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Sweden's experience with shifting care out of hospitals

Lessons for England

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Sweden is recognised internationally for its reputation as a high performing and innovative health system. The country has made significant gains in delivering high quality care and achieving better health outcomes while maintaining moderate cost levels.

In the UK, there is a big political push to improve health outcomes and part of this agenda involves moving care out of hospitals and into patient's homes and communities. The RCN supports the shift to move care into the community, where clinically appropriate. However, tough economic pressures and short-term planning have created a divergence between national rhetoric and the local reality of a stretched and underinvested community sector and workforce.

The RCN believes that there are pertinent lessons to be learned from Sweden's example, for instance good practices around integration of health and social care, developing robust care pathways and focusing on system wide improvements. This briefing adds to the RCN report *Moving care to the community: an international perspective*¹ as it explores some of the good practices in Sweden and identifies learning opportunities for England.

I. Swedish health care system

Sweden's health care expenditure accounts for 9.9 per cent of its GDP. The Swedish health care system is publically funded and largely decentralised with shared responsibility for health care distributed between central government, the 21 county councils (typically includes several municipalities)/ regions and 290 municipalities. Health care services are financed through taxation (national and local taxes), national subsidies, government grants and user charges (17 per cent). About 4 per cent of the public have voluntary health insurance that is predominately paid by their employer. Local government in Sweden is split into county councils that oversee public health provision at a regional level, whilst municipalities situated within county councils are responsible for primary care, social and long-term care services. Health care provision is managed by county councils while the central government sets standards, oversees regulation and determines the national priorities. Sweden's municipalities are responsible for providing care for the elderly, people with physical disabilities and mental health disorders, care services in patient's homes and other supportive accommodations (ie care homes).^{2,3}

II. Key national reforms in Sweden

Sweden was one of the first countries to recognise the limitations of hospital delivered care and the importance of primary care and prevention care strategies, especially for older people. The economic recession in the 1990s helped the country to acknowledge the need for health sector

¹ RCN (2013) *Moving care to the community: an international perspective*.

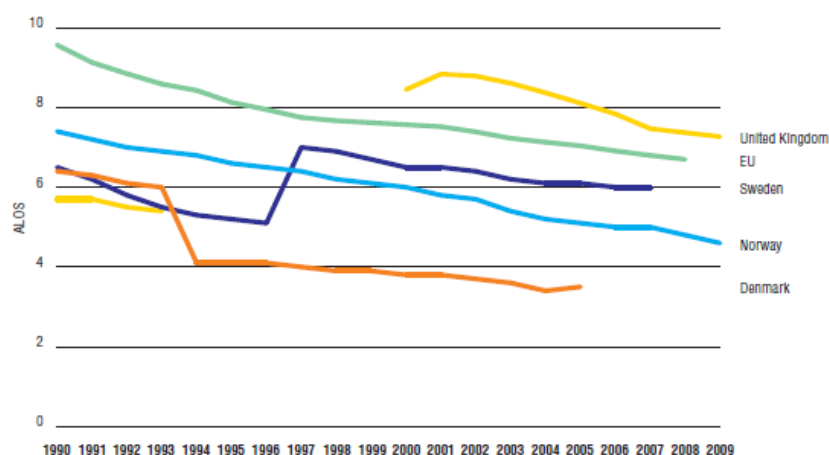
² The Commonwealth Fund (2010). <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/International-Profiles-of-Health-Care-Systems.aspx>

³ Anell A, Glennard AH, Merkur S (2012). Sweden: Health system review 2012. *Health systems in transition* 14(5): 1-159. http://www.euro.who.int/_data/assets/pdf_file/0008/164096/e96455.pdf

reforms and a push towards restructuring hospital services. In the mid 1990s care for older people shifted from county councils to municipalities who assumed the responsibility for provision of social care services and recruiting the quality staff (doctors, nurses and nursing assistants) to deliver this care.

Hospital reforms in the 1990s focused on two main objectives: increase specialisation and concentration of services. 24/7 emergency care services were concentrated in larger hospitals, while smaller hospitals provided more specialised care like outpatient treatment and community services. As the focus shifted away from acute, episodic care to primary and preventative care, the average length of stay (ALOS) for surgical procedures in hospitals gradually decreased following an initial spike between 1995-97 (figure 1). Today, the ALOS in Sweden is still lower compared to other European countries.

Figure 1: Average length of stay in acute hospitals between 1990- 2009



Source: Anell et al., 2012; WHO Europe 2011

National reforms over the last decade have strengthened the development of primary and preventative care models and movement of services to the community⁴:

Year	Type of reforms
2003	Reforms were initiated to improve collaboration between county council and municipalities and encourage integration and continuity of care. It addressed financial responsibilities of municipalities to provide care resources for patients discharged from hospital. Between 2001 and 2004, the government allocated SEK 9 billion to improve collaboration networks.
2005	A new 'waiting times guarantee' was introduced based on the '0-7-90-90' rule meaning immediate contact with the health care system for consultation (zero delay); getting a GP appointment within seven days; consulting with a specialist within 90 days; and receiving treatment no longer than 90 days after diagnosis. This also included all elective care treatments.
2005	Reforms designed to increase patient choice of providers whereby patients were

⁴ *Ibid.*

	not restricted to their home county; this increased competition between private and public sectors.
2006	Increased emphasis on quality and efficiency indicators between county councils and municipalities- this reform was designed to increase transparency and promote good practice and innovative ways of delivering care.

III. Strengthening integration and coordination in the community

- ‘Chains of care’- introduced in many county councils to reduce unnecessary variations in practice and focus on local health care needs. Chains of care are defined as a condition-specific, evidenced-based care pathway spanning across acute, secondary and tertiary settings with care delivered by a variety of providers using a multidisciplinary team approach. This model was introduced at a national level with support from policy makers and politicians who view the model as the building blocks for local health care.^{5, 6}
- ‘Local health care’ is defined as a family and community-orientated, primary care system addressing local care needs in collaboration and coordination with hospital services. It focuses on specific speciality areas like long-term conditions, family and child health and care of older people. Regional variation is based on local health care needs.⁷

Chains of care have been implemented in Sweden for a decade now, however there is still some scepticism relating to the initiative’s effectiveness. Success varies across regions. Few Swedish county councils have been altogether unsuccessful, partly due to top-down approaches creating barriers in developing and implementing these chains of care at local level. Where there has been success, it has been attributed to securing the buy-ins from system and clinical leaders.⁸

IV. Examples of good practice

Jönköping county council is recognised both nationally and internationally for its best overall ranking on quality indicators; gains in chronic disease management; patient-centred and integrated care pathways; and improvements in sepsis and infection control. More recently, Norrtälje municipality has begun to receive attention following the introduction of its integrated health and social care service model. Both these models are recognised as examples of good practice.

Jönköping county council

Located 330km southwest of Stockholm with a population of about 330,000, this county council has three hospitals and 34 care centres (including specialised care centres, primary health clinics,

⁵ Ahgren B (2007). Creating integrated health care. *International Journal of Integrated Care* 7: e38

⁶ Ahgren B (2003). Chain of care development in Sweden: results of a national study. *International Journal of Integrated Care* Oct-Dec; 3: e01.

⁷ Robertson H (2011). *Integration of health and social care- a review of literature and models and implications for Scotland*.

Commissioned by the RCN Scotland.

⁸ *Ibid.* 4

rehabilitation facilities and pharmacies) across 13 municipalities. Jönköping is often recognised for its strong sense of community spirit.

Some achievements and initiatives that Jönköping is known for include:

- *Leadership and effective governance*: Stable leadership was one of the key foundations of success in Jönköping. The former council's chief executive officer (CEO) Sven-Olof Karlsson was elected to the role for 20 years consecutively (until 2008). Karlsson introduced many reforms, bringing inspiration from other health systems, especially the United States. The CEO and governance board encouraged open dialogue between municipalities and system and clinical leaders, all working towards a shared purpose for Jönköping.⁹
- *Developing a patient-centred approach*: To improve patient flow and integrate care, a group of clinicians, providers and local council representatives came together to develop 'chains of care' using the case study of Esther, an 88-year-old Swedish woman living in the community with a chronic care condition. By mapping Esther's care pathway across the system, this group was able to identify gaps in service and strengthen joined-up care between systems and sectors. The project helped to re-design intake and transfer processes across the continuum of care; integrate documentation and communication across providers; introduce team-based phone consultations, and educate patients on self-management tools and skills.^{10,11}
- *Improving primary care*: in Jönköping, there was a strong emphasis to improve coordination of care between sectors; facilitate smooth transitions post hospital discharge; link patients to proper resources in the community and strengthen primary care. By addressing these issues, the county was able to reduce the number of hospitalisations for paediatric asthma cases from 22 to 7 per 10,000. Influenza vaccination also increased by 30% (over four years) which lead to a reduction in hospital admissions, especially for older people.¹²
- *Establishing 'Qulturum'*: a learning centre was established in 1999 to facilitate continued learning and provide a 'meeting place for quality and culture' for all staff, from managers to front-line clinicians. It encouraged a learning culture where groups would meet and share innovative ideas on service improvement and build on their knowledge and skills. Learning modules covered sessions on information gathering for balanced scorecards, capturing data on performance indicators and using models to improve care pathways.¹³
- *Putting quality at the heart of reforms*: in 2001, a new approach was introduced called the 'Big Group Healthcare' that consisted of gathering clinical and system leaders from across the

⁹ Baker, G.R., A. MacIntosh-Murray, C. Porcellato, L. Dionne, K. Stelmachovich and K. Born (2008). *High Performing Healthcare Systems: Delivering Quality by Design*. "Jönköping County Council." 121-144

¹⁰ *Ibid.*

¹¹ Baker GR, Dennis JL (2011). *A comparative study of three transformative health care systems: lessons for Canada*. Canadian Health Services Research Foundation. http://www.chsrf.ca/Libraries/Commissioned_Research_Reports/Baker-Denis-EN.sflb.ashx

¹² *Ibid.*

¹³ *Ibid.* 8

county to share ideas, report on progress relating to performance and quality benchmarks and assess links between quality, performance and finance.¹⁴

'Quality is nothing special; it should be integrated in everything that we are doing. I think it is very dangerous to have an agenda where you talk Monday about finances, Tuesday about quality and Wednesday about another thing. You must work with all these at the same time'

Sven-Olof Karlsson, former CEO Jonkoping County Council

Evidence from Jönköping county council initiative revealed a 20 per cent reduction in hospital admissions and a redeployment of resources to the community, a 30 per cent decrease in length of stay for heart failure patients and reduced waiting times to see specialists.^{15,16}

Norrtälje municipality

The 'Norrtälje model' also called 'Norrtälje Integrated Organisation' was set up in 2006 to deliver integrated health and social care, combining a purchasing organisation with an integrated provider and salaried physicians. Prior to the introduction of this model, the Stockholm county council provided primary and secondary care for its citizens while the Norrtälje municipality funded and provided care for older people, people with disabilities and mental health conditions. The case for change came when the primary hospital in Norrtälje was threatened with closure. The community along with system and clinical leaders and trade unions came together to develop a model of care that improved quality, but more importantly addressed sustainability. Before the model was launched, guarantees were given to staff with regards to protection of pay, terms and conditions. The model involved new contracts for employees, new financial and reporting systems, patient reporting and monitoring medical records, co-ordinating patient pathways for stroke and improvements in care services for older people.^{17,18}

The Norrtälje model is made up of three separate organisations, working jointly to provide a shared model of integrated care:

- *TioHundra Forvaltningen* is the financial arm of the model, established to administer pooled budgets (from Stockholm and Norrtälje municipality) for all care services. It also collects payments and pays providers.¹⁹
- *Tio-Hundra* is jointly owned by the Stockholm county council and the Norrtälje municipality to deliver health and social care services for the citizens in Norrtälje.
- A joint governance board was set up to commission services. Representation on the board consisted of 12 elected members, six from the municipality and six from

¹⁴ Andersson-Gäre B and Neuhauser D (2007). The Health Care Quality Journey of Jönköping County Council, Sweden. *Quality Management in Health Care* 16(1): 2-9

¹⁵ *Ibid.* 8

¹⁶ *Ibid.* 10

¹⁷ Robertson H (2011). *Integration of health and social care- a review of literature and models and implications for Scotland*. Commissioned by the RCN Scotland.

¹⁸ Øvretveit, J., Hansson, J., & Brommels, M. (2010), "An integrated health and social care organisation in Sweden: Creation and structure of a unique local public health and social care system", *Health Policy*, **97**, 113–121

¹⁹ SPICe Information Centre (2012). *SPICe Briefing: Integration of health and social care: international comparisons*. http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/SB_12-48.pdf

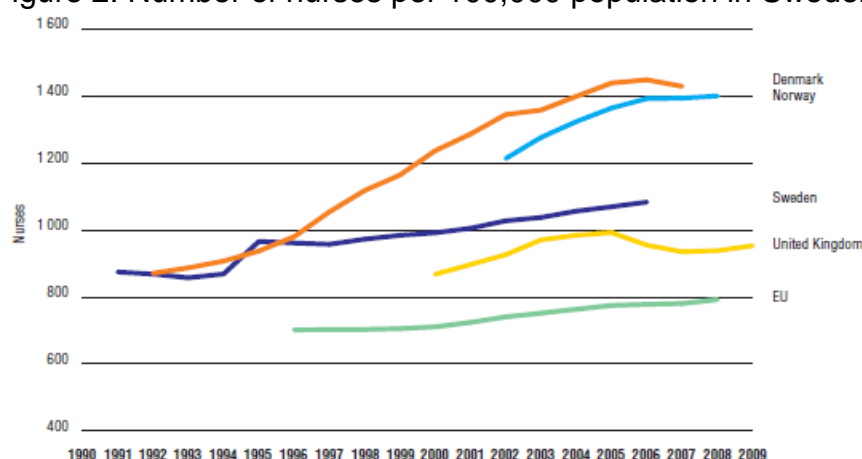
Stockholm county council. It also includes employee representation.²⁰ It is unclear if a nurse sits on this governance board.

Initial financial reports and anecdotal evidence suggest improvements in efficiency, decrease in inpatient psychiatric care and decrease in overall hospital admissions in Norrtälje. Costs have remained the same. Wider system issues still need to be ironed out - for example, it is not known if clinical care coordination has improved as a result of integration or more likely barriers impeding coordinated care have been removed, facilitating system-wide improvements.²¹

V. The nursing workforce

The number of nurses in Sweden has increased slightly from the mid 1990s and in 2008, there were about 1100 nurses per 100,000 population (figure 2). This is still lower than nursing numbers in Denmark and Norway, but higher than in other European countries and the UK. In the early 1990s, municipalities began to employ more district nurses to address local needs and support the movement of services to the community. However, over the last few years, there has been a decline in the number of nurses working in the community, according to the Swedish Nurses Association. The cause for this decline is unclear. In 2010, the National Board of Health and Welfare in Sweden released a report that highlighted a fall in the number of specialist nurses despite increasing demand and increase in the number of graduated specialist nurses entering the labour market. According to the national nurses association in Sweden, approximately two out of every three district nurses will retire by 2020 (Vårdförbundet, 2012) creating a nursing shortfall in the community, especially of specialist and district nurses.

Figure 2: Number of nurses per 100,000 population in Sweden



Source: Anell et al., 2012; WHO Europe 2011

VI. Lessons for England

²⁰ *Ibid.* 16

²¹ Øvretveit, J & Brommels, M 2011 *Review of research into comprehensive integrated care systems, Stockholm*, The Medical Management Centre, Karolinska Institutet. <http://ki.se/content/1/c6/14/27/43/IntegrCareRev21Nov2011.pdf>

Shifting care to the community has been a government priority in England for over a decade with the aspiration to deliver care closer to patient's homes, improve care pathways and health outcomes, and reduce inappropriate hospital admissions. Community nursing is at the heart of this agenda as nurses' interface between health and social care systems, helping to navigate and coordinate patient care pathways towards a positive health outcome.

In spite of the urgency of the matter, evidence from the RCN's *Frontline First* campaign show that provision of care in the community has declined and community workforce numbers are struggling to meet increasing health demands. There is a continued disconnect between rhetoric and reality on the ground as NHS providers struggle to meet efficiency savings targets.²²

There are a few learning opportunities for England based on Sweden's integrated care initiatives. They include;

- *focus on quality and system improvements*: The Jönköping case study stresses the importance of placing quality at the centre of the reforms. The continual pursuit of system improvements allowed Jönköping county council to raise care and quality standards and achieve better health outcomes. In England, with the current financial pressures and the need for £50 billion in NHS efficiency savings by 2020, there is concern that the mindset for reforms is shifting away from long-term sustainability and improving health outcomes to short-term approaches that deliver quick financial wins. Regulators like the Care Quality Commission and Monitor need to enforce strong regulation to ensure that NHS organisations are implementing reforms with quality, safety and performance improvements benchmarks in mind rather than financial stability only. Furthermore, Sir Keogh's review into the 14 NHS trusts with high mortality rates confirm some systemic issues like poor workforce planning, lack of strong leadership, early warning signs being ignored and absence of a culture of openness – all impacting on safety and quality. The review identified 'ambitions' for trusts to aspire to with a focus on ability of hospital boards and leaders to use data to drive quality improvement.
- *promoting a patient-centred approach*: Both Swedish examples place a lot of emphasis on the patient's journey and engaging patients in service redesign. By mapping 'Esther's' journey and transition between sectors and systems, a comprehensive care pathway was developed with involvement from key stakeholders. A similar model has been incorporated in Torbay Care Trust in England. However, more NHS organisations need to consult patients on care redesign initiatives. Some of this engagement might be achieved through Local Health Watch, however there needs to be clear and transparent processes in place.
- *delivering integrated care*: A few Swedish regions have launched integrated health and social care initiatives to develop collaborative working between organisations and facilitate smooth transitions. As part of this initiative, an integrated management structure and financial budget was set up. Furthermore, local providers and clinicians were incentivised and jointly engaged

²² RCN (2012). *The community nursing workforce in England*.

from the beginning to promote partnership working. England can learn from the experiences in Sweden, as the current social care system is fractured without a stable funding structure. Unless a commitment is made to address social care funding, systemic issues relating to provision of social care services will only worsen. The RCN has been calling for the government to urgently address the funding issue.

- *strengthening the workforce*: in Jönköping county council, leaders recognised the importance of investing and developing the workforce to facilitate smooth implementation of the reforms. Frontline staff received training on quality and performance enhancement techniques and delivering effective care pathways. In England, there is a visible gap in community workforce investment. A recent RCN community survey highlighted a worrying picture of England's community services where services are facing budget cuts, community nurses numbers are falling and social care cuts are putting tremendous pressure on poorly staffed community teams to compensate for inadequacies in social care services; all these factors are leading to a re-emergence of 'revolving door' patients admitted back to hospital. Investment in the community workforce should be a priority for the government and the NHS. NHS commissioners and providers need to jointly address this problem before the sustainability of community care deteriorates further.

VII. The RCN's view

Reforms in Sweden demonstrate the success that can be achieved with strong leadership, good integration, partnership working, reducing red tape and bureaucracy, and investing in the community workforce. England has much to learn from the experiences of Sweden, especially in promoting stable leadership, addressing gaps in service provision and tackling systemic funding and workforce issues.

The RCN believes that the priority should be given to better aligning the community workforce with system redesign. NHS Commissioning Boards should work closely with providers to iron out gaps in services and implement a whole system approach to address future health and social care service needs.