

The history of health care in Mittenälvborg then, now and afterwards

Part 2 – The time of primary health care

A global perspective

We begin the story with an economic and medical survey. During the hundred years until about 1970 Sweden had prolonged and sustained economic growth, that did not have many equals in the world. The first decades after the second World War meant a strong rise for international as well the Swedish economy. Then the crisis-stricken 1970s came and the favourable development was interrupted definitively in 1974. As a result of shocking oil price increases in 1973 and 1978, Swedish shipbuilding and shipping were hit. The oil crisis also hit other parts of the energy-hungry Swedish business community. Sweden calculated that the oil price rise would be short-lived and that the current policies would bridge the gap until next economic upturn. But was this shown to be an erroneous assumption. The Swedish business community was also hit by a home-made crisis, aggravated by the damaging effects of oil prices. When wages increased as did the employers' contribution, this greatly increased costs in Sweden in the middle of 1970s. In 1982 the budget deficit had grown to 12% of GNP. It became necessary to slow down the expansion of the public sector and to review a range of activities. But it would be too late before this won general acceptance.

The expansion of the public sector coincided with women's major entry into the labour market, as among other things an expansion of day nurseries and pre-schools were required. Thus in 1965 one married woman in three was gainfully employed, but at the start of 1980s two out of three married women worked outside the home. Most were employed in the health care and the social care sectors.

In Sweden the public sector's growth has developed through tax financing. With an accelerating public sector the wealth quota, i.e. the wealth's proportion of

GNP, also increased. On the turn of the century in 1900 the low wealth quota of 10% gradually increased to 20% by about 1950. Then, the wealth quota was increased at a faster rate until 1980, when it amounted to 50%. Since then, it has varied around this level.

During the past century the population had doubled and the average life-span had increased, as had the average height and weight. The general welfare policy contributed to this. Both through public and individual obligations the welfare initiatives have also meant subsidies for deprived society groups. The welfare created its own disease picture. Reduced physical activity and obesity in its wake resulted in an increase of heart and blood vessel diseases. The ageing population of the country became subject to more and different cancer diseases.

Most of the Swedish 19th century can be described as an economic and social success, though it concerned in smaller degree the century's last quarter. Public income could not cover the increased costs of the welfare State. Even high priorities such as child-care, medical service and old person's care and aid to unemployed were threatened. Health care was affected by the enforced reconstruction and savings policy. In the public debate, policies were set on rejecting State monopolies and instead increasing private elements within the social sector. Many of these requirements were the subject of parliamentary resolutions. The changed relations imply that Sweden before the turn of the 20th century was in a transition period.

Health and medical care

The reform activity until the middle of the 1980s was aimed at complementing, and developing the Swedish welfare reform in the form of different social insurances, expansion of care and investment on education.

During the 1960s, 1970s and 1980s many reforms came about that influenced the primary care, such as 'seven-kronor reform' and regulated hours of work with a total salary for the doctors, National Board of Health and Welfare's programmes followed the principle of expansion of open care with bigger and smaller health care centres. The 'Dagmar reform' of 1988 with special compensation to the county councils among other things financed development projects. The 'Ädel reform' in 1992 transferred the responsibility for the care of the elderly to the municipalities.

SPRI (the Swedish Institute for Health Services Development) – an institute for planning and rationalization of the health and social care – was formed in 1968 in order to assist the responsible authorities in the implementation of health care. Lerum's primary care development was very much influenced by collaboration with SPRI, that contributed with resources to many development projects in primary care in Lerum. One of the first SPRI reports discussed the organization of open care and primary health care and it became accepted by our county council and influenced primary care expansion in Älvsborg and in Lerum. New health care laws in 1982 and 1992 meant a transition from health care policy to health policy, which strongly reinforced the development of the primary care in Lerum. The latter meant also that primary care responsibilities for the care of the elderly passed towards the municipalities – the so called 'Ädel reform' (the noble reform). Much discussion then turned to the whole of primary care becoming the municipality's primary responsibility. This was rejected by the physicians and their organizations. The county council produced new health care plans in 1974 and 1980 and a health plan in 1977. All these consolidated the expansion of the primary care but the economic squeeze upset this. The hospitals' resources increased even more than those of primary care.

During the 1980s and 1990s a change of system occurred. Areas of responsibility were changed between health care and social care. A reform about family doctors that was decided in order to increase the continuity of care was questioned. An increased freedom of choice of care was implemented for people but also for the care staff's operations and work patterns. They wanted to make more effective use of resources. More private providers were involved. They began to apply market principles to the control of public care. New budgetary control of purchases was introduced and market forces allowed to operate in order to introduce some competition within the public sector.

The parliamentary auditors, however, questioned this development. In a report in 1991 they said that "The providers have, contrary to the state intentions, built up a care structure with a strong emphasis on expensive specialist care". Despite repeated political statements about the priority of primary care as the basis of health care, investment had continued in hospital based care.

The build up of primary health care in the 1970s

We describe here the 'idea of primary health care' (Primärvårdsbegreppet), coined of National Board of Health and Welfare in 1969, and the contents and objectives of primary care. The formulation and implementation of goals goes as a marker throughout the document, with terms such as Neighbourhood, access to care, overall vision, continuity, quality/security, collaboration. The health care centre, the basic unit of primary care, involved a shared location of activities, formerly scattered throughout health care, complemented by pharmacies or pharmacy affiliates.

We describe how district doctors' area responsibility continued in primary care's population responsibilities, and remained in this form in Lerum despite several attacks from politicians and others in an attempt to impose a Swedish model of family doctor ("Husläkarreformen") and the option for a patient to choose a doctor outside the district boundaries. The spheres of activity of general medicine are described with a society-oriented medical profile. The objectives are clarified.

The health care district of Lerum

The health care district of Lerum, later a primary care area, was formed in 1970 corresponding to Lerum's municipality with the population centres Gråbo, Floda and Lerum – all having their health care centres – Lerum already from the start in 'he House of Health' (Hälsohuset) in Lerum's centre, Floda in 1976 and Gråbo in 1978. The previous doctor's surgeries are also described.

'Brobacken' – Lerum's first health care centre in the primary care block in the southern public health service district

In 1970 it was started in Hälsohuset in Lerum, built for three doctors, district nurses and midwives, dental care staff and pharmacists. At the same time the county council's health care been divided into northern and southern districts, each with its board and district manager (in the south Arne Aldman, a physician). After some years, the activities were divided up into ten blocks with block managers – also physicians. Bengt Dahlin became the first block manager of primary care in the southern district. The block's early time is described. For primary care the problem of emergencies was solved by establishing central emergency centres. Mittenälvsborg had one in Alingsås, the town in the middle of

Mittenälvsborg near to the local hospital. All that is described.

Brobacken, a health care centre for development

Brobacken's health care centre, with Bengt Dahlin as first manager, started in February 1970 and functioned as a pilot and development unit in open care. We immediately accepted the primary care concept and its objectives. A majority of projects were implemented in order to improve the quality in the care. The first laboratory in primary care in Älvsborg was employed for functional quality assurance. The first urinary clinic (urindispensär) was established, so that urinary tract infections were handled in a logical programme.

Moreover, nurses were added, who dealt with hypertensive patients. The nursing home's economic manager added a dietitian, a function that only hospitals had till then. However the queues grew and the access to doctors was poor. SPRI then was engaged in order to solve the problems. The 'Lerum model' project was implemented. The first objective was investment to improve quality and access in the primary care. Their solutions were successful and the ideas spread throughout the country (at least 450 units accepted the system).

The Lerum model

This is described in its parts with solutions on access to acute care, This included continuity, quality of the first contact, how one would prioritize and interact with the hospitals ("KÅR", a programme/register about measures to take when a patient contacts the health centre), a booking system both for urgent cases (with degrees of urgency) and repeat visits with invitation procedures. One very relevant and popular form "R/P-blanketten" was designed. It followed the patient from the telephone contact, through the different activities in office hours, to the typed record. It was used also in the booking procedures. The management function at the health care centre was helped with care planning. As a bonus a health care information system was developed that later spread to many other sites in Sweden.

New health care centres – new challenges

The health care centre at Floda was the next new unit that started with new

and enthusiastic staff under the direction of Bengt-Ivar Nöjd, who moved there from Brobacken health centre. They took up the Lerum model's care planning system. Moreover, they started several special functions such as how to handle hypertension patients efficiently, diabetes consultations, keep-fit projects, trials to detect alcohol addicts and with an accompanying care programme (Bengt-Ivar Nöjd), smoking-cessation clinic and programmes for balanced diet and health activities. A production study was implemented from medical records. Many reports were produced. Hans Lundgren, as one of the most enthusiastic innovators, came to take an active interest in a new care project at county council level, and the diabetes complex in a health centre. It later resulted in the first disputation at the Institute of General Practice and Family Medicine at Gothenburg University.

The health care centre at Gråbo was inaugurated in 1978. It was one of the first in a new generation of health care centre buildings, with the different functions in their own wings of the building. Bengt Dahlin moved over from Brobacken to the new health care centre and became its first manager. This was a return to Gråbo where he began as a district doctor in 1962. Gråbo health care centre took up the Lerum model but developed further the information management system with focus on the primary care medical registration. A paper-based problem oriented medical record (POMR) was created and the records archive was modernized, in collaboration with SPRI (Gert Ljungkvist, Annika Hässler and Bengt Dahlin). Evaluation of the activity had begun to be discussed in the 1980s. As a part of the discussion, the registration elements for primary care had been published in a report, also in collaboration with SPRI. The medical record was later computerized (electronic medical record - EMR) so that the R/P-form and the Lerum model's whole care planning systems were included in a large experiment with computer-aided administration for an entire health care centre. This is described in all its functions. Among others, one module had direct transfer of prescriptions to the health care centre's pharmacy. The experiment was a county council project to find out the computer's potential in patient administration. It was initiated in 1984 and was completed in 1987 with many reports. The experiment, in close cooperation with Kronan health care centre in Sundbyberg, resulted in the first comprehensive, operational computer-aided care information system in primary care in Sweden – in fact in the whole of Swedish health care.

The chosen computer system, Swede*Star, could be used for evaluation of health activities using the base data reports which were integrated in the system.

However, it was not considered suitable for application to the extensive county council system in Älvsborg.

The health care centre's function after the computer introduction (1985) is described. Many procedures had been changed and the work of personnel influenced. Especially the doctors' secretaries had a key function in the computerized activity which increased their status as a consequence. This is also described.

New health care centre in Lerum in 1984.

The relocation from Brobackens health care centre into a new modern health care centre was longed-for. This included our own strategic two-floor building (once again a new generation of health care centre buildings), where all units had good functional rooms. The paediatricians, who had their own quarters at Pomona, agreed after some indecision to move in along with the others. They soon settled in and found that the close contacts with the others was positive. Much activity took place in the new health care centre, which is described in other sections. An innovation was the introduction of 'open surgery' – quick access for patients without previous telephone contact. The open office was closed down in 1997 and replaced by an emergency service and more access to nurses' telephone advice. The district nurse office in Hulan, situated there already before the new health care centre was opened, moved in to the centre. Gunnar Hedelin, head doctor at Brobacken and at the new health care centre, resigned as such in 2001 and then the manager's role was changed.

District doctors for children

Several paediatric posts were created at Mittenälvsborg during and after 1975. One was placed in Alingsås tied to the paediatric department in Borås' hospital. The others became children's district doctors in Lerum tied to primary care and facing the old surgery in Pomonaområdet. After some years the staff was doubled. Gradually the paediatricians in Alingsås also became attached to primary care as children's district doctors. Christer Forsell, the first paediatrician in Alingsås, has described his activities in Alingsås, Anita Harling/Glanz, a nurse, tells how it began in Lerum. Ragnar Bergström, paediatrician in Lerum tells about Lerum with 'a child office in the time (1995)'. Also the children's district doctors wrestled with the objectives of continuity and access. "Small patients are also patients" states Ragnar Bergström in an article in 1996.

The private doctors in Lerum are described by Beng-Ivar Nöjd.

District care and preventive care.

The development from 1979 to 2000 is described. Mother and child health care was developed strongly during this period. Barbro Svalin, district nurse in Lerum, told us in an interview about what happened in the district care in 1970 to 2000. Evy Johansson, midwife in Lerum during many years, tells about the considerable development of mothers' health care. The child health care basic programme is presented and how a children's dietetic activity was established in Lerum.

Youth surgery sessions became a new activity during the 1990s as part of primary care investment in Lerum. Anita Glanz was involved from the start, as described in an article in 'Vårdsidorna'.

The psychiatric service has also got a chapter.

Company health service. Internal service was situated in Alingsås. External was tested in an experiment at Vårgårda health centre.

Public health work became an ideal in primary care.

The health care law in 1983 takes up responsibilities for the health both at individual and the population at county council level. A health care initiative would become a part of health care at all levels. This was already established in the county council's health plan in 1977. Lerum began immediately to work on health projects, that are described in other sections (Brobacken, Floda health care centre, collaboration with the pharmacy, R & D). This section contains a description of different methods of prevention, such as self-care (with the pharmacist's participation) and health management and about the Centre for Health in southern Älvsborg.

We also describe public health work in Lerum.

Care of old people in development.

Solweig Kärrman and Barbro Hallengren gave a picture of early development from poor relief, via homes for old people and finally care in people's own home or community institutions. How we worked in Lerum with different models is described, such as the consequences of the so called Ädel reform, then the

municipality took over the entire geriatric care. Primary care responsibilities within long-term care during 1970s and 1980s with some projects is emphasized. The activity at the nursing home Tuvängen is described by Barbro Hallengren. Physiotherapy linked to geriatric care is described by Margareta Brantdahl, a head physiotherapist, and occupational therapy in Lerum by its head May Thyren. These activities were also very progressive.

Cooperation one of Lerums ideologies

Cooperation is a prestigious word in primary care at Lerum. In this section many cooperative projects and collaborative situations are described: Cooperation with the social services within the municipality was a project already running in the early 1970s, and later in POSOM, an intersectoral group for psychical and social therapy after disasters such as the tsunami catastrophe. Disaster planning, that functioned at a big railway disaster in Lerum in 1987 is described too. Almoners or social workers who helped in primary care are also discussed. Lerum had chosen to interact with the social services from the start. In order to rehabilitate the long-term sick, cooperation between many disciplines is needed. A model is described that was prepared in Lerum along with the rehabilitation clinic in Borås central hospital at the start of the 1980s. It builds on the fact that it can take months to get a long-term sick-listed patient back to work. If the staff do not interact quickly, the process becomes an endless discussion that ends in the patient's early retirement. An important factor that should have been noticed in the 2000s was the increase in early retirements. Cooperation with the hospitals is described with different models, indicating how cooperation in the care chain is necessary for effective care.

The pharmacies

The pharmacy and its information to the public and contacts with primary care have been given a separate section. In Lerum in 1980s a collaborative project was implemented. A brochure for self-care was produced which partially built on the experience from patient advice information and the register of contacts which were both part of the Lerum model. The pharmacy manager Gunnel Anderberg put a lot of effort into the project, as he did in the Gråbo trial with computerized medicine prescriptions. That is described here and in the section about information systems and computerized medical records.

Out-of-hours duties in primary care

This involved a series of projects with cooperation between primary care and hospitals. The history is described, from an emergency centre in Alingsås in 1970 with collaboration with the hospital until the hospital took over night duties and until the night watch finished as in most primary care. An investigation in 1988 revealed details of the activity. It gives also possible solutions to the complex of problems. One solution was decentralization, with Lerum's primary care area doing its own day and night duty. The Swedish Medical Association's guidelines for out-of-hours duties was reviewed. The recommendations of the investigation included evening office-hours duty to be done at the health care centres, with later opening of the emergency room. An evening open surgery was implemented at both Lerum and Floda's health care centres in the 1980s but had to be phased out gradually.

House doctors – various models had been tested

Two laws establishing a family doctor's organization are reviewed from 1978 and 1992. The Lerum group examined various models for implementation on the two occasions. The models built on the responsibility of the district's inhabitants – an area and a population concern. Against the latter law's provisions (non-socialist version), that involved listing the patients to the individual doctors (a doctor-centred model), the doctors in Lerum reacted with a letter to the politicians that is quoted. They experienced that the society model which Lerum had built up would create an avalanche and they would function as private doctors in a primary care system without teamwork, broad contacts in society, preventive work and development works, but with strong competition between the doctors to gain the patients' favour – in other words – against everything in the activities at Lerum as in this description of primary care. The story ended with a change of politicians and doing away with the law in 1994. Lerum could continue as earlier – to follow its path towards high patient-doctor continuity and good access to primary care, with good cooperation within the team and with the outside world in firmly established patterns.

Research and development – R & D.

Development works were a guiding principle for primary care at Lerum from the

start. Many change projects were implemented that involved development – breaking new ground. The cooperation with SPRI (the Swedish Institute for Planning and Rationalization of the Health and Social Sectors) gave the resources to many development works. Other resources came from the county council, in particular when Lerum got its own administration. "Dagmar" means were another financing source. So, the county council's first unit for development then started in Lerum in 1988. Special means were allocated both for services and for other resources. It meant an upward path and better organization of the development work. This was described in terms of what a development unit stands for and what was the position in the whole country in 1990. Cooperation with the Institute of General Practice/Family Medicine at the University of Gothenburg was intensified. The Älvsborgs county council's R & D policy and organization during 1990s is described. When the county council handed over to the western region, the R & D organization got a new shape, that is described by Henric Hultin, one of the workers in that field.

Education

This has been an important component of the quality development of general medicine and of the local care in Mittenälvsborg. Much of the focus has been on the doctors' education, as also in this description, but during the 1990s the initiatives increased for nurses and midwives too.

A fund for district doctors' postgraduate education, "Provinsiälläkarfonden" was created early on from the district doctors' allocated patient fees. It made possible the early investment in postgraduate education of the district doctors. In Mittenälvsborg it resulted in a local supplementary training. A model, still in use in Mittenälvsborg, was developed in a project with southern Älvsborg and Åtvidaberg involved – a member-ruled, problem-oriented education of district doctors. As the chief district doctor in Mittenälvsborg, Bengt Dahlin was the local project manager. The project is described and its positive consequences.

AT-doctors (a phase of doctors training and education) had arisen on the scene already in 1970. When general medicine became a distinct speciality, training was implemented for general practitioner specialists. Stage-formulated courses for tutors were implemented through NLV (the board for doctors' further education). A start of these was made in a special course in the little town of Hjo (Hjo-kursen) in 1980 with Lennart Råstam (later professor at Lund/Malmö University) and Bengt Dahlin as course leaders. The course is described and is similar to the consequential courses in the county councils. In order to be able to lead ideologically as a future

general doctor, specially formulated courses in general medicine were implemented. Starting in beginning in 1983 several of them were located in Lerum at Aspenäsgården. The course content and the results are described.

Contact with the universities through the institutes of general practice, and earlier with the first R&D centre at Dalby in Skåne had been good.

Perhaps as a consequence, Bengt Dahlin was appointed as working life representative in the board for undergraduate education at the medical faculty in Gothenburg in 1990. This enabled the oversight the basic education's organization and contents. This made it possible to get the health care centres and the district doctors included in the education concept.

The result was a new course – how to manage the consultation between doctor and patient (Konsultationskunskap) – that meant that the students during semester five visited primary care with district doctors as tutors during a week. The district doctors became teachers at the university (universitetslärare). The process is described.

In conclusion in this section, the district nurses' education is commented on as well.

Information systems

As the reader will have noticed, information systems with the Lerum model have been an important development sector in Lerum since 1975. It continued with the problem-oriented medical record. The health care centre in Gråbo became completely computerized in 1984, and during the 1990s the whole primary care in Mittenälvborg was computerized. This describes the development in more depth. Especially, the trial at Gråbo is described in detail. Several reports about the project will be found in the list of references.

The project manager summed up the Gråbo trial: "The operation was successful but the patient died". The computer system – Swede*Star – in Gråbo was phased out as the county council in Älvsborg decided to invest in a very much simpler system – ProfDoc. An IT tutor, Gunni Andersson (tutor about ProfDoc) described her experiences as like the changed work of doctors' secretaries during the 1990s. The Swedish Medical Association's political document of computer programs in 1980 and 1991 is reviewed. In conclusion, two reports about IT before the 2000s mention that more flexible systems and better compatibility are required.

Politicians and the official organization

Initially, the changes of direction that the organization is taking are demonstrated – from central management to total decentralization and once again to considerable centralization.

Much of the action takes place about the time when Lerum ran its own primary care area with its own politicians and administrative management. It was an important and positive time in Lerum's primary care history that showed the positive value of decentralization to an organization. The section reviews the county council's management policy in 1986 as a basis of the decentralization. Various operators have described the organization. About an action plan for delegating decisions down to health care centre level and some of them to heads of the different sectors. We review a project "Hjalmar", that describes the content and structure of the health care centre's management.

In 1993 a new centralized policy and official organization was prepared. Bengt Dahlin commented on it ("New Älvsborg") in a letter in May 1993, to be quoted. The result of the reorganization was to return to that when the block organization started in 1972. The whole of primary care in southern Älvsborg got a head manager in Borås – Kerstin von Sydow, area director was a good choice. She could continue much of the Lerum ethos throughout her area of primary care. The secretariat of Mittenälvsborg moved to Oscarsgatan in Alingsås for basic administration, where it still is today (2005). The circle was closed.

But the development continued in the county council's direction, until 2000 when the region of West Gotaland took charge of health care. However, none of the central turbulence seemed to be able to influence the basic units in the primary care, the health care centres, where the personnel worked on as before, but frustrated over all upheavals.

In 2007 the day came for the next reorganization that involved primary health and dental care being detached from politician's responsibilities. Dental care came under a regional board with registered office in Skövde. The primary care board covers southern Älvsborg located in Borås. More about this in part 3. Kerstin von Sydow described the organizational change:

Constant changes and development of our organization is taking place, but we shall never forget the duty to our patients' welfare. The head for

southern Älvsborg and the new dental care board have good conditions for a close dialogue with local activities. It also make for better conditions for a dialogue between primary care and the other sectors such as the hospitals in Borås and Alingsås.

Aspirations, personnel and production

In this section, we describe how resources have been allocated and used/prioritized in primary care over the years. A 'service stairway', designed in Lerum, became noticed throughout the country. It showed how many doctors are needed relative to the staff area's size and to the visits per inhabitant per year. Primary care could, accordingly, take health care responsibility with high continuity with one doctor per 2,600 inhabitants, required that you 'delivered' 1.5 visits per doctors per year to the inhabitants. This was never achieved: the number of visits at the end of the 1970s was 1.4 visits per inhabitant per year. Then the number of visits fell, and has kept just above one visit per inhabitant per year, in spite of the considerably increased number of doctors and a reduced number of inhabitants per doctor. Take a look on the tables that is presented – quite interesting.

The Swedish model

The expression 'the Swedish model' has no real definition. The name has sometimes been considered as a way to highlight Sweden's discrepancy from others countries concerning economy, policy, ideology and institutions. During the 1930s special areas of social and employment policy were stressed that distinguished the Swedish compromise between capitalism and socialism. Later came the good relationships between the labour market's parties, SAF and the Swedish Trade Union Confederation, symbolized by "Saltsjöbadsavtalet" in 1938 and the transition to central salary negotiations during the 1950s – to be highlighted. Also the Swedish welfare State with its labour market and equality policy and different transfers is a part of the picture.

Like the general Swedish model, the health care model was paid for by coordination and agreement between equal parties. The condition was therefore

that primary care – as ‘open care’ was called – and the ‘closed care’ of specialists and hospitals, could get on well as equal partners where both had something to give and to take. A fundamental problem was, however, that the partnership was not equal from the start. Ever since Axel Höjer’s days (1930s), the bulk the resources had gone to the hospitals' specialist care, while the primary care considered itself an orphan.

In an official report at the start of the 1990s the Swedish model was said not to be working. One quotation demonstrates the weakness of the Swedish health care system:

In the middle of the 1990s, Swedish health care was being rapidly restructured. During the last four decades it has undergone strong expansion and got a specific Swedish formulation – the Swedish model. This is now in the balance. It shakes the welfare State's to its foundations as a Minister for Finance, Kjell Olof Feldt said. "Health care stands before a new paradigm. A contraction of the public sector is going on".

Finally, the economic discussions are followed up, as a part of the description of primary care development up to the year 2000. The economic situation is closely related to the future development and the problems of primary health care.

In part 3 we describe a discussion of different possible solutions for the future open care.

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