Emerging Health Leader Scholarship Final Report:

The Development of an Emerging Leader:
Lessons from Sweden: Health Care & Leadership

Scholarship Sponsored by:

Respectfully Submitted by Jennifer Duff, CHE

Canada and Sweden are highly regarded as among the world’s best in the sport of hockey. Likewise, they are also highly regarded in regards to the delivery of healthcare. In May 2011, 17 senior health care leaders from Canada, and one from the United States, traveled to Sweden to study health care service and delivery models. Thanks to ARAMARK Canada, the Canadian College of Health Leaders, and the Emerging Health Leaders, a 19th joined the group – the writer and recipient of the 2011 Emerging Leader Scholarship. The experience was profound.

Sweden Study Tour Participants 2011.
The Swedish Health and Medical Services Act and the Canada Health Act are harmoniously similar whereby we share similar values and priority is given to those who are in the greatest need of health and medical care. In Canada, while our system is publicly administered and operated on a non-profit basis through federal fiscal transfer to the provinces, responsibility for health and medical care in Sweden is divided by the state (at the National level), county councils, (the provincial level) and municipalities. The county councils in Sweden however, carry most of the cost of health care through tax revenue they raise themselves. Personal income tax rates in Sweden are lofty at roughly 55% for those earning approximately $84,000 per annum. However, it is important to note that citizens receive free education including university, free dental care up the age of 21, and a national pharmacare program is provided. Healthcare spending to gross domestic product in Sweden is 9.4% compared to 10.4% in Canada; impressive when you consider that Sweden boasts an aging population and, similarly, as mentioned, provides its citizens with a national pharmacare program and dental care.

The Health and Medical Services Act (Sweden) sets out the responsibilities of the county councils and municipalities for health and medical care. While the principle of public administration in the Canada Health Act is the most widely understood as it refers to insurance but not delivery, Sweden, too, demonstrates the ability to provide private services within the public sector, which will be elaborated on later. Likewise, the principles of comprehensiveness, universality, and portability are similar if not completely consistent between our two countries. Accessibility is also a similar value. User fees are widely used in the Swedish system for the provision of basic services because local taxes provide the main funding base thereby limiting economic expansion. User fees only make up 3% of revenue and there is an annual cap for how much the individual must pay. In this sense, while the user fee is low, it demonstrates the principle that there is a cost when services are received, thereby creating awareness by the user. While Canada boasts 33.7 million habitants discernible with diverse cultures, aboriginal and indigenous communities, and diversity among its peoples, Sweden’s population is merely 9.3 million, is geographically smaller than Ontario and is its population is predominantly born within the country.

However, similar to Canada, Sweden faces the same pressures of rising costs, waiting lists, and quality care issues related to health care. To remedy these challenges, five
key observations were made that are different to our traditionally Canadian approach. I will attempt to explain these five items briefly and one additional learning that was perhaps the most fundamental. Perhaps they might provide some food-for-thought for our Canadian system at the national, provincial, and local level.

**National Registries**

In Sweden, the Swedish Association of Local Authorities (SALAR) represents the interests of government, professionals, and employers within Sweden’s municipalities and county health regions. In order to monitor and track patient problem’s, interventions, and outcomes nationally, the SALAR created National Quality Registries that are comprehensive in nature. They contain individualized data concerning patient problems, medical interventions, and outcomes after treatment within all healthcare fields. Caregivers who have the greatest use for the data have the responsibility for developing the system, its contents, and the databases that contain data pure enough for clinical research. iv There are currently over 90 national quality registries that are established in Sweden, all of which track patient wait times and outcomes locally and nationally. Each database is supported administratively with human resources to support their infrastructure and submission of personal data from a patient perspective is voluntary.

Where the notion and practice of registries or wait lists is not novel, what is fascinating is Sweden’s ability to set this up nationally and track more than simply wait times. For example, in British Columbia, we have the BC Surgical Patient Registry that merely provides information to evaluate and monitor wait times provincially. Sweden has differentiated among several different types of surgeries, and provides more than wait time data within each registry as mentioned above.

For example, the Swedish Heart Surgery Registry has recorded all heart operations performed on children and adults in Sweden since 1992v. This registry has recorded approximately 8000 cardiac interventions annually since 1992. Furthermore, like all the registries, this registry has its own website (www.urc.uu.se/hjartkirurgi/index.htm). Internet access to data via each unit (or hospital) is available, as is data in an excel file for further analysis. The information from the registry is reported to health services at meetings and symposia. The registry report presents transparent data on surgical outcomes at the unit/hospital level, allowing users to view how their hospital compares with others. vi Related to quality improvement, the registry, not unlike all others, enables one to review trends in care, wait list management nationally, and complications after surgery, for example. Other examples of registries include: Swedish Cruciate Ligament Registry, National Breast Cancer Registry, HIV Registry, Vascular Registry, and National Hip Fracture Registry.

While it seems as though we’ve made great strides in Canada to develop registries provincially, it seems apparent the power of national data and broadening our existing registries to be inclusive of more than wait times.
Privatization in the Public Sector

Sweden faces similar economic pressures as we do in Canada. The rising costs of healthcare and demand for quality services furthermore elevates the requirement for fiscal stewardship in a publicly funded system. Following a reorganization that occurred in the 1990’s, a stronger focus on primary care and the privatization of some services within the publically administered system occurred.

In Sweden, private health care operators are permitted to compete with their public counterparts but only under very strict guidelines. On the Sweden Study Tour, we visited two centres within the public system that were administered by private providers. These examples from Sweden suggest that private healthcare can exist in unison with public care. Costs can be controlled and elements such as efficiency, incentive and engagement can be fostered. Ideologically, providing private care in the public system is done to promote optimum care.

We visited The Stockholm BB Centre, a Maternity Department in the Danderyd's Hospital, operated by a group called the Praktikertjanst Group. This group is Sweden's largest private provider of healthcare and is owned and operated by the health care practitioners themselves. The Praktikertjanst Group consists of dentists, doctors, physiotherapists, dental technicians, psychoanalysts, midwives, nurses, who manage and work at approximately 2,300 clinics. The business is run like a cooperative and we learned that when there is greater than five percent revenue over budget the profit is shared among the owners. Emphasis on quality care, usage of a balanced scorecard, and quality outcomes for patients are on the forefront. For obvious reasons, if quality of care is not achieved and patient outcomes are bad, the private provider is at risk of losing its contract within the public system.

Likewise, we also visited PRIMA Vuxen Psykiatri (www.primavuxen.se ). PRIMA Child and Adult Psychiatry were selected amongst a bid approach as it was demonstrated that they were able to administer high quality care within the public system in relation to cost. The service was put up for bid as there were long waiting lists and quality issues that the
public and county council were dissatisfied with. The successful bid went to psychiatrists in the public system that wanted to implement an improved model of care. A contract was created and terms of quality care were defined. The contract is for three years and reimbursement and funding is organized per the number of patient visits and other care related activities. As such, creative funding models such as activity based funding continue to evolve in Canada. This privatized approach within the publicly administered system, rich with incentives for providers within the private enterprise, seems to be a worthy venture to provide quality care.

An evening at the Canadian Embassy in Stockholm, Sweden. Pictured is John King, National Chair, CCHL, and the Canadian Ambassador’s delegate, myself & Ray Racette, President & CEO, CCHL.

**Care of the Elderly**

Sweden has Europe’s proportionally largest elder population. Unlike Canada, where care of our aging population falls under the scope of provincial funding and our healthcare system, the municipalities in Sweden are responsible for care of the elderly in their home or in specially adapted housing. Community home care is funded and coordinated based on referrals from primary health care centres and hospitals. While assessment and eligibility criteria for placement in the community varies across county councils, admission to long term care homes is deemed the last resort, however a patient can receive up to $300 in services to keep them in their home from the municipality. The most enticing piece of learning, however was that after being deemed ‘alternative level of care’ (ALC) for five days or more, the municipality is charged between $300 and $350 until the client is transitioned back home or to a long term care facility. Hence, Sweden has effectively built an incentive program to facilitate returning clients to their home, or other suitable housing thereby alleviating pressure on the acute health care system.

Moreover, during our visit to the SALAR and given Sweden’s aging population, we learned that the Swedish Social Ministry declared that all ‘elderly people in Sweden must be better taken care of’. Moreover, this should be done by using quality registries as a tool combined with a network of developers tracking diagnosis, intervention, and process
via national registries. Hence, a strategy titled \textit{Seniors’ Alert} was created where primary care providers identify risks and plan and execute preventative actions related to seniors’s care. The SALAR was able to share convincing data to suggest that this focus on the country’s aging population combined with tracking via National Registries enables them to provide quality care as evidenced by falls reduction, reduction in pressure ulcers, and reduction in hip fractures.

\textit{Swedish Colleagues at the SALAR with myself, John King & Ray Racette.}

\textbf{Primary Care, Healthy Populations & Focus on the Whole Person}

While one of the main principles of health care in Sweden is equal access to service, the Swedes have spectacularly focused on healthy populations and excellent primary health care. A policy, referred to as the “Riksdag”, was created in April 2003. This policy was created at the National Level and the overall aim is to create societal conditions for good health on equal terms for the whole population. Through high taxation to residents, Sweden’s population is well cared for in relation to the determinants of health: education, housing, access to dental and health care, etc. We had the opportunity to meet a young professional, Ulrika, who was the Art Administrator for the Orebro County Council. One per cent of the budget for all new construction projects in Sweden is required to be dedicated to art and decorum to beautify the environment. Ulrika’s job was to rotate art among all hospitals in the county, purchase new pieces annually, and help provide design support to new patient care spaces. Every hospital that we visited had beautiful pieces of art work displayed throughout the facility. Ulrika’s budget is $250,000 annually. In addition, we were fortunate to experience cafeteria style lunches on everyday, prepared by the same professionals who prepared food for the patients. The food was gourmet, complete with fresh bread, freshly cooked roasts, chicken, ham and an array of fresh vegetable choices. Coffee was available in every staff and meeting room inclusive of equipment to make cappuccinos, lattes, and milk foam!

Patient rooms, particularly the ones we viewed at BB Stockholm (maternity unit), eerily, but in a homely and welcoming sense, resembled an IKEA show room, with freshly
decorated linen, bright, modern and funky lighting, side tables’ utilitarian in nature, and large, clean bathrooms that put the bathroom in my one bedroom apartment in Vancouver to shame.

We were able to learn about excellent examples of primary health care in action while on the Sweden Study Tour, such as the scope of midwifery care and women’s reproductive health. In Canada, where women generally visit their family physician for annual gynecological examinations, in Sweden, the midwifery profession completes annual examinations and follows up with infants and children up to seven years of age.

The emphasis on the ‘whole’ person and Sweden’s collective focus on primary health care seem to elevate this nation’s overall health status. While inequities amongst the population undoubtedly exist in regards to education, health, social status, etc., Sweden seemingly depicts a model to be desired in how it cares for its people and inhabitants of the country. While we value these same characteristics in Canada, it was remarkable to see them depicted in numerous different ways in the span of one short week.

A tour of the hospital in Orebro included a guided art tour. We are in the main atrium of the hospital learning about the latest exhibit.
Physician Compensation

There are approximately 29,000 physicians in Sweden, 90 per cent of who are compensated by salaries. Hence, unlike our incalculable fee-for-service structure in Canada, physicians in Sweden are employed by hospitals or primary health care facilities. As discussed previously, there are physicians who are employed by groups such as the Praktikertjanst Group; however, for most who work in the public sector, their salaries are negotiated on a national level, inclusive of working hours, benefits including pensions, on-call duties, and working conditions. While physician compensation is a topic worthy of more detailed discussion and interpretation, it goes without saying how vastly different these remuneration structures are between Sweden and Canada and what the apparent, and perhaps, favorable aspects, of the Sweden compensation structure exist.

The five aspects described above are aspects of the Sweden health care system that struck me as outstanding and worthy of transferring and relaying more information to Canadian colleagues. While not without its challenges, it is no wonder Sweden has one of the best health care systems in the world.

In conclusion, I’d like to point out perhaps one of the most valuable piece of learning from the Sweden Tour. This is the power of mentorship and coaching for emerging health leaders. The leaders that participated on the Sweden Study Tour demonstrated great core values and the characteristics important for health care leadership. They collectively set a great example for me, as an emerging leader, to aspire to. People often think of mentoring as a one-on-one relationship between an experienced executive and a young upstart. However, in this sense, the Sweden Study Tour enabled me to build a ‘personal board of directors” that I can connect with throughout my career. I was mentored and coached for an entire week in regards to how to prepare for an interview, what questions to ask, values-based leadership, and work-life balance including many
aspects about the Swedish health care system. Some of the professional relationships developed, I am certain will last throughout my career.

Great new friends, mentors and colleagues from across Canada.

Thank you to ARAMARK Healthcare, Emerging Health Leaders, and the Canadian College of Health Leaders for a remarkable leadership development experience.

Catching the train back to Stockholm at the end of the tour.
The Emerging Health Leader Scholarship is sponsored by ARAMARK Healthcare and is supported by the Canadian College of Health Leaders and Emerging Health Leaders. More information is available at [www.cchl-ccls.ca](http://www.cchl-ccls.ca).

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