conducted in line with the Medical Practitioner (Compensation) Act and the Physiotherapy (Compensation) Act.

The Inquiry has been tasked with reviewing how doctors and physiotherapists who provide services under the Medical Practitioner (Compensation) Act (LOL) and the Physiotherapy (Compensation) Act (LOF) can be integrated with ordinary primary care and its systems of health care choice and with other outpatient care.

Today there is criticism from all actors involved of the existing system in which the doctors and physiotherapists involved operate. The criticism addresses, among other things, the difficulties faced by the regions when planning their health care, as they find that they to a limited extent can influence the opportunities of doctors and physiotherapists to establish a practice and the content of the care provided. Criticism from those who operate under the national tariff scheme concerns, for example, the fact that what can be done and how, along with the existing compensation system, has not been designed and adapted to today's health care needs or to how health care is currently run. There is also input that the system does not enable an insight into and control of health care activities to a sufficient extent. Questions of whether open-ended contracts are compatible with EU legislation regarding the importance of upholding competition have also been raised.

Several earlier proposals for changes have been submitted. The system in which relevant doctors and physiotherapists operate and the legislation that regulates it, however, continues to apply and has largely remained unchanged for many years. The view of what is the most appropriate and, seen in relation to the whole, the best way of changing this system will, of course, differ between different actors in different parts of the system and also over time. However, overall there is a view that a change is needed. Here, we submit proposals that as far as possible address the criticism of the system that has been voiced but which also embrace the value of several ways of working in health care. The proposals we submit in this section are part of a context and a whole, where other ongoing changes in health care are taken into account in line with our remit as set out in our terms of reference.

We submit two alternative *proposals* for how the existing system by which licensed physiotherapists and certain specialist doctors are affiliated to the publicly funded health care system could be developed. Which of the two proposals should be advocated depends on which health care perspectives, values and objectives are prioritised.

The *first proposal* would make it compulsory for the region to also set up a system of freedom of choice in physiotherapy and psychiatry. The *second proposal* would involve further developing the existing system into a reworked, supplementary, nationally

designed system that seeks to create a long-term approach and facilitate the establishment of smaller health care practices in geographical areas where access to health care is lower. Both the proposals involve abolishing LOL and LOF and the Medical Practitioner (Compensation) Ordinance (FOL) and the Physiotherapy (Compensation) Ordinance (FOF). We submit *proposals* for transitional provisions that would make it possible for doctors and physiotherapists affected to convert or conclude their practice based on the new conditions.

Chapter 7. The role of education and research in the transition to good quality, local health care.

We have shed light on the area of research, development and education throughout the Inquiry's previous reports. Safeguarding development and innovation is a crucial and central part of a sustainable and lasting social system, covering environmental, social and economic sustainability. Research, development and education is one of the perspectives that must be carefully taken into account in the transition to integrated health care, when health care shifts its focus from the traditional hospital environment to more health care being provided outside hospitals and, in the long run, increasingly to health care in the home. This means that conditions must also be established for robust and lasting research and education outside the traditional environments and at both the health care system's providers, regions and municipalities.

The question of skills supply in the health care sector is one of the greatest challenges facing modern society in Sweden and many other countries. This being the case, education in all its forms, as the basis of adequate skills supply, also becomes a central question in the Inquiry's dialogues, and in the work of the Inquiry itself. Unlike the position when it comes to research, the providers' responsibility for education (other than undergraduate internships (AT) and specialist training residencies (ST) for doctors) is not regulated in HSL, a factor we have raised in previous reports. Many people have told us that although to everyone it goes without saying that such a knowledge-based area as health care is entirely dependent on the link with education, there is a risk of this aspect being neglected since it is not included in the legislation that regulates core activity. To

safeguard the skills supply of the future, all actors must take an active responsibility and be involved in education initiatives at different levels. We have previously announced our intention to return to the question of the need to also regulate the education mandate in HSL.

We *propose* that the duties that currently, through agreements and other contracts, oblige regions and municipalities to take part in education and ensure that the need for work placements is met, be clarified by a statutory responsibility laid down in law. The new provision must state that regions and municipalities are to ensure that education takes place in the health care for which they are responsible. The provision is introduced with the aim of making the importance of education for skills supply clear and to enable more health care actors to be involved in the question of education. Furthermore we *propose* that the fundamental mission of primary care include contributing to educating the professions that are engaged in primary care.

In terms of research, we have already shed light on the challenges in terms of transferring resources from hospital-based activities to local care in the longer term, not merely in a financial sense but also in terms of culture and skills supply. Here, we report back on dialogue questions raised in the previous report and particularly highlight one piece of input on research funding in primary care, specifically in the field of general medicine.

Chapter 8. An appropriate health care governance structure

In line with its terms of reference, the Inquiry is to analyse whether the division of health care into inpatient care and outpatient care is still appropriate, on the presumption that health care is to be good quality and organised and run effectively based on the health care needs of the individual. The analysis is to be conducted from a patient perspective in relation to the other proposals of the Inquiry.

Summarised briefly, since the entry into force of the Health and Medical Services Act of 1982, today's conceptual division into inpatient and outpatient care performs no organisational function in the legislation. The division into these forms of health care is thus merely a solution in technical legal terms. The fact that after 1982

regions also chose to organise their activities based on these definitions is thus not regulated by legislation.

There is unanimity that the current structure and division between forms of health care is a contributing factor to the inefficiency of the health care system. New treatment options and new ways of organising health care have led to health care that previously required hospital admission now being able to be provided and carried out at locations other than in hospital and so shifted to the outpatient (non-hospital) form of care. However, the existing governance system is often perceived as rewarding inpatient care, which means that such a shift is not occurring to the extent desired. Interest in the question of the appropriateness of the division into inpatient and outpatient care looks different, to a certain extent, compared with the other questions covered by the Inquiry; those who are responsible for and work at system level on governance and management, systems of description and the economic perspective find it interesting based on its actual legal structure and the consequences that follow on from this. For many others, it is more of an issue that is interesting in principle, depending on how well it facilitates the transition of the health care system taking place. We are aware, and during the course of the Inquiry have often been reminded, that making changes to the fundamental terms “outpatient” and “inpatient” care is a major intervention in the structure of the current system. Opinions differ as to how important it is to make such changes to enable and facilitate the transition to integrated care, and the extent to which these terms entrench a traditional culture that needs to be changed in order to attain a modern health care system.

Initially, the chapter presents a number of the starting points laid down by the Inquiry based on current legislation and our own analyses.

In the chapter we then present the reasons for our *assessment* that a division into different forms of care remains appropriate. We make the assessment that the descriptive systems used today are not appropriate for governance and monitoring of the health care of today and of the future, and therefore present *proposals* that they need to be investigated and modified. Our view is that even if such a review is carried out, in the long term the definition of inpatient care should be modernised in terms of its name and its content. As

a result of the major changes that changing the definition would bring about, and considering the consequent difficulties of describing the consequences of such a change with any certainty, the Inquiry chooses to present this as an *assessment*. The chapter presents one potential way of creating such a new definition, termed specific care (sw: *särskild vård*).

Chapter 9. Facilitating ongoing transition

To attain the aim of a modern, equitable, accessible and effective health system with a focus on primary care, it is not sufficient, as the Inquiry has pointed out ever since day one, to only make changes to today's primary care. The work of transition spans the entire Swedish health care system, whose providers are both the region and the municipality (and a small proportion also from the state), and all of us who work in it in various ways. Together, we form a complex system, with several different levels of decision-making, care providers, professions, and, above all, all the different people whose health and medical care needs it is our job to meet.

Pursuing coordinated development towards the shared goal is thus a significant challenge that will involve a long-term, gradual process and demand great perseverance from us all. It will take more than one or two major political decisions at central government level in the years ahead. It will take decisions at all political levels, and broad political support to ensure that the decisions and the focus stand the test of time. In this chapter we highlight different forms of support structure that we see it as being vital that the national level provide to the providers and other affected actors in the health care system.

In line with the Inquiry's original terms of reference, we are to analyse how resources can be transferred from hospital care to primary care. As we described in earlier reports, such a transfer of resources cannot be described solely in economic terms. To at least as great an extent it involves a gradual transfer of skills for both health care activities and for education and research, and sometimes making resources and skills available to different parts of the system via new ways of working and/or new technological solutions.

Although the transition to integrated health care covers all health care provision, the Inquiry judges, as expressed in our terms of reference, that there is a need to also look specifically at how primary care is resourced. The transition will not be possible without strong primary care capable of forming the basis of more local and integrated health care provision.

We make the *assessment* that during the remaining transition period, 2021–2027, the State should gather several of the economic investments regulated in agreements between the Government and the Swedish Association of Local Authorities and Regions into one overarching transition agreement. The agreement should comprise two parts. One part would cover an overarching transition grant to be allocated to regions and municipalities according to an allocation formula, the size of which is fixed for the period of the agreement. In the other part, the overarching areas involved would be laid down from the start, but the focus and size under each of these areas may vary from year to year and between different providers, according to need.

Chapter 10. On the remit regarding mild mental illness

In August 2019, the Government decided on additional terms of reference for our Inquiry. In addition to that stated in previous terms of reference, the Inquiry is to investigate the underlying conditions for developing a new form of rapid and appropriate primary care interventions in cases of mild mental illness, with aims that include preventing more severe illness and sick leave. This additional remit extends the length of the Inquiry to January 2021.

The background to the terms of reference is the Government's view that there is a need to rapidly be able to offer support to people with mild mental illness. Rapid and appropriate local health care interventions could firstly help to prevent more severe ill-health and sick leave, and secondly, by care being given at an appropriate place in the system based on the person's needs, help to improve access to specialist psychiatry for those in need of specialised care.

The focus of the remit is thus mild mental illness that does not require specialist treatment. The remit also includes defining the term "mild mental illness". According to the terms of reference, it is

up to the Inquiry Chair to judge which form of milder mental illness is to be offered this new form of intervention.

The Inquiry has already included the area of mental health in earlier reports. In our previous proposals for the design of primary care, one starting point is the basic mandate of primary care, which covers both somatic and mental health. A holistic approach is a fundamental element in person-centred health care. In the field of mental illness, it makes sense to hark back to the Inquiry's previous proposals emphasising the importance of preventive interventions and health promotion.

In addressing this expanded remit, the Inquiry's approach will involve the same broad-based dialogue as before, in line with the original terms of reference. This chapter therefore presents a number of dialogue questions on which the Inquiry is keen to receive input.

Finally...

...we would like to thank everyone who made this journey possible. Everyone who has contributed in various ways to the movement that the transition to good quality, integrated health care has become. The journey has only just begun. Perhaps the whole point is that it will never be complete and that we will constantly need to develop things further and adapt, with sensitivity and with the intention to of preserving what is good and changing what is less so. We hope that we have contributed to building some parts of the road ahead. We have produced a road map and a vision. We have suggested milestones and set out the choices of path. Finally, we would like to reiterate what we said at the start. Health care is a team effort, and a change like this, if it is to be feasible, involves a vast amount of teamwork. It is vital to involve people with patient experience and health care staff. Learning and knowledge are part of our shared process.

*“Yes, there is goal and meaning in our path -
but it's the way that is the labour's worth.”²*

² Boye, K, *In motion*, 1927. Translation by David McDuff, published with his kind permission.