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Healthcare in Sweden:
Challenges in Hospital Care

Erik Svanfeldt
erik.svanfeldt@skl.se
Health and Social Care Division
Swedish Association of Local Authorities and Regions (SALAR)
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The Swedish healthcare system

- Tax-funded and decentralised
- Covers all residents
- The regions finance most of the healthcare and also provide most of the services
- Municipal responsibility for
  - primary care in special housing
  - primary home care in ordinary housing in 20 of 21 regions

- The 21 regions are divided into six medical care regions
- Seven university hospitals

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Challenges of different kind (1)

- Economy
- Demography
- Epidemiology
- Healthcare workforce
- New health technology
- Digitalization
- Patient safety
- Person-centred care

Challenges of different kind (2)

- High quality and good medical results – but less good concerning continuity of care, accessibility and patient involvement
- Inequalities in health and healthcare

<u>Two parallel processes:</u>

- Development of ”nära vård” (close care/community care/local care)
- Concentration of highly specialized healthcare:
  - national level (up to 5 units throughout Sweden)
  - regional level (6 units or more)

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Development of ”nära vård”

- Swedish healthcare historically focused on hospital care and emergency care
- Transformation of focus from immediate and acute episodes to prevention, health promotion and integrated care pathways involving the patients as co-creators
- The patient’s experience is central: geographical proximity, accessibility and relations
- Primary care is the hub interacting with other specialized health care providers (inpatient or outpatient), municipal healthcare services and social care

”Nära vård” includes many different services

- Primary care
- Advanced home care (“ASIH”)
- Mobile teams
- Digital medical appointments
- Occupational healthcare services
- School health services
- Youth Guidance Centres
- Student Health Services
- Hospital and other specialized healthcare services
- Social care

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National Specialized Medical Care (1)

- The National Board of Health and Welfare provides licences
- A new legislation was set in place on 1 July 2018, replacing a previous system
- Can be performed at a maximum om five healthcare units in the country
- Treatments in need of concentration are nominated by expert panels

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National Specialized Medical Care (2)

- The National Board of Health and Welfare decides what types of treatments should be designated and at how many care units
- A board of politicians from each of the six medical care regions decides where the treatments should be provided. The chairman is the Director-General of the National Board of Health and Welfare
- So far 15 diagnosis (all decided before 1 July 2018)
- All medical fields will be reviewed until 2022

Level structuring in cancer care (1)

“A National Cancer Strategy for the Future” (2009) has five overarching goals:

- Reduce risk of developing cancer
- Improve the quality of taking care of cancer patients from a patient’s perspective
- Prolong cancer survival time and improve quality of life after a cancer diagnosis
- Reduce regional differences in survival time after a cancer diagnosis
- Reduce differences between population groups in morbidity and survival time

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Level structuring in cancer care (2)

- Regional Cancer Centres (RCC) in cooperation
  - One of ten tasks was to suggest concentration of certain interventions
  - Inventory of low volume care or complicated procedures that should be concentrated to less than six hospitals
  - Advanced diagnostics and treatments now nationally concentrated in ten medical fields
  - Decisions taken by 21 regions
- Integration with the structure of National Specialized Medical Care

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Thank you!