Summary of the International Health Policy Survey 2021 Swedish report

This is an English summary of a report published in Swedish that presents the results and analyses of the Commonwealth Fund's International Health Policy Survey (IHP), an international study that is conducted annually. In 2021, the study assesses the Swedish populations' older adults' opinions on the quality of health care in comparison with those of the populations in ten other countries.

The purpose of the study is to identify areas of improvement in the Swedish health care system, from the perspective of the population and the patients. Further, the study aims to contribute to improved understanding of the strengths and weaknesses in Swedish health care, and ultimately to initiate deeper analyses and discussions which may contribute to its improvement. Although the study encompasses many questions and areas of importance, it cannot fully describe the entire health care system. Therefore, we use other relevant knowledge sources as a complement.

The study conducted in 2021 included a number of questions concerning the populations' experiences of the Swedish health care system in relation to availability, coordination and quality. The report is focused on the Swedish results compared with those of the other countries, and the Swedish results compared with the last study among those aged 65 years and older, performed in 2017.

The survey focuses on different sub-populations on a three-year cycle: the general population, older adults, or doctors. The latest study was conducted in 2021, including around 3,000 randomly sampled individuals from the Swedish population aged 65 years and older. The response rate was 44 per cent. An analysis of the non-responses revealed uneven response rates between certain groups. Therefore, the data were weighted in order to adjust for such differences and provide results that were representative for the Swedish population older than 65 years. It should be kept in mind that international comparisons are subject to some limitations: the methodology of the study differs between countries and there are significant differences in the structure and organisation of their health care systems. On the other hand, the major strength of the study is that the same questions are posed to the populations in eleven different OECD countries, regardless of health care system.

In order to deepen the understanding of the Swedish results, the data are analysed in relation to various individual relationships and background variables. We investigate if the answers differ depending on an individual's demographic (gender, age, relationships, and background) or socioeconomic factors (level of education, income), health (self-assessed health, any chronic illness), or various contextual background factors, such as area of residence and whether or not the person has a regular doctor or nurse. While the survey covers several relevant variables of explanatory value, there are probably other

factors which are not investigated that could affect correlations. For example, the data are based on self-reports, and we lack information about past health consumption or existing registered diagnoses. It is important to note that any correlations found in the analysis reflect a covariance of the variables, which is not the same as a causal relationship.

1. Results and conclusions

This report covers many results and touches upon several topics. This section is a summary of the most important results, from our perspective. These findings lay the foundation for our conclusions and recommendations.

It is important to note that this study is based on patient-reported experiences, and that the Swedish health care generally shows good medical results. Therefore, there might be differences between the experience of the health care system and its medical results.

The section is divided based on the following three questions:

- How do Sweden's results compare with those of the other countries in the study?
- Which changes can be found in the Swedish results compared with the last study among those aged 65 years and older, performed in 2017?
- Which correlations do the Swedish results reveal in relation to various individual background variables and circumstances?

1.1. Swedish health care in an international comparison

Sweden generally shows poor results in comparison with the other countries, but there are improvements in some areas

Compared with the results from the other countries in the study, the Swedish results are generally poor. We recognise some general tendencies from earlier IHP studies, where Sweden has shown long waiting times and problems with coordination in the health care system. However, few people abstain from seeking health care due to cost. Although the Swedish results are poor, there are several improvements compared with in 2017. An example is seen in the care of chronic illnesses, with more individuals answering that they have had multiple kinds of support from health care, compared with in 2017. We also see some deteriorations compared with in 2017, including in specialist health care and in coordination of health care.

It is particularly worrying that results related to patient-centred health care, for example coordination and continuity, have remained poor, without improvement over time. Therefore, we see great challenges related to the current health care policy goals to strengthen the primary care. In summary, the results of this study show that the main challenges for Swedish health care are waiting times, coordination, and support for those with complex illnesses.

The proportion of individuals aged over 65 years with a regular doctor or nurse has increased

In Sweden, 69 per cent of those aged over 65 years responded that they have a regular doctor or nurse for their health care needs, which was an increase with 8 percentage points compared with in 2017. Seeing a regular doctor or nurse was more common among those with a chronic illness. However, Sweden was still the country in the comparison with the lowest number of patients repeatedly seeing a regular doctor or nurse. In Sweden, it was more common to return to a regular health care centre, with 93 per cent responding that they did so. This figure had decreased by 3 percentage points since 2017.

The results regarding patients' experiences of appointments with their regular health care contact have deteriorated over time. Compared with in 2017, fewer elderly individuals responded that they were often or always involved in decisions concerning their care, and that the doctor spent enough time on their appointments. Further, fewer individuals responded that health care personnel were familiar with important facts in their medical history.

It is likely that the increase in appointments with a regular doctor or nurse is due to a number of ongoing projects. Central aspects are that the government implemented a policy reform to strengthen primary care in 2018 and that a national system for knowledge-based health care was established as a cooperation between Swedish regions. The reform had as one of its objectives to increase continuity in primary health care, and more specifically to clarify patients' right to repeatedly see a regular doctor or nurse.

Patients continue to report long waiting times for non-urgent health care

The elderly Swedish population reported among the longest waiting times for health care not occurring at an emergency department. Long waiting times are something that Swedish patients have repeatedly reported in the IHP studies and no improvements have been seen over time. In comparison with the other countries in the study, Sweden generally has longer waiting times and patients have more difficulties getting health care in evenings and on weekends. 29 per cent responded that it was easy to access health care in evenings and weekends. The reported waiting times had not changed since 2017, with one exception: fewer people responded that they had received health care within two days compared with in 2017.

A relatively low number of elderly individuals abstain from health care due to cost, but the number who abstain from dental health care due to cost has increased

In Sweden, few people aged over 65 years responded that they abstained from health care due to cost. However, the number who abstained from dental health care due to cost was relatively high and had increased since 2017. 11 per cent responded that they had abstained from dental health care due to cost. In Sweden, the fee paid by the patient is substantially higher for dental health care than for other kinds of health care. Research has shown correlations between dental health and other health. However, there are major knowledge gaps concerning the dental health of the elderly population.

Health care for individuals with a chronic illness has improved in several areas

There are relatively small differences between the countries in the study as regards occurrence and treatment of chronic illnesses. However, there has been a positive development in Sweden since 2017, with the elderly population responding that the treatment of chronic illnesses has improved in several areas. One area that has improved significantly is the number of individuals with a treatment plan for their disease that they can use every day. In 2017, 40 per cent responded that they had such a plan, and in 2021 that figure had increased to 70 per cent. Further, in this study, about half of the individuals with a chronic illness had discussed their care goals and priorities with health care personnel. In 2017, only a third reported having had such discussions.

The number of individuals with a chronic illness who responded that health care personnel kept in contact with them between appointments had increased by 5 percentage points between 2017 and 2021, to 22 per cent. However, the number of patients who responded that they could contact health care personnel with questions or receive advice about their health state had decreased by 4 percentage points since 2017, to about 73 per cent.

The data from this study cannot completely explain the reasons for the positive development in the care of individuals with chronic illness. However, the government and the Swedish regions have designated this an area of special focus. The national knowledge-based health care system has produced support material and guidelines on several chronic illnesses.

Patients report remaining shortcomings in the coordination of health care

Coordination of health care remains a problem in Sweden, with the country's figures being the lowest among all countries in the study, for all questions on coordination. Compared with in 2017, the results are worse for half of the questions. Sweden is one of the countries where fewest patients receive help from their regular health care contact who coordinates their care, which could be related to the fact that fewer patients repeatedly see a regular doctor or nurse compared with in the other countries in the study. However, the older Swedish population does not meet with a larger number of different doctors than patients in other countries. In Sweden, 56 per cent responded that they had received help from a regular health care contact who coordinated their care, a relatively low number compared with the other countries. Sweden is the country where the largest proportion of patients responded that health care sometimes lacked important information about them in connection to and after visits to a doctor in specialist health care, though the figure was lower than in 2017.

A high proportion of the respondents stated that they had received various kinds of health care and support when they were discharged from a hospital, but Sweden's figure was lower than the average in the international comparison. However, the number of individuals who had received written information about symptoms to monitor after discharge had increased by 6 percentage points since 2017, to 64 per cent.

The pandemic has affected health care for individuals older than 65 years

Although this study was not focused on the covid-19 pandemic, the results have likely been affected, since the health care system has been heavily burdened during this period. Sweden's elderly population responded that they had used digital video calls with a doctor somewhat more during the pandemic than before: 43 per cent had used digital video calls in 2017 and 45 per cent in 2021.

The covid-19 pandemic has affected those who receive help to manage daily activities in their homes. Among the respondents, 20 per cent reported that such help had been cancelled or limited during the pandemic. Thirteen per cent responded that they did not want other persons in their home due to the pandemic, and thus were unable to receive the help needed to manage their daily activities.

The proportion of elderly individuals who had experienced emotional distress during the preceding 12 months had increased since 2017, and the majority of those in need of a meeting with health care personnel due to mental illness had not received support or treatment from health care. While we have not been able to study whether there were any correlations between the covid-19 pandemic and the elderly population's mental health, other studies have shown that this is one of the groups most likely to experience anxiety due to the pandemic.

1.2. Analysis of the Swedish results

We performed regression analysis of the results of the IHP study as regards responses and background variables among the respondents. The purpose of the statistical analysis was to investigate any correlations between patients' experiences of the health care system and their demographic, socioeconomic, health, and contextual background factors. It is important to keep in mind that these are statistical correlations, not causal correlations. In other words: we could not determine if a background variable caused a certain experience of the health care system.

Patients´ experiences of the health care system correlate with respondents' background and health, and having a regular doctor or nurse

We have analysed correlations between the results and various background factors for most of the questions in the survey. A consistent trend is that individuals with a single health care contact had more positive experiences of the health care system, while individuals with self-assessed illness had more negative experiences. These results are consistent with those of the IHP 2020, which studied the general Swedish population. However, we see relatively small differences in relation to socioeconomic circumstances.

Individuals with a regular doctor or nurse generally have better experiences of the health care system

Overall, those with a regular doctor or nurse reported better experiences of the health care system than those returning to the same health care centre. For example, those seeing a regular doctor or nurse were more likely to respond:

- That they were involved in decisions concerning their own care.
- That health care personnel spent enough time with them.
- That health care personnel were familiar with important facts in their medical history.
- That they received help to coordinate or plan the care they receive from other doctors.
- That they received support for care related to chronic illnesses. Examples could include having discussions concerning their own care goals and priorities, being able to contact someone or have someone contact them between health care appointments, or having a treatment plan that could be used every day.

The possibility of having a regular doctor or nurse is not equally common throughout the elder population, and geographical differences appears to be unjustified

Having a regular doctor or nurse was not equally common throughout the population. It was more common among individuals older than 75 years and among individuals with one or more chronic illnesses. These results are likely to reflect increased needs in these groups compared with among individuals younger than 75 years or without chronic illnesses. However, the results show that repeatedly seeing a regular doctor or nurse was less common among individuals living in sparsely populated areas. This difference is likely not based on needs.

Individuals who describe their health as poorer or are limited in everyday life generally have negative experiences of the health care system, but individuals with chronic illnesses have more positive experiences in some areas

Individuals who described their health as poor, who had emotional issues such as anxiety or sadness, or who were limited in their daily activities, often had more negative experiences of the health care system than individuals in good health. The cause of these differences cannot be addressed based on the results of this study. Since our analysis cannot provide information about causal relationships, we cannot determine if individuals with poor health received worse health care or if individuals who were given poor health care for other reasons were in poor health as a consequence thereof. However, this is an important question which should be investigated further.

Individuals with one or more chronic illnesses have more positive experiences of the health care system in some areas than individuals with poor health for other reasons. For example, it was more common for individuals with a chronic illness to repeatedly see the same doctor or nurse. Further, individuals with chronic illnesses felt more involved in decisions concerning their own care and more often responded that health care personnel

spent enough time with them and were familiar with their medical history. This might reflect a difference in health care consumption between individuals with and without chronic illness.

There are relatively small differences between different demographic and socioeconomic groups

There was no clear pattern in the results of the IHP 2021 concerning negative experiences of the health care system in relation to different demographic or socioeconomic groups, when adjusted for different aspects of illnesses. However, we could see relationships between some background factors and some experiences of the health care system.

Females generally had more negative experiences than males in some health care areas. Fewer females than males responded that health care personnel spent enough time with them and that they had undergone a medication review when they left the hospital. Females with chronic illness also had more negative experiences of the health care system than males with chronic illness.

Individuals with a foreign background were more likely to abstain from dental health care due to cost, even when we adjusted for low income. They were less likely to be involved in decisions concerning their care than individuals with a Swedish background. Further, it was less common that individuals with a foreign background had a designated health care staff member they could contact between health care appointments in case of any questions regarding their chronic illness.

Individuals who had finished secondary school had more negative experiences from contacting the health care system than individuals who had only finished primary school. Further, individuals living in sparsely populated areas experienced accessing health care on evenings and weekends as more difficult than individuals living in urban areas.