Abstract

Day 3, International Day – Afternoon Session – National Strategies in Centralised and Federal State Systems

Mats Larson, Carelink, Schweden

A report from Sweden"

The Swedish healthcare system is decentralized. The 21 County Councils have the legal responsibility to provide healthcare-services to the inhabitants in each County. On the national level the responsibilities are mainly of policy- and supervisory-nature.

On the regional, County-level there are ICT-strategies in most Counties. Theses are developed, decided and managed independently – and show a great variety both in content, ambition and structure.

On the national level in Sweden however, there is no corresponding strategy-document. There are laws and instructions that govern issues such as integrity and transparency – but no specific strategy document to guide or align the development of ICT-support in healthcare.

A National ITC-strategy vs. National Infrastructure

In a decentralized system – who has the legitimacy to develop and maintain a common strategy involving the independent actors? Who has the mandate to make the decisions and supervise and control such a development?

During 2002 the benefits and potential challenges with a national strategy on ICT in healthcare were discussed amongst County mangers and with the Swedish government. The experiences from Denmark, the UK and other countries where national policy-documents were at hand were explored.

This process resulted in an attempt to try to develop a common understanding of the benefits and values of building a common ground for ICT in Swedish healthcare. Given the decentralised structure - it was suggested that such a development should be based on consensus amongst the parties involved – rather than having a strategy decision “imposed” on the sector. This common ground has been described as an “ICT Infrastructure for Swedish healthcare”.

By highlighting the infrastructure, focus is given to communication and conditions that are necessary to support communication and information exchange. It is not only a matter of networks but also security-models for safe and secure transmission of data. In the discussions the term has also been given an even broader interpretation – stretching into interoperability, the structure of the information (content) and common specifications of basic services.

Abstract

A “first step” in defining and developing the Infrastructure is now on its way. This process is coordinated by Carelink – see www.Carelink.se. The Swedish Health Net – Sjunet, forms an existing base for this development. Experiences from building this national network “bottom up” are providing guidance and inspiration when additional services are discussed.

There is an expectation that the infrastructure can be segmented into different tiers – reflecting the degree of alignment and ambition of its users. One way to define the structure could be to regard basic communication-services as a first level – and security and different databases for identification as a second. On these basic levels all healthcare providers would be expected to join and participate in both development and financing. In fact, several of these functions are already well on its way to being implemented. Higher up in the structure more complex services could be addressed and managed. On theses levels only those who see obvious advantages would adopt and participate.

The decisions to join and use the Infrastructure must be based on the added value that each party can seen in a common solution – rather than having it imposed by a central decisions. Over time one can also expect that more services and functions could be included.

The underlying expectation is that all actors would join this national process. Recently all County Council Directors declared an ambition to pursue this model – they have also pronounced that they, as a group, take on the responsibility to “manage” the initial phase.

Mats Larson
Director
Carelink – Sweden

Mats.Larson@Carelink.se

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