Summary of the National Action Plan for the Development of Health Care

Challenges to the health care of the future

REGERINGSKANSLIET

Ministry of Health and Social Affairs, Sweden

Challenges to the health care of the future

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Preface

On 29th November 2000 the Swedish Riksdag (parliament) wrote health care history when a majority of the parliamentary parties resolved on an action plan for the development of health care during the years ahead. Through this action plan, a funding increment of MSEK 9,000 development agreements and local action plans, the Government is now making a concentrated effort to improve primary care, elderly care and psychiatry. This amounts to a shift of emphasis in health care, aimed at improving its quality and availability.

Health care in Sweden presents a contradictory picture. On the one hand there are depictions of crisis, long waiting lists, staffing shortages and stressful working conditions. On the other, Sweden has a uniquely low infant mortality rate and high average life expectancy. More elderly people than ever before are receiving care for severe acute illnesses and care on a planned basis.

At the same time as care has been so greatly improved and become capable of doing so much more, resources have not kept pace with possibilities. There is a heavy imbalance between outpatient care, which has incurred greater responsibilities without any corresponding growth of resources, and in-patient hospital care.

To cope with the care requirements of the future, a shift of emphasis will be needed in health care services. This is not a new idea. The question of primary care as a basis of health care services has been under discussion for 30 years, but little has happened. The action plan, coupled with policy measures of various kinds, will make possible the initiatives needed in order to transform the basic structure and focus of health care.

Care shall continue to be provided on equal terms and according to needs, it shall continue to be democratically controlled and to be equitably funded. Swedish health care must therefore be given renewed strength. Thanks to the growth of the Swedish economy and to the National Action Plan, we have now made considerable headway. Opportunities for the development of health care in Sweden are unusually good at present. Let us make the attempt.

Lars Engqvist
Minister for Health and Social Affairs

A broad grip to strengthen health care

"We have to find forms for effective co-operation between primary care, hospitals and the municipalities."

Lars Isaksson, Chairman of the Federation of Swedish County Councils

Despite the economic crisis of the 1990s, health care in Sweden has coped very well with its tasks, but there are shortcomings which have to be remedied. Outpatient care away from hospitals, primary care under county council and municipal auspices has not been given resources and capacity commensurate with its wider responsibility for patients with increasing care requirements. Co-operation between different parts of health care is not what it ought to be. Care also needs to be developed so as to be responsive to the patient's need of information, participation and influence. To cope with the care situation of the future, outpatient care in municipalities and county councils needs to be reinforced and general medicine developed, as well as opportunities for the population to choose their own regular family doctor.

As part of the renewal of health care, the Government has drawn up a National Action Plan. This work has proceeded in close dialogue with patients' organisations, personnel organisations, the medical professions and other interested parties.

This publication summarises the National Action Plan for the Development of Health care which the Riksdag adopted on 29th November 2000. The quotations come from the conference arranged by the Ministry of Health and Social Affairs in December 1999 to being about a dialogue with representatives of health care services concerning the development and focus of primary care. The boxes are excerpts from the agreement on development initiatives in which the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the State have committed themselves to an approach in keeping with the action plan.

Care shall be provided on equal terms and according to need, shall be democratically controlled and shall be equitably funded. The action plan is based on the following principles:

- Primary care in county councils and municipalities shall constitute an efficient base of health care.
- Older persons shall receive better health care through better medical attention.

- Co-operation between different sectors of care shall be improved.
- Children, young persons and older persons with mental illnesses shall receive earlier and better support.
- Greater support shall be given to persons with mental functional impairments.
- Private, co-operative and non-profit care providers shall be given better opportunities of operating outpatient health care on a contracting basis on behalf of municipalities and county councils.

Municipalities and county councils are to receive a funding increment of merely MSEK 9,000 between 2001 and 2004 for the improvement of health care. The county council will receive 70 per cent, the municipal sector 30 per cent of this increment. The use to be made of this funding between 2002 and 2004 is governed by an agreement between the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the State. All county councils are to draw up action plans of their own with reference to local conditions. The local action plans are to clarify the mission of primary care, the prospective development of co-operation with municipal caring services for the elderly, and the improvement of psychiatric care. These local action plans are to be presented during 2001.

The aim of achieving a shift of emphasis in proximate and outpatient care is not really new. The great difference compared with previous initiatives is that this one combines a variety of measures: the National Action Plan, the agreement between the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the State, the local action plans, the funding increment of MSEK 9,000, and an annual follow-up of the measures taken. The MSEK 9,000 are not to be regarded as a general reinforcement of county council and municipal finance.

The National Board of Health and Welfare will have the important task of ensuring that the money has been used for developing health care. A staging post is programmed for mid-year 2003, and a comprehensive follow-up report is to be submitted to the Government in December 2005.

Given this background, the action plan is mainly concerned with necessary initiatives for developing the basic structure and focus of health care. This in turn means that the action plan does not cover all the various parts of health care, nor does it cover all groups of illnesses.

Several different initiatives are in progress in the community which will also help to improve proximate and local care. Co-operation deficiencies are one question which cuts through all the fields highlighted in the National Action Plan. The Co-operation Commission has analysed current problems relating to interaction between county council health care and municipal caring services. The Commission has presented a proposal to solutions in the report SOU 2000:114 and the questions are under consideration during 2001.

> “The National Action Plan provides a unique opportunity for a rallying of forces to improve availability and create continuity in primary care, elderly care and psychiatry. It is a manifestation to bring about a shift of emphasis in Swedish health care so as to augment inter-professional co-operation in health care and to augment interaction between county councils and municipalities.”
>
> Kaj Essinger, the Federation of Swedish County Councils

Health care today

"Few professional categories are so dedicated to their work as the people who work in caring services. I won't use the word 'vocation', instead I call it 'responsibility and dedication'. But many people, on account of poor working conditions, feel exploited by their employer."

Ylva Thörn, the Swedish Municipal Workers' Union

Health care in Sweden works very well. Despite the economic downturn of the 1990s, health care has improved. Sweden has a uniquely low infant mortality rate and high average life expectancy.

More elderly people than previously are receiving both care for severe acute illnesses and care on a planned basis. Forms of treatment common among older persons, such as cataract, hip joint and coronary surgery, increased heavily during the 1990s. Medico-technical progress has made it possible for more older people to see, to hear and to move without pain.

The past decade has also witnessed a strengthening of the patient's position. We have acquired more opportunities of choice and the right of influence and participation in our treatment.

Development governs the need for care

At the same time as care has improved and can do so much more, resources have failed to keep up with possibilities. Waiting lists for care have grown longer, staff have been subjected to heavy stresses and patients have suffered.

Cataract surgery is a case in point. Thus 33 000 operations were performed in 1992, at the same time as there were 16 000 people on the waiting list. Eight years later the number of operations had risen to 57 000, and yet the waiting list had almost doubled, and now stood at 31 500. This is not due to more people having suffered vision impairments or more people having grown older. Today the operation can be performed for a milder vision impairment than used to be the case. This has been made possible by improved methods of treatment.

Older people who, ten years ago, could only obtain relief of their symptoms, can today receive active care and live longer with an elevated quality of life.

Public demands and expectations where care is concerned are of course developing parallel to the growth of treatment opportunities. Using the new information technology, people can find out for themselves what is possible, and they expect things which are being done elsewhere in the world to be also possible on their home ground.

Imbalance in care

The allocation of tasks between outpatient and in-patient care changed during the 1990s. Reduced lengths of stay in hospital have meant outpatient care assuming responsibility for larger numbers of patients requiring greater care. Many illnesses which used to require in-patient, hospital care can now be managed on an outpatient basis, as for example in the case of patients requiring follow-up and support for such chronic conditions as asthma, diabetes, depression, psychoses, hypertension or heart failure. The same can also apply to all the persons, older ones especially, who are looked after at home or in special housing accommodation, many of them suffering from more than one illness, and/or people whose lives are drawing to a close.

This change has come quickly, without additional resources being channelled into outpatient care. Outpatient, proximate health care, therefore, has difficulty in coping adequately with all its various tasks, with the result that primary care is not always available to people who are suddenly taken ill. Patients are forced to turn to the emergency departments of hospitals, where they encounter long waiting times. Purely medically speaking, emergency care works well. The long waiting times are a matter of apportioning emergency patients between hospitals and outpatient care. The load on hard-pressed emergency medical services could be lightened if outpatient care were improved.

Proximate outpatient care today is not measuring up to people's needs and expectations. Local

care, quite simply, has not been given the prerequisites for accomplishing its mission as the basis of health care.

More care in the home

The great majority of people, illness and advanced age notwithstanding, prefer to go on living in their homes for as long as possible, if they can get the help they need. During the 1990s, patients who were previously cared for and lived in hospital long-term care units were also given the opportunity of continuing to live at home or in specially adapted forms of housing accommodation. Elderly and sick people now have a better chance of leading independent lives.

The Ädel Reform, introduced in 1992, had the effect of making outpatient care a partly municipal responsibility. Some 20 per cent of Swedish health care is today provided under municipal auspices. The municipalities have established special forms of housing accommodation, they have built up a 24-hour organisation for providing support and assistance in patients' homes, and they have recruited medically trained personnel.

But interaction between municipal care and county council primary care leaves much to be desired. Information concerning patients whose medical treatment has been completed and who are therefore transferred from hospitals to the municipalities is not getting through. Many patients need medical support in the home, but there are not enough doctors for this care to function adequately. Instead patients are turning to emergency medical care with problems and complaints which could have been dealt with by outpatient staff.

The care which older and chronically ill persons used to receive in hospital long-term care units has been transferred to outpatient care in the municipalities. Families are today assuming greater responsibility for their sick and elderly members than used to be the case. It is fair to say that care has been transferred from in-patient to outpatient care and that the emphasis has shifted from public service to the care provided by relatives.

Continuing pressure on caring services

The pressure on health care is not going to diminish in future. On the contrary.

Demographic developments speak for themselves: more people in age groups requiring a great deal of care and fewer people of employable age. Medico-technical progress and advances in the pharmaceutical industry are now creating better opportunities for curing or relieving disease and injuries. And age is tending less and less often to be a limiting factor.

Focus on primary care

"We must make primary care an appealing workplace, capable of attracting young GPs in larger numbers. The cause of the present-day situation is a shortage of GPs. Sweden has a unique medical situation, with few general practitioners. An international comparison makes this extra clear."

Carl-Eric Thors, District Physician, the Swedish Medical Association

Proximate and local care shall be the basis of the entire health care system. There is no "right answer" to the question of what primary care should include. Creating one and the same model for the organisation of proximate, local health care nationwide is impossible. The way in which health care is to be organised and the personnel categories to be employed in it are questions for each county council to decide. Accordingly, each county council must define its primary care mission in accordance with local and regional conditions.

There must be a clear balance between assignment and resources in primary care, and people must know what they are entitled to expect from proximate care.

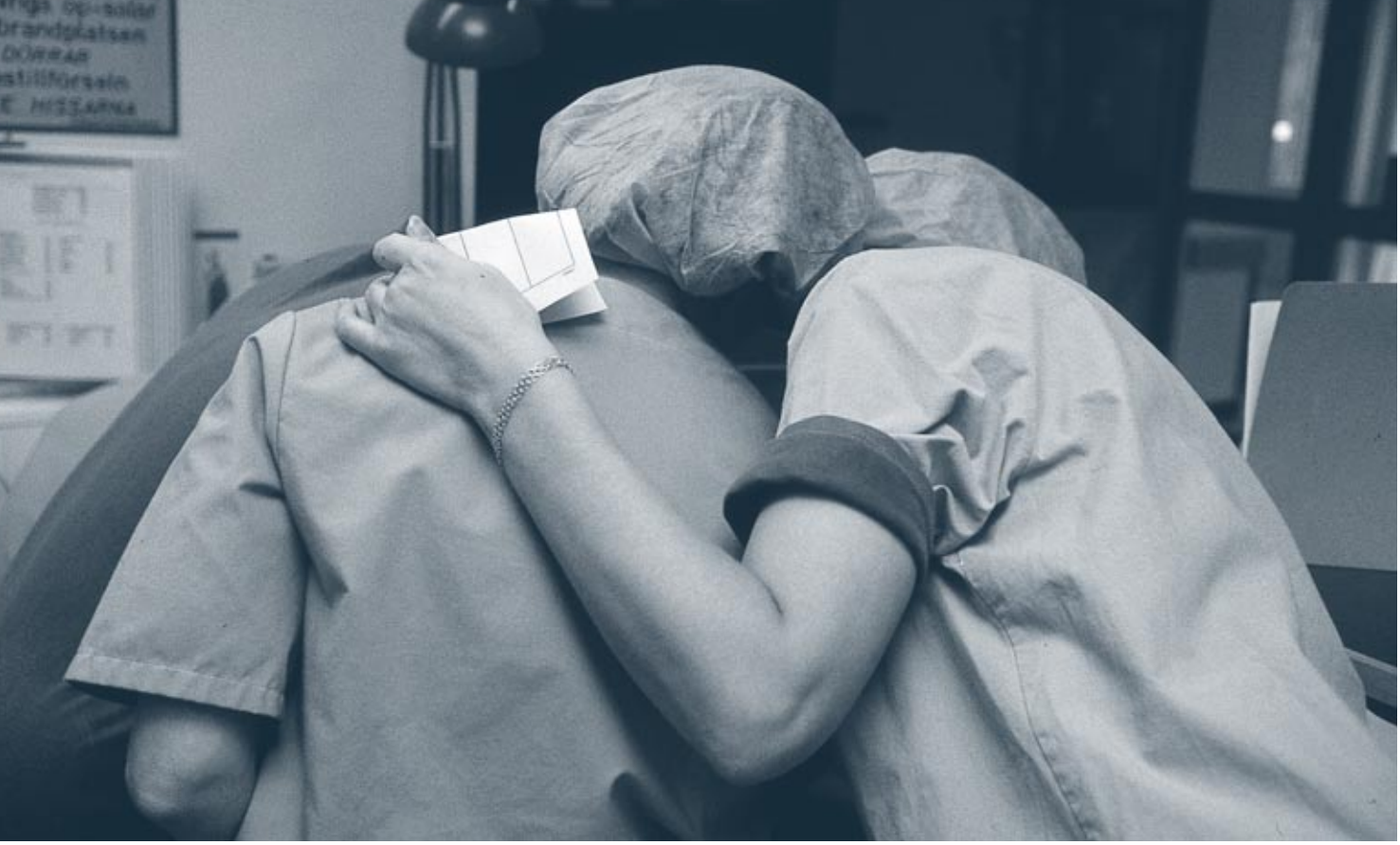
Basic prerequisites for the viability of outpatient care are extended reception hours and scope for more home visits and examinations. In addition, people must have the opportunity of establishing a long-term, trusting relationship with health care. A secure, permanent physician contact is one way of improving public confidence in outpatient care.

Permanent physician contact

To enable primary care to form the basis of the health care system, the number of general practitioners will have to be increased. People wishing to do so will then be able to have a doctor of their own, a family doctor.

Together with the district nurse and other professional categories in the caring system, the family doctor shall see to it that people have a long-term, secure and safe relationship with the caring system. The family doctor and other members of the team shall be residents' advisers and guides within the health care system. Availability is crucial to the possibility of making primary care the basis of the health care system. Help must be available at any time of day or night.

Interaction between primary care and other parts of the health care system does not always work properly. This means a duplication of tasks for personnel, but also poor follow-up and uncertainty for the patient. Information between different parts of the caring system, e.g. between hospitals, county council primary care and municipal home nursing, is often deficient. This



is a source of insecurity, above all to older persons, the chronically ill and long-term patients. With a permanent physician contact in primary care, these problems can be averted.

A whole variety of professional categories are needed for the care of patients with chronic conditions like diabetes, hypertension, heart failure and psychoses. The same applies in home nursing, mother and child health care and rehabilitation/habilitation. In primary care, all personnel categories need to have a good relationship with patients and to co-operate with each other and across professional boundaries. Those wishing to do so shall be able to establish a relationship with a family doctor of their own choosing. This permanent physician contact shall be a doctor who is a specialist in general medicine. The underlying intention is to strengthen the general medical competence of primary care. Primary care, of course, can also employ other physicians with other specialist qualifications, e.g. in geriatrics, psychiatry or paediatrics.

More doctors

Sweden has one of the world's highest physician ratios, with one practitioner for every 350 inhabitants. We have too few GPs, only one per 2 250 inhabitants. The number of specialists in general medicine will have to be increased if primary care is to be capable of serving as the basis of the health care system. The Riksdag considers it possible for the number of primary care specialists in general medicine to be raised by 220 annually up to and including 2005 and by 200 annually thereafter up to and including 2008.

In order to recruit more general medical specialists for primary care,

- primary care must be given a clearer remit. A clearly defined remit increases the prospects of personnel creating a good working situation

and work environment, thus enhancing the prospects of recruiting more GPs

- it must be made possible to employ different forms of management in primary care
- opportunities of training, in-service training and research must be improved. Medical training must be made to concentrate more on general medicine. If 30 per cent of all specialist appointments in future were to refer to the speciality of general medicine (as against 17.4 per cent today), the number of general medical specialists could be increased by 100 annually compared with today. Physicians in other specialities should be able to receive further training as specialists in general medicine. General medical research is to be actively supported.

> “Primary care is the foundation of the good health situation we have in Sweden, above all where mother and child health care is concerned, but we must not close our eyes to the deficiencies that exist.”
>
> Eva Fernvall, Chairman of the Swedish Federation of Salaries Employees in the Hospital and Public Health Services

Given this background, the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the Government agree that:
The county councils will be responsible for

- defining the task of primary care, e.g. with respect to function and availability, according to regional conditions,
- all inhabitants wishing to do so will have access to and will be able to choose a personal physician/family doctor in primary care,
- all inhabitants will have access to information about primary care – options, availability and information,
- residents will be able, at any time of the day or night, to access adequate competence and response, primarily in primary care,
- medical staffing ratios in primary care will be substantially reinforced,
- knowledge development in primary care will be strengthened through support for research and development work and through improved opportunities for competence development and in-service training.

Caring services for older persons

"Primary care physicians must be included in municipal caring teams, not only for the direct care of patients but also as tutors and facilitators for municipal caring staff."

Ulla Åhs, the Swedish Association of Local Authorities

Older persons and persons with functional impairment shall have the opportunity of receiving care and attention at home or in special housing accommodation. People benefit from remaining in their home environment if they are able to feel secure and confident of receiving the care they need. People with extensive and prolonged needs of care shall also have the opportunity of living in their accustomed surroundings or in special accommodation.

Unfortunately, municipal health care is subject to a number of deficiencies which we will have to overcome if this care is to work adequately for older persons and the long-term ill.

Improving quality by training

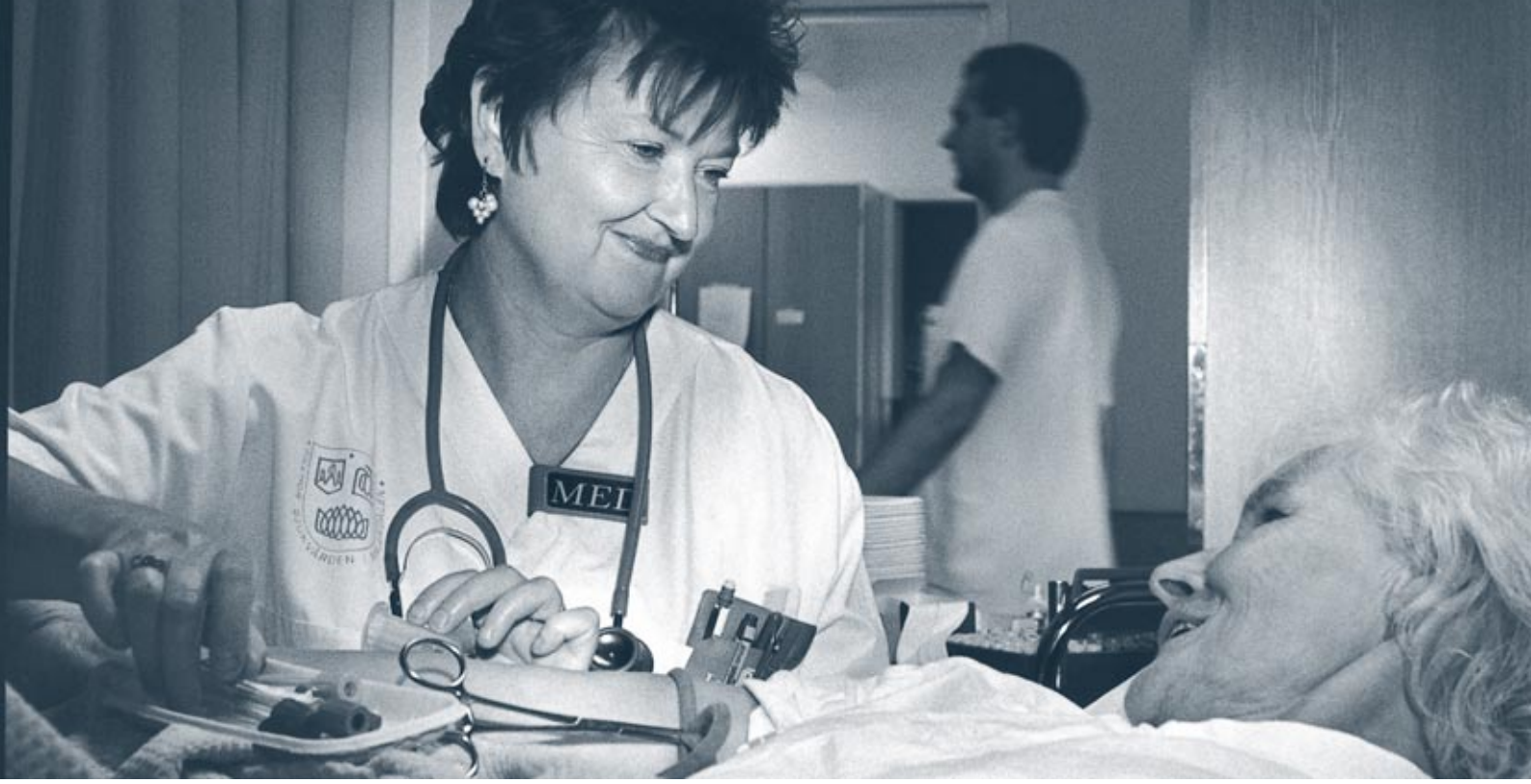
The increasing load on municipal caring services has not been matched by the corresponding training for personnel. The municipalities shall actively endeavour to enhance the competence of employees, so that the quality of the medical care will be increased. Everyone employed in municipal caring services shall therefore have at least high school qualifications for employment in caring services.

The municipalities are to recruit more people with post-secondary qualifications, e.g. nurses, and more nurses are to be given the opportunity of deepening their medical knowledge.

Better involvement of physicians

The physician has an important and pivotal role to play in the care of the elderly and persons with functional impairment in special housing accommodation and in home nursing. The sick and elderly living at home or in special accommodation have to be certain of prompt medical attention when needed, at any time of the day or night.

Doctors, unlike other caring staff in municipal caring services, are employed by the county councils. This division of personnel between municipality and county council has created problems. Several reports indicate that, following the Ädel Reform, the role of the physician has been regarded as of minor importance in the care of the elderly. Nor has it been self-evident that physicians in primary care are to take over the responsibility previously vested in the physicians of hos-



pital long-term care units. The task of the medical profession in primary care has to a great extent centred round health centre reception activities.

The time allowed by physicians for direct contacts with residents of nursing homes was halved between 1994 and 1998, falling to about four minutes per resident per week.

The need for physician involvement has become increasingly apparent as the care requirements of persons relying on municipal caring services have grown. This applies to the treatment of individual persons but also to support for other personnel, for activities and for ongoing quality-related activities.

It will continue to be the responsibility of county councils to ensure that people living in special housing accommodation or receiving home nursing can obtain the medical assistance they need.

Co-operation

Care must always be individualised. Patients shall not need to worry about whether care is provided by the county council, different parts of the county council or the municipality. Things do not run smoothly at present when a patient has to switch from one caring sector to another. When a patient is discharged from hospital, it happens that the physician in the outpatient caring system, which then becomes responsible, is not informed.

At the same time, it is important for older persons not to have to change care providers more often than is necessary. Health care in special housing accommodation or home nursing must be good enough for the patient to receive there the health care which he or she needs. Hospitalisation must be an exception, reserved for situations where the care of the patient requires the competence and resources of the emergency hospital. Advancing age and functional impairment often mean that it takes longer to settle down in new surroundings and adjust to new routines. A change of care provider can very easily cause confusion and insecurity.

Co-operation between municipality and county

council is a prerequisite of good care. Municipalities and county councils must therefore co-operate so as to co-ordinate the care given to groups of patients they have in common.

There must also be better co-ordination between health care, social security and social services. Better co-ordination of resources can lead to systems working more efficiently and the public, as a result, obtaining better care, at the same time as public expenditure is kept within limits. The Government is to lose no time in drawing up a scheme of financial co-ordination, the purpose of which will be to achieve improved health and a reduction of sickness absence.

Support for families

It is a well-known fact that families play an important part in the care of the elderly and of persons with functional impairment. The care provided by the family and other close relations is very extensive and has grown in recent years.

Many municipalities offer assistance to families, but on the whole this support is weak and next-of-kin do not always receive the help they need. For the period between 1999 and 2001, the Government has earmarked MSEK 100 for the encouragement of new forms of carer support. All municipalities have drawn up action plans for this purpose. The municipalities are to invest in the expansion of short-stay places, relief opportunities and support groups. Many municipalities are also to run outreach activities for discovering "hidden" carers. The task of drawing up action plans has been undertaken in close partnership with relatives' associations and other NGOs.

Carer support is so important that the funding assistance provided by the State should continue after 2001. The Federation of Swedish County Councils, the Swedish Association of Local Authorities and the State have therefore agreed on a continuation of the special funding arrangement between 2002 and 2004, in keeping with the National Action Plan concerning policy for the elderly. This support is to be provided as part of the general State Grant and not, as previously, in the form of incentive grants.

Given this background, the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the Government agree that:

The municipalities will be responsible for:

- enhancing the medical quality of special housing accommodation and home nursing, e.g. by an increased proportion of employees receiving adequate training, i.e. at least high school qualifications for caring service employment or the equivalent,
- more graduates being recruited, e.g. as nurses, occupational therapists, physiotherapists, psychologists and social workers,
- more nurses being offered the opportunity of deepening their medical knowledge,
- relatives caring for the sick, the elderly or persons with functional impairment continuing to receive strong support in keeping with the National Action Plan on policy for the elderly.

The county councils will be responsible for:

- persons living in special accommodation or receiving home nursing being medically examined by a doctor, obtaining medical advice or being visited in their homes by a doctor when necessary, without delay.

The county councils and the municipalities will be responsible for:

- all patients obtaining care on the right level, through a development of co-operation between county councils and municipalities.

Mental illness

"Another important thing is that primary care is a joint organisation, and getting such different organisations as municipal social services and medical services, for example, to pull together has been immensely difficult."

Ilmar Reepalu, the Swedish Association of Local Authorities

Several studies during the 1990s indicated a growth of mental illness in Sweden. Feeling in bad mental shape at some time during life is closely bound up with life itself and is something which everyone experiences from time to time. Many people cope with these problems on their own, others do so with support from their nearest relatives. Sometimes medical assistance is needed in order to cope with the situation, mostly within primary care but sometimes also from psychiatric care. Often a combination of measures is needed from various quarters, such as child care, school and one's employer.

If the right measures are taken at an early stage and in the individual person's own surroundings, mental illness need not become so profound and lasting as has previously been assumed.

Certain groups are more prone than others. Children and young persons affected by mental illness are one such group, and it is especially important that they should receive care at an early stage. Persons with mental functional impairment requiring both physical and psychiatric care are one category which has received insufficient attention. More attention also needs to be paid to older persons in need of psychiatric care.

Mental illness among children and young persons

A large proportion of children and young persons suffer from mental illness. The pressure on child and youth psychiatric services increased during the 1990s, partly because of more children and young persons resorting to psychiatric receptions,

but also because persons working with children, e.g. in schools, child care, child health care and social services, need help and support from child and youth psychiatry.

Children and young persons between the ages of 16 and 25 often find themselves in limbo between child and youth psychiatry and adult psychiatry. Better co-ordination is needed so that these children and young persons will receive continuous care.

There is a great need for preventive work among children and young persons in danger of developing and deepening mental illness. This also calls for co-operation between different sectors of society, not least between social services, child care and schools.

Children and young persons showing signs of mental problems must be given the right support early on. The same applies to children and young persons with both mental problems and substance abuse.

Persons with mental functional impairment

Persons needing both physical and mental care often occupy a very weak position in society and have inferior living conditions to those of the rest of the population. Prolonged mental illness makes it difficult to form contacts with other persons.

Much remains to be done in order to improve opportunities of a good life for persons with mental functional impairment. Today neither physical nor mental caring needs are being adequately provided for.

Close co-operation between primary care, psychiatry and social services is needed in order to provide for the needs of persons with mental functional impairment.

Mental illness among older persons

Mental illness among older persons is a hidden problem. The mental symptoms of older persons are often different from those of younger ones. Observation and treatment of older persons with mental illness therefore requires special knowledge.

It is important that the clinical picture of older persons should be identified, so that the diagnosis can be segregated from dementia development. Dementia and mental illness are two completely different pathological states requiring different approaches and treatment.

Given this background, the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the Government agree that:

The county councils will be responsible for

- offering early and adequate support to children and young persons presenting signs of mental problems,
- developing the content of care for children and young persons with mental problems and substance abuse,
- catering to the caring needs of young persons between the ages of 16 and 25 through co-ordinated initiatives from child and youth psychiatry and adult psychiatry,
- paying special attention to persons with mental functional impairment, so that their psychiatric and somatic caring needs are provided for through advanced co-operation between county council primary care, psychiatry and social services,
- identifying older persons with psychiatric needs and offering them treatment.

Increased diversity of care providers

"The great advantage of working in a co-operative is that the management is there at the sharp end, not somewhere else. And above all, there is a vast difference in the decision-making process. Decisions can be made and put into effect the same day."

Sara Söderberg, retired assistant nurse and former leader of the AKKA nursing co-operative

Personnel are the medical system's prime resource. To unleash creativity and innovative thinking, the medical system must create stimulating environments to work in. Working procedures are needed which will release the will power and ability of the individual and the team. This calls for a long-term endeavour with all personnel categories participating.

One way of encouraging creativity and innovative thinking is by permitting alternative forms of management in health care. Private, non-profit and co-operative care providers can contribute experience and innovative thinking which are capable of changing organisational structures for the better. A diversity of management forms in care will multiply opportunities for the personnel to design their own working situation and environment. This can among other things improve the prospects of recruiting more physicians for primary care.

"It's a matter of utilising all new ideas. The step from idea to implementation must be a short one. An employee who has an idea must be able to test it for a week in order to evaluate and disseminate the experience afterwards. In this way several health centres in Västerbotten have been able to eliminate waiting times and waiting lists."

Mats Gustavsson, family doctor,
Västerbotten County Council,
Institute for family medicine

Given this background, the Federation of Swedish County Councils, the Swedish Association of Local Authorities and the Government agree that:
The county councils and municipalities will be responsible for encouraging a diversity of management forms in outpatient care and other caring services by enabling increasing numbers of private, co-operative and non-profit entrepreneurs to sign contracts with the medical authorities.

Institute for family medicine

"We need democratic, professional health care. To get there we need a massive commitment to research in general medicine and funding for in-service training."

Jonas Sjögreen, family doctor, Västerås

Proximate, local care should be the foundation of health care in Sweden. The personnel employed in care must be enabled to be as confidence-inspiring and knowledgeable as the patient expects. There are many fields of primary care in urgent need of development. The role of primary care as the patient's co-ordinator and adviser needs to be reinforced. A new attitude also needs to be developed in work with the mentally disadvantaged and elderly persons in special housing and in home nursing. Medical and nursing professions are knowledge-intensive and treatment methods and working procedures are evolving rapidly. Personnel categories, therefore, are under heavy pressure to raise their competence in keeping with developments.

All professional categories need scope for establishing good relations with the patients and for co-operating with each other across organisational boundaries, regardless of mandatorship. Team work and information exchange are necessary, and competence development, therefore, is also needed to encourage the development of operational and working procedures.

During work on the Action Plan, ideas for an Institute for Family Medicine have taken shape. This Institute is to serve as a centre of knowledge and knowledge dissemination, e.g. by creating in-service training opportunities for primary care personnel. It is important that the Institute should be efficient and flexible, so as to be capable of responding to the needs of all personnel categories. A special investigator has been appointed to consider how the Institute's activities are to be built up. The investigator is to report on 1st June 2001 and is to obtain successive acceptance of the proposals made, so as to facilitate the inauguration of the activity, which is planned for January 2002.

Further reading

Nationell handlingsplan för utveckling av hälso- och sjukvården (National action plan for the development of health care)
Government Bill Prop. 1999/2000:149

Prioriteringar i vården – Perspektiv för politiker, profession och medborgare
Slutrapport från prioriteringsdelegationen (Caring priorities – Perspectives for policy-makers, professionals and the public. Final report of the Prioritisation Advisory Panel)
SOU 2001:8

Döden angår oss alla – värdig vård vid livets slut
Betänkande från Kommittén om vård i livets slutskede (Death concerns all of us – terminal care with dignity. Report of the Terminal Care Committee)
SOU 2001:6

Sjukhus med vinstsyfte (Profit-making hospitals)
Government Bill Prop. 2000/01:36

Samverkan – om gemensamma nämnder på vård och omsorgsområdet
Betänkande från Samverkansutredningen (Co-operation – concerning joint boards in the caring sector. Report of the Co-operation Commission)
SOU 2000:114

Hälsa på lika villkor – nationella mål för folkhälsan. Betänkande från Nationella Folkhälsokommittén (Health on equal terms – national public health targets. Report of the National Public Health Committee)
SOU 2000:91

Välfärd, vård och omsorg
Forskarvolym från Kommittén Välfärdsbokslut (Welfare and care. Research volume from the Welfare Accounting Committee)
SOU 2000:38

Upphandling av hälso- och sjukvårdstjänster
Betänkande från Utredningen om sjukvårdsupphandling (Outsourcing of health care services. Report of the Health care Outsourcing Commission)
SOU 1999:149

Det gäller livet – stöd och vård till barn och ungdomar med psykiska problem Betänkande från Barnpsykiatrikommittén. (A matter of life – support and care for children and young persons with mental problems. Report of the Child Psychiatry Committee)
SOU 1998:31

Nationell handlingsplan för äldrepolitiken (National action plan on policy for the elderly)
Government Bill Prop. 1997/98:113

Swedish Government website:
www.regeringen.se
Ministry of Health and Social Affairs website:
www.social.regeringen.se

This is a short version of the Government bill “National action plan for the development of health care” (Gov.bill 1999/2000:149). This short version is also available in Swedish and as a cassette recording.

A still more concise summary of the most important information in the bill is given in a fact sheet. Like the short version, the fact sheet is also available in Swedish and also in French, easy-to-read Swedish and as a cassette recording.

These various versions, and additional copies of this publication, can be ordered from the Ministry of Health and Social Affairs (Health care division), 103 33 Stockholm, tel. +46 8 405 10 00, fax +46 8 781 04 81.

The complete version in Swedish of the Government bill “National action plan for the development of health care” (Gov. bill 1999/2000:149) can be ordered from the Printing Works of the Riksdag (Riksdagens Tryckeriexpedition), 100 12 Stockholm, tel. +46 8 786 58 10, fax +46 8 786 61 76.

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