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With reference to the priority setting hearing, 13 December 2004

We have chosen to submit a coordinated description of developments in Sweden. We consider that this, together with the two reports on our local experiences in Östergötland included with this document, will serve to answer your questions satisfactorily.

The Swedish debate over the requirement for open prioritisation from the national perspective originates from committee work undertaken during the first half of the nineteen nineties.

In January 1992 the government appointed a committee whose task it would be to weigh up the part played by, and the basic ethical principles applying to, medical health care in order to provide guidance and a foundation for open discussion over prioritisation.

The motive for conducting this survey comprised the following four factors:

- rapid medical-technology development,
- demographic development entailing an increasing number of older people and a dwindling labour force population,
- increasing demand for and expectations of medical health care and
- presiding economic conditions.

Special emphasis was placed on openness, i.e. the principles of prioritisation and the reasons behind these must be reported openly. The work of the committee resulted in a change to legislation.

Changes to the medical health care act

The objective of Swedish medical health care is to provide equally good health and care for the entire population.

Furthermore, as from 1st July 1997, those most in need of care shall take precedence. The Riksdagen directive to change medical health care objectives includes national guidelines designed to be followed when applying prioritisation to health care.

These national guidelines comprise a platform of ethics and four priority groups.

<u>Platform of ethics</u>

The platform of ethics comprises three ethical principles

- *The principle of human values*, states that all people are of equal value and have the same rights irrespective of personal properties and functions within society. This principle works to ensure respect for the values, rights and dignity of the private individual.

- *Need-solidarity principle,* entails resources being distributed according to needs. This means that resources are invested in those areas where the need is greatest and most useful to patients.
- *Cost efficiency principle,* states that medical health care, when choosing between different areas of operation or measures, should strive to effect a reasonable relationship between costs, in the shape of different kinds of resources invested, and their effect, measured in terms of improved health or better quality of life.

The need-solidarity principle has long been established within Swedish medical health care. Solidarity entails more than equal opportunities for care, it includes making efforts to ensure that the results of care are as similar as possible, i.e. that everyone shall attain the best possible health and quality of life. Moreover, solidarity entails special regard paid to the needs of the most vulnerable (those with reduced autonomy). These include children, those suffering from senile dementia, the comatose and others who for various reasons have difficulty in communicating with their surroundings. People unable to make use of their care rights have the same rights as those who are able to do so.

The implication of the need-solidarity principle is, that if prioritisation is necessary as an efficient measure, a greater proportion of care resources shall be allotted to the most needy, those with the most serious illnesses and the worst quality of life. This still applies even if consequences mean that other groups will not have their requirements fully met. When assessing the degree of need for a particular measure, we must weigh up the severity of the illness, the permanency of the condition and the consequences of the condition. How great the need is depends on the severity of the illness and, very probably, on how long it can be expected to remain in place.

The guidelines point out that it is against these ethical principles to allow the requirements of anyone to remain untended owing to the person's age, weight at birth, lifestyle or economic situation.

On the other hand, in some cases it is possible to take into account circumstances that limit the usefulness of the proposed medical measures.

Four prioritisation groups
A division into four groups has been made based on degree of urgency and ethical guidelines

I. Care of grave emergency level diseases.
Care of serious chronic diseases
Palliative care and care of those in the final stages of life
Care of those with reduced autonomy.

II Prevention
Rehabilitation

III Care of milder acute and chronic diseases.

IV Care for other reasons than those of disease and injury.

Need coverage shall be greater in the highest priority groups and lower in the lowest priority groups. The degree of need coverage depends on the resources available.

Developments since 1997

The medical health care act is decisive to the health care policies of the county councils and municipalities. The county councils, and to a certain extent the municipalities, are responsible for the application of prioritisation guidelines as laid down by the act. Both county councils and municipalities are responsible for almost all financing of these activities from funds generated by taxation.

In actual fact the government has done little to establish these guidelines by means of parliamentary resolution. Several years ago a prioritisation delegation was appointed to follow up and examine how priority work was being developed within the nation. This resulted in a well-written report.

Further, the government has assigned the Social Welfare Board to draw up national guidelines for care and treatment of persons suffering from serious chronic diseases. As from 2004 prioritisation guidelines have had official support. Priorities are to be based on the ethics principles the Riksdagen has decided are to apply for prioritisation work within medical health care.

The purpose is for guidelines to provide national support for the work of those responsible for providing health care in regard to such matters as prioritisation. The objective is to assist in ensuring that:

- medical health care resources are used efficiently,
- resources are distributed according needs based on open and distinct prioritisation decisions,
- in the event of ill health and disease that patient and kin needs are met in the best possible way.

The National Swedish Audit Bureau, tasked with examining government resources, has recently published an audit report in which it is described how the bureau has examined government action in resolving prioritisation guidelines so that these can be used by those responsible for providing health care. The report is fairly critical, and implies that the government has not done enough to establish tangible parliamentary guidelines for open prioritisation work in health care, and that consequently these guidelines cannot be put into practice.

<u>Development within the different county councils</u>

Despite a lack of clarity over government policy in regard to the tangible application of these guidelines, several county councils have got to grips with this matter on their own initiative. Östergötland being one in point. Background, implementation and experience gained from our work are contained in the two reports enclosed.

Sincerely

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