

Sweden - A Star Performer in the Eyes of an Emerging Health Leader

Lessons in Quality and Patient Safety

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Introduction

Sweden and Canada both have primarily publicly funded health care systems that are rooted in similar basic values of universality and comprehensiveness – providing everyone with health care, regardless of age, means, or health status.

Sweden's population of 9.5 million is one of the healthiest in the world (1, 2). In 2010, the average life expectancy was 81.5 years and infant mortality was 2.5 per 1000 live births (3).

It is also one of the oldest populations in the world with over 18% of its population over the age of 65 years and 5.3% over the age of 80 years (1).

At the same time, Sweden has also successfully maintained health care expenditures at approximately 9.5% of its gross domestic product (GDP) over the past 30 years (1).

On all these counts and more, Sweden outperforms Canada. Canada's lengthening wait lists, growing chronic disease burden, shortage of health human resources, and escalating health care costs that reached 11.4 % of its GDP in 2010 is cause for reflection (4). What is Sweden doing right and what might we learn from the Swedish experience?

For the past ten years, the Canadian College of Health Leaders (CCHL) has taken senior leaders on study tours of the Swedish health care system. In April 2012, thirteen senior leaders from the public and private health sector along with the recipient of the 2012 Emerging Health Leader scholarship set out on a journey to learn about health care in Sweden.

This report highlights key lessons learned from the 2012 CCHL Sweden Study Tour. It provides an overview of the Swedish health care system and a comparison of select health indicators for Sweden and Canada. It also describes examples of Sweden's performance in the areas of quality and patient safety that serve as inspiration to challenge the status quo in Canada and spark new ways of thinking.

Overview of Sweden's Health Care System

Swedish Health Care - A Shared Responsibility

Sweden's three independent levels of government - the national central government, regional county councils and local municipalities – are all involved with health and medical care. The central government establishes the political agenda and overall goals and policies for the health care system, while Sweden's 21 county councils and 290 municipalities are responsible for the provision of health care (1).

Central Government

The overall responsibility for health care is at the national level with the Ministry of Health and Social Affairs (the 'Ministry') (1). The Ministry establishes goals and policies for the health care system (1). A semi-independent public body, the National Board of Health and Welfare (the 'Board'), acts as the government's advisory and supervisory agency for health services, health protection, and social services (1). The Ministry and the Board work with several other central governmental bodies involved in the health care system (1).

Regional Government

County councils are required to provide their residents with good quality health care and promote good health in the entire population (5, 6). Thus, county councils are responsible for all matters related to health care from primary care to hospital care as well as health promotion and disease prevention (1, 7). As a result, health care planning in Sweden takes place at a regional level by each of county councils, in accordance with the needs of their residents.

County councils own and operate most hospitals, health centres, and health institutions (3). However, a small number of private clinics and facilities exist (6, 8). This allows county councils to purchase specific services from private clinics and thereby, improve access to health care services when necessary (9). To a degree, county councils regulate the private practitioner market by establishing conditions for accreditation that must be met in order for new private primary care practices to be eligible for public funding (8).

Local Government

Municipalities are responsible for the provision of long-term care as well as care for the elderly, the physically disabled, and those with long-term mental illness (1, 5). Municipalities operate public nursing homes and home care services (1). However, some private nursing homes do exist (8).

Health Care Finance and Expenditures

Sources of Finance

Sweden's health care system is financed primarily through income taxes levied by county councils and municipalities on their residents (1, 5). These taxes finance approximately 71% of health and medical costs (8). The remainder of health care services are financed via grants and subsidies from the national government (approximately 20%), sales and other revenues (approximately 6%), and patient fees charged by both county councils and municipalities (approximately 3%) (1, 5, 6, 8).

Patient fees are an integral part of the health care system. Various levels of government establish user fees for hospital stays as well as consultations with physicians and other health care professionals (7). These fees, and their respective ceiling limits, vary from one county

council to another. These are outlined in Table 1 below. Typically, after a patient incurs an annual cost of SEK 900 to 1,100 (135-165 CAD), medical consultations within 12 months of their first consultation are of no additional cost (9). Children and young adults under the age of 20 receive free medical treatment and are not required to pay user fees (8).

Table 1: Patient Fees for Medical Care in Sweden

Service	Fee*
Hospital stay	80 SEK (12 CAD) per day for first 10 days, then 60 SEK (9 CAD) per day
Primary care physician visit	100 - 200 SEK (15-30 CAD) per consultation
Specialist physician visit	300- 350 SEK (45-52.50 CAD) per consultation

*Once the annual high cost ceiling is reached, patients are not required to pay additional user fees

Source: The Swedish Institute (9)

Health Care Benefits

Sweden’s health care system does not have a basic or essential health care or drug benefit package per se. Rather, three underlying principles – “the principle of human dignity, the principle of need and solidarity, and the principle of cost- effectiveness” ensure that all residents receive health care service in the event of illness or injury (1).

Because of the extensive public health care system in Sweden, only a small percentage of individuals have traditional private insurance (7, 8). However, the number of people with private insurance has tripled since 2000 (8). Private insurance, which is generally paid for by employers, allows individuals to get quicker access to specialists in ambulatory care and avoid wait lists for elective treatments (8).

Pharmaceutical Benefits

To avoid excessive prescription drug costs for patients, Sweden subsidises the costs of specific drugs and establishes a ceiling for how much patients have to pay themselves.

The Pharmaceutical Benefits Board decides which drugs should be subsidized by the national pharmaceutical benefits scheme using a systematic and continuous evaluation process. If a prescription drug is to be subsidized, the Pharmaceutical Benefits Board will directly negotiate its price with manufacturers (1). In this way, the Pharmaceutical Benefits Board enables rational and cost-effective use of drugs throughout the country.

Patients pay 100% of the cost for any prescription drugs listed in the national drug benefit scheme up to 1,800 - 2,200 SEK (260-330 CAD) per year depending upon where they reside (9). Patients pay the full price for all non-prescription drugs and any prescription drugs that are not subject to reimbursement (8).

Dental Care

In Sweden, dental care is free of charge for everyone aged 19 or under (10). Those who are aged 20 and older, receive a subsidy of between 150 – 300 SEK (22.5-45 CAD) for preventative dental care and general examinations (8). In addition, there is a high cost protection scheme for dental care services. People must pay for costs up to SEK 3,000 (450 CAD) themselves. However, if someone incurs an annual cost between 3,001 – 15,000 SEK (450.15 - 2,250 CAD), they will be reimbursed 50%. If they spend over 15,000 SEK (2,250 CAD) on dental care, they will receive 85% of this cost in reimbursement.

Extensive Social Insurance Benefits

Sweden provides extensive social insurance benefits to all residents. This includes sick leave, parental leave, basic retirement pension, supplementary pension, child allowance, income support, and housing allowance (1).

Sick leave - Employee Benefits

Collective agreements from the labour market result in collective insurance schemes that provide additional benefits to almost all Swedish employees (7). Employees receive approximately 80 percent of their salary as sick leave pay if they are away from work for more than one day. If an employee's sick leave extends beyond two weeks, the benefits paid will be reduced and assessed at regular intervals (11).

Health Care Expenditure

In 2010, total health care expenditure in Sweden expressed as US\$ purchasing power parity per capita was \$3,758 compared to \$4,445 in Canada (3). In the same year, 81% of health spending was funded by public sources (i.e. central government, county councils, and municipalities) (3).

In 2011, 89.6% of the total county council expenditure related to health and dental care, representing a net increase of 3% from 2010 (12). At the municipal level, 24.4% of total expenditure was spent on care for the elderly and disabled (12).

Health Care Delivery System

Primary Care

Swedes access primary care through local primary health centres, district nurses' clinics, as well as child and maternity health care clinics (1).

Almost one quarter of primary health centres in Sweden and nearly half of those in Stockholm are privately run (1, 13). Primary health centres usually employ general practitioners, physiotherapists, and nurses. General practitioners mostly work in group practices (8). Although they perform home visits, they do not follow their patients that are admitted to hospitals. General practitioners also refer patients to specialists when needed. However, they

do not have a 'gate keeping' role in primary care and therefore, patients may see specialist physicians without a referral (8). Similarly, physiotherapists in primary health centres receive referrals from general practitioners and may also see patients without referrals.

District nurses are often the first point of contact in primary care (8). Many nurses are specialized in specific clinical areas such as diabetes, respiratory, cardiology, and urology. They have limited prescribing privileges and act under the supervision of physicians (8).

Child and maternity health care clinics employ midwives that provide pregnancy testing, prenatal care, family planning (which includes contraceptive counselling and prescribing oral contraceptives to women), and testing for sexually transmitted diseases (14). Midwives also deliver the majority of babies in Sweden. Research indicates this is one reason why infant and maternal mortality in Sweden is one of the lowest in the world (9).

Public Health

Health promotion falls under the responsibility of county councils in Sweden. Thus, prevention and health promotion activities are integrated into primary care (8). For example, blood pressure testing and cholesterol measurement take place at primary health centres. In addition, general practitioners immunize children and provide health education programs regarding tobacco, alcohol, and diet.

Secondary and Tertiary Care

Patients requiring treatment in hospital can go to one of Sweden's 60 hospitals that provide specialist care and 24-hour emergency care (9). For highly specialized care, county councils coordinate service provision through eight regional / teaching hospitals (9). This model allows county councils with smaller catchment areas to leverage on expertise in larger centres.

Between 1980 and 2010, the number of hospital beds decreased from 15 per 1000 population to 2.7 (3). Over the same period, the number of acute care beds also fell from 5.0 per 1,000 population to 2.2 (3). At the same time, many changes occurred to shift health care services from inpatient hospital care to outpatient care in hospitals and primary care (8).

Wait Time Guarantees

In 2005, Sweden's national government established maximum wait times for access to primary care, specialist care, and treatment (including elective care) in order to address long-standing concerns regarding access throughout the country (9). Every county council must ensure that their residents are able to access a primary health centre without delay, see a general practitioner within 7 days, consult a specialist within 90 days, and wait no more than 90 days after being diagnosed to receive treatment (9). The Stockholm county council has established more aggressive wait times for their residents in an attempt to improve access to specialists. These wait times are outlined in Table 2 below.

In 2010, approximately 90% of patients saw a specialist within 90 days and received treatment or surgery within the following 90 days (9).

When a county council is unable to provide care to its residents within the established wait time, residents are free to travel to any other county council of their choice for medical care. In these situations, the ‘money follows the patient’ and the ‘home’ county council pays for the patient’s travel costs (9).

Table 2: Maximum Wait Times (days) for Medical Care in Sweden

	National target	Stockholm County Council
Primary health centre	0	0
General practitioner	7	7
Specialist Physician	90	30
Treatment	90	90

Source: The Swedish Institute (9)

Social Care

The Swedish health care system is closely linked to social care.

Municipalities in Sweden finance and deliver long-term care for the elderly, as well as those with disabilities and long term mental illness.

The primary service provided for the elderly is home care (also referred to as ‘home help’). This includes help with activities of daily living such as shopping, cooking, cleaning, and laundry. It also includes personal care such as help with bathing, toileting, getting dressed and in and out of bed. In addition, there is a wide range of other services available such as transportation, foot care, meals on wheels, security alarms, and home adaptations (15). In 2007, of the total costs for municipal elderly care, 38% was spent on home based care (15).

Municipalities are also responsible for providing ‘special housing’ for the elderly which includes nursing homes, residential care facilities such as old age homes, service houses, group homes for persons with dementia etc (15). In 2008, 60 per cent of municipal costs for elderly care related to special housing (16).

Health Human Resources

There are approximately 2.4 physicians, 11 nurses, and 1.4 midwives per 1000 inhabitants in Sweden (3).

Sweden has six medical schools and every year, approximately 1,110 students enter medical school. In comparison, Sweden’s 30 nursing schools take approximately 5,500 new students annually (1).

To qualify to become a registered physician, 5.5 years of study must be followed by a 21-month period of training and a written examination. Thereafter, about 70% of physicians continue an additional 5 years of study in one of 62 recognized specialist fields (1, 8). Almost a quarter of them become specialists in general medicine (8). In contrast, nurses need to complete 3 years of basic education followed by specialist training. However, in order to work as a midwife, an individual must first complete a nursing program, have at least 6 months work experience as a nurse, and then complete another 18 months of midwifery education. Therefore, a midwife in Sweden is also referred to as a nurse-midwife (13).

Pharmaceuticals

Drugs sold in Sweden must be approved and registered by the Medical Products Agency (1). Once approved, the Pharmaceutical Benefits Board decides whether a specific drug should be subsidized by the national pharmaceutical benefits scheme.

In 2009, the state-owned Apoteket chain of pharmacies lost its monopoly. Since then, approximately 200 pharmacies have opened up in the country (9).

Financial Resource Allocation

Health Care Facilities

County councils vary in their approach to resource allocation (1). In fifty percent of the county councils, payments to hospitals and primary health centres are generally based on global budgets. Twenty five percent of county councils use a blended approach - per case payment with expenditure ceilings for hospitals and capitation for primary care. In other county councils, capitation models are used for primary care and global budgets are used for everything else. Regardless of the method of resource allocation, payments are based on full costs (1).

Private health care centres that meet accreditation conditions and have an agreement with their county council will be reimbursed with public funds (8). On the other hand, those that do not have such an agreement will not be reimbursed and their patients will have to pay for all charges 'out of pocket.' As a result, even though there are public and privately owned health centres in Sweden, both are generally publicly funded (8).

Health Care Professionals

Most health care professionals – physicians, nurses, dentists, physiotherapists – are mainly salaried employees since most providers in Sweden are publicly owned.

In 2003, physician salaries were approximately 48, 100 SEK (7,215 CAD) per month (1). This includes compensation for on call during non-work hours. Nurses salaries were 23, 000 SEK (3,450 CAD) per month and dentists earned on average 35, 300 (5,295 CAD) per month (1).

How do Sweden and Canada Compare?

In 2010, Sweden spent 1.8% less on health expenditures as a percent of GDP than Canada (3, 16, 17). Between 2000 and 2009, health care spending, in real terms, increased by 3.9% per year in Sweden compared to 4.6% in Canada (3, 16, 17). Sweden has more physicians, nurses, and hospital beds per 1000 population than Canada (3, 16, 17). Sweden, while having a much older population, outranks Canada in health status and performance, with higher life expectancy, lower infant mortality, and lower risk factors. Details on these and other key OECD indicators are found in Table 3 below.

Table 3: OECD Data for Sweden and Canada

Key Indicators	Sweden	Canada
<i>Health Expenditures</i>		
Total expenditure on health as % of GDP	9.6	11.4
Annual growth rate of total expenditure on health, in real terms	3.9	4.6
Total expenditure on pharmaceuticals and other medical non-durables as % total expenditure on health	12.6	16.7
<i>Health Care Resources</i>		
Physicians, per 1 000 population	3.8 [∅]	2.4 [¥]
Nurses, per 1 000 population	11	9.3
Total hospital beds, Per 1 000 population	2.7	3.2
Curative (acute) care beds, Per 1 000 population	2.0	1.7
<i>Health Status</i>		
Life expectancy, Total population at birth, Years	81.5	80.8
Infant mortality, Deaths per 1 000 live births	2.5	5.1
<i>Health Care Activities</i>		
Average length of stay, All causes, Days	5.7	7.7
Caesarean section, per 1 000 live births	168	262
<i>Risk Factors</i>		
Tobacco consumption, % of population age 15+ who are daily smokers	14.0	16.3
Alcohol consumption, liters per capita (age 15+)	7.3	8.2
Obese population, self-reported, % of total population	12.9	17.5

∅ Practising physicians providing care directly to patients.

¥ Practising physicians and other physicians working as managers, educators, researchers, etc. (adding another 5-10%)

Source: OECD Data 2012 (2010 or nearest year) (3)

Lessons Learned from Sweden

Driving the Quality Agenda

Bundled Payments and Care Guarantees

The Stockholm County Council reimburses total hip and total knee replacement surgeries using bundle payments for the care cycle as a means to include responsibility for avoidable complications (18, 19). Both private and public providers are paid the same fixed amount of 56,300 SEK (8,445 CAD) per surgery (20).

This bundle payment covers the cost of pre-op evaluation, laboratory tests, radiology, surgery and related admissions, prosthesis, drugs, inpatient rehabilitation for up to six days, one follow-up visit within three months of surgery, and any additional surgery to the joint within the next two years (18). If a patient acquires a post-operative infection requiring antibiotics, the 'care guarantee' is extended to five years (18).

Bundle payments are an integral feature of OrthoChoice – a Stockholm based initiative that began in 2009 as a way to supplement public hospitals with private providers that would perform these surgeries and help reduce the wait list (19, 21).

Later this year, researchers from the Stockholm County Council, the Karolinska Institute and the Institute for Strategy and Competitiveness at the Harvard Business School will publish health outcomes and cost data from the OrthoChoice initiative (21).

Canadian health care leaders should keep a look out for these results. All Canadian provinces strive to achieve and maintain wait time targets for total hip and total knee replacement surgeries. To meet these targets, services are occasionally outsourced to private surgical centres. If the results from the OrthoChoice initiative suggest that bundled payments reduce overall costs and improve patient outcomes, health care leaders should apply similar payment principles when contracting similar services to private or public providers.

Regional Comparisons and Quality Registries

Every year, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions collaborate to report on regional comparisons of quality and efficiency (22). The public, media, patient associations, county councils, and other organizations have access to this report (22).

The report serves two main purposes. First, it improves transparency and thereby increases accountability. Second, by publishing health outcomes, patient experience, wait times, and costs for each region, it promotes quality and efficiency, and creates a certain level of competition for performance between regions (22).

In 2010, regions were compared on 134 indicators that are generally focussed on medical outcomes (22). This includes general indicators such as life expectancy and cost in addition to indicators specific to certain types of diseases or treatment (22).

Many of the medical quality indicators originate from the National Board of Health and Welfare registers and national quality registers (22).

Sweden currently has 73 registries that contain individualised data such as patient age, sex, diagnosis, medical interventions, and outcomes after treatment (23). In addition, Sweden has seven competence centers that promote synergy among registries and enable cost sharing for technical and analytical support (23).

In Canada, the Canadian Institute of Health Information and Statistics Canada most recently reported on 52 indicators (24). While provinces and territories have developed additional reporting systems, the level of detail varies substantially due to their ability to collect, interpret, and report on health data. If we apply lessons from the Swedish model and establish more comprehensive indicators at a national level and create organizations to promote collaboration between and within provinces regarding “technical operations, analytical work, and use of registry data to support clinical quality improvement,” we may be in a better position to inform Canadians on key outcomes, service levels, and expenditures (23, 24).

Care for the Elderly

In 2012, several new activities are underway to address the challenge of an increasing number of elderly people in Sweden, many of whom have multiple diseases. One of the key initiatives is the central government’s introduction of performance bonuses to achieve better outcomes for the most ill elderly people (25).

The Swedish Palliative Registry strives to improve end of life care for every dying patient in Sweden. It is based on two key requirements: annual reporting on the number of beds, access to different professions on weekdays (including on call) , and availability of written protocols for standard work in end of life care; and completing a questionnaire about the patient’s last week in life as soon as possible after the patient’s death. If health care and social care providers register at least 70% of total deaths, their respective municipalities and county councils will be eligible to receive performance based funding (total 50 million SEK, 7.5 million CAD available) (25).

The Swedish Dementia Registry is intended to ensure those suffering from dementia receive the same high quality care throughout the country. To incent increased registration, performance based funding for 2012 has been established for new cases registered (total 50 million SEK, 7.5 million CAD available) (25).

The Swedish Registry for Behavioral and Psychological Symptoms is aimed at mapping symptoms using a neuropsychiatric inventory scale, identifying reasonable causes, and measuring outcomes based on national guidelines (25). Municipalities will receive performance based funding (total 20 million SEK, 3 million CAD available) if care providers begin to work in a standardized way at these symptoms and use the register (25).

By 2036, projections indicate that 24% of Canada's population will be over the age of 65 years, leaving many in the health care sector wondering whether the health care system as we know it now, will still exist (26). Developing pan-Canadian indicators specific to this segment of our population and using economic incentives to improve our ability to collect, interpret, and report on data would no doubt improve our ability to understand where we need to accelerate our progress as it relates to seniors care.

Focus on Patient Safety

National Targets for Rational Antibiotic Use

In 2011, Sweden's national government created performance based targets to increase the rational use of antibiotics and reduce the risk for bacteria to develop antibiotic resistance.

A total of 100 million SEK (15 million CAD) is available to be shared between the 21 county councils if they increase compliance to local treatment recommendations regarding common infections in outpatient care and decrease the number of antibiotic prescriptions by a specified amount. Eligibility for the funding is based on achieving a ten percent reduction of the difference between the number of antibiotic prescriptions per 1,000 inhabitants in 2009/2010 and the national goal of achieving a maximum of 250 prescriptions per 1,000 inhabitants by 2014 (27).

This innovative approach to improve rational use of antibiotics may not be easily replicated 'as is' in Canada, but it does make one think about future possibilities.

Infection Control and the Role of Dress Code

Due to the rise of antibiotic resistant bacteria and escalated costs to treat nosocomial infections, the National Board of Health and Welfare issued regulations on basic hygiene in the Swedish health system (28).

All health care professionals that work directly with patients must undertake activities necessary to uphold a good standard of hygiene (28). In addition to the typical hand hygiene protocols we strive to follow in Canada, Sweden regulates a dress code. Specifically, it states "health service personnel shall during... direct contact with patients, observe the following to limit the risks of health-care associated infections:

- Working-clothes shall have short sleeves.

- Working-clothes shall be changed daily or more often when needed.
- Hands and lower arms shall be free from wristwatches and jewellery (28).”

As a result, hospitals supply all staff with short – sleeved work clothes that may only be worn at work and must be washed by the hospital’s laundry facility. All staff arrive to work in their personal clothes and then change into their uniforms before entering patient care areas. The underlying philosophy behind these requirements is that hand washing may be done more effectively when wearing short sleeves and no jewellery.

In 2008, 819 patients contracted MRSA in Sweden leaving one to wonder about the impact a strict dress code and hand washing protocol may have on nosocomial infection rates in Canada (22).

Improving Prescribing Patterns

The national government uses performance-based indicators to incent county councils to improve prescribing patterns. For example, in 2012, 325 million SEK (48.75 million CAD) will be distributed amongst county councils that reduce the number of inappropriate drugs for patients with psychosis in nursing homes and residential care facilities by at least 10% (25). However, there is a catch. The amount of funding will vary depending on the number of county councils that reach the target. If a minimum of five county councils reach this target (representing approximately 25% of the county councils in Sweden), 325 million SEK (48.75 million CAD) will be distributed among them (17). If less than five county councils achieve this target, only 200 million SEK (30 million CAD) is available to share amongst them (25).

County councils regularly monitor prescribing patterns. Committees assess similar drugs and share recommendations on efficacy and price to all physicians in a given county council (7). Physicians receive reports that compare their prescribing patterns with those of their colleagues. If physicians do not follow recommendations related to prescribing, they receive coaching by peers, and no retribution (7).

How to influence prescribing patterns remains a challenge for Canada. Clinical practice guidelines and protocols, as well as formal continuing education opportunities are easily accessible, but changing behavioural patterns is no easy task. It is however, imperative that we adopt innovative strategies across the country to move us forward in the right direction.

Reducing Pressure Ulcers

In 2006, Karlskoga Hospital in the county of Orebro, Sweden created a vision - no pressure ulcers should occur during any patient stay.

Since that time, the incidence of pressure ulcers dropped from 9% to 4.3% (30). Several strategies were implemented to achieve these results:

- Engaging and training all staff over a five day period on how to reduce pressure ulcers, starting at the outset of the patient journey and teaching staff how to get patients out of their homes and into an ambulance stretcher in a safe manner. Offering a refresher course every 6-12 months to review how to move patients and avoid hurting yourself;
- Introducing risk assessment scales in every department to facilitate skin/tissue assessments for at risk patients;
- Tracking the incidence of pressure ulcers up to four times a year and sharing results with all staff and management; and
- Collaborating with industry to introduce pressure-relieving mattresses throughout the facility, and obtain airflow mattresses.

This enhancement to the patient safety culture at Karlskoga Hospital also transformed staff safety. Since the start of this initiative, the number of sick days due to work related incidents during patient transfers fell from 20 days in 2006 to 0 days in 2012 (30).

As an emerging health leader, this was a lesson in recognizing excellence in leadership. Each of the leadership capabilities outlined in the LEADS framework – lead self, engage others, achieve results, develop coalitions, systems transformation – were demonstrated at Karlskoga Hospital.

Conclusion

Sweden's population is one of the healthiest in the world. This stems, in part, from a number of contributing factors – access to health care services for all in need, national policies with local delivery and accountability, control over expenditures, public and private providers, and management of clinical activities. Many of these issues are currently under debate in Canada.

So what can Canadian health care leaders learn from the Swedish experience and apply today that will not require major reform?

The 2012 Canadian College of Health Leaders' Sweden Study Tour offered many examples of how to improve quality and patient safety: innovative bundled payments for providers performing total hip and knee replacement surgery; national quality registries to support quality improvement efforts; annual regional comparisons of outcome focussed indicators; performance based funding to incent appropriate prescribing and encourage use of new quality registries; and standard dress codes to improve infection control.

The time is now, to challenge the status quo in Canada and experiment with new ways of thinking to address issues related to quality, patient safety and performance improvement. After all, as the saying goes, it would be insanity to do the same thing, over and over again, but expect different results.

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