

Scandinavian rheumatology 1990

ABSTRACT—The author describes his Royal College-funded tour of Scandinavian rheumatology units in 1990. He compares the funding, organisation and staffing of these units with those of their British counterparts and concludes that more local control, accountability and funding might improve health services. Consideration of the greater use of short-stay and day hospital facilities and the often imaginative ways in which Scandinavian rheumatology units are integrated into their hospitals may lessen the insecurity that many British rheumatology units currently face. Most pressing is the need for general agreement about ways of achieving protection within the NHS for the interests of those with chronic disease.

Rheumatology in the UK faces an uncertain future [1]; in the USA inpatient rheumatology has fared extremely badly since the introduction of the diagnostic-related groupings (DRGs) which now govern reimbursement of hospital expenses [2]. How are European countries with health systems comparable to ours faring in the face of universally soaring costs? In May and June 1990 I was able, with the assistance of the Medicine Foundation and the Royal College of Physicians of London, to visit many of the major Scandinavian rheumatology units.

I visited the Hvidovre Hospital, Copenhagen, and continued to Malmö, Lund, Gothenburg and Uppsala in Sweden. I then travelled to Finland where I visited rheumatology units in Helsinki and Heinola and attended the 23rd Scandinavian Rheumatology Congress at Tampere. I did not visit Iceland, and in Norway, due to lack of time, I touched only at Kristiansand (which was also the only non-teaching hospital on my tour). However, despite the obvious differences between the four countries the similarities in the units were striking.

Organisation

Rheumatology in these countries is organised along lines instantly recognisable to any British rheumatologist. Patients, their diseases, and their social problems are almost identical to those with which we are familiar, so it is hardly surprising (yet nevertheless reassuring) that the practice of the specialty is so similar to ours. However, the fabric of the buildings and the level

of funding of the service are consistently better than in Britain. All is not rosy: everyone is resigned to cuts in services and, particularly in Denmark, there was widespread acceptance that health service provision would have to be trimmed. It is also obvious that these are real cuts, and the loss or redeployment of many medical posts is taken for granted. Nevertheless, basic differences in health service organisation between Britain and these countries may allow their changes to evolve more smoothly than ours.

The most important difference is that in Scandinavia health services are funded at county level from local taxation (with help from central government). Additionally, patients have to make a contribution (currently £6–8) to the cost of each outpatient visit and, in Finland, to each day of their hospital admission. Prescription charges are the norm. Local political accountability and the realisation that health services are not 'free' are thus deeply ingrained in public thinking. Nevertheless, apart from Finland, private practice as we recognise it is rudimentary except in the largest centres in Denmark and Sweden; in Sweden many consultants undertake a limited amount of private outpatient consulting, often subsidised by the State, but private inpatient treatment is unusual. Moves are afoot to curtail even the limited state subsidies. In Finland, however, consultants routinely treat their private patients in State hospital wards.

Another major difference from the United Kingdom is that the need to pay other counties for regional services such as renal dialysis and other tertiary referrals has led to the adoption of elaborate accounting procedures with a level of computer back-up that few British hospitals can currently match. All the hospitals I visited possessed sophisticated computing systems, often evolved with difficulty from earlier systems. At Hvidovre the hospital computer is used not only for hospital accounting but also for ordering investigations, drugs and meals. It is linked to the national social services computer (with appropriate data protection mechanisms) allowing accurate estimations of referral patterns. In all hospitals laboratory results are accessible from ward or outpatient department printers and are issued as flowsheets, allowing immediate comparison with previous results. This, together with a high level of laboratory automation using 'dry' chemistry and haematology, means that fewer people are involved in the rapid production and collection of results. I frequently encountered the complaint that erythrocyte sedimentation rate tests (much favoured in all departments I visited) took too long and retarded the smooth running of outpatient clinics, since the results of all other routine tests were available within half-an-hour while the patient waited!

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Medical manpower

In all centres there were far more doctors than in most British hospitals; in the outpatient clinic of one Swedish teaching hospital the rheumatologists allow an hour for a new patient consultation and 45 minutes for a follow-up visit. Continuity of care is prized and patients rarely, if ever, see a different doctor at each outpatient visit. However, teaching hospital doctors are expected to maintain high levels of research in return for carrying this relatively light patient load. Large parts of each working day are devoted to research, and some physicians take 'internal sabbaticals'. Research and publication are generally regarded with pride.

Group management

Rheumatology wards are very similar to those in the United Kingdom except that all patients are housed in one-, two- or four-bedded rooms, some with their own toilet. In some units there were, surprisingly, no consultant ward rounds recognisable to British doctors; instead a group management approach was used with twice-daily unit conferences at which all staff (including consultants) were present. Team members were expected to contribute to discussion of all clinical problems and to accept responsibility for them, with consultants visiting individual patients when necessary. Most units start each working day with a full departmental meeting at 8 am; this seems to have an extremely good effect on departmental morale and to influence considerably the style of the department, as well as enforcing punctuality!

This group management approach is greatly helped by outstanding record-keeping. Teams of typists working throughout the 24 hours keep all records (including those in the emergency admitting areas) immaculately up to date. As a result it is quite unusual to see a handwritten note in any patient's folder.

Departmental integration

The rheumatology departments are integrated in different ways into their respective hospitals. All hospitals I visited have their own rheumatology wards (in Sweden usually in a self-contained block on the hospital 'campus'); by British standards most have a generous number of beds. But this can be deceptive; in those rheumatology departments which are also on acute medical 'take' as many as half of the beds are occupied by long-term social admissions. The rheumatologists are prepared to pay this price for being part of the mainstream of internal medicine, and also feel that they benefit from the wider variety of cases they admit. In some units the 'internal medicine-rheumatology' ward is augmented by an 'orthopaedic-rheumatology' ward, and in one hospital the rheumatology and orthopaedic departments are about to be merged as a cost-cutting manoeuvre; this is viewed with consider-

able trepidation by the rheumatologists. In such combined units, firm guarantees have been given to avoid overrunning rheumatology beds by (for example) orthogeriatric patients.

Doctors' dress is generally casual, although older consultants tend to be more formally attired. Demarcations between different grades of doctor are also less obvious than in Britain; there appears to be no consultant 'elite' as we recognise it. Specialists with tenure in teaching hospitals invariably have a higher qualification which is usually granted after a public 'defence' of a thesis consisting of a bound collection of five or six published, refereed papers with an associated unifying commentary reflecting original research on a particular topic. Copies of these theses are often held and referred to in other universities' rheumatology departments as the definitive work in their field.

The team approach

Scandinavian rheumatology departments take justifiable pride in the team approach to patient care using doctors, nurses, therapists, and social workers. This is very similar to the approach aspired to in the United Kingdom, with the addition of some inventive use of outpatient resources which might have particular relevance in the many British departments faced with large-scale bed closures. A close liaison is maintained between hospital and community-based care teams. For example, in Denmark the district nurse will visit inpatients to make a detailed assessment of medical, social and functional needs well in advance of discharge, and will have responsibility for allocating available resources. Group education of outpatients with rheumatoid arthritis (often described by the English term 'training') is the norm, and involves family, friends, and the therapy team. The aim of these sessions is to reinforce previous teaching of joint preservation and a positive attitude toward the disease, given while the patient was an inpatient. Several departments have day hospitals for the investigation and treatment of patients who are not ill enough for inpatient admission but who require more attention than can be given at an ordinary outpatient visit. The system is also useful for avoiding social admissions where the patient has a dependent relative at home. It is likely that these day hospitals also help to predict and prevent the crises of dependency which are a frequent cause of bed blocking in rheumatology wards.

General practice

In Gothenburg I accompanied a consultant rheumatologist on a visit to a general practice health centre on a council housing estate. This consultant spends several half-day sessions every week on such visits, helping general practitioners to improve the management of patients with rheumatic disease. Unlike their British and Danish counterparts, general practitioners

in Sweden are not independent contractors; they work for and in health centres owned by local government. This leads to patchy provision of out-of-hours services and, rightly or not, is widely perceived by hospital staff as inhibiting among general practitioners a sense of involvement with both workplace and patients. An attempt is being made to redress the bias toward hospital medicine in Sweden; in the Gothenburg area alone, approximately 100 hospital-based medical posts have recently been transferred to the primary care sector.

Rheumatology training is currently undergoing reassessment at both undergraduate and postgraduate level. Possibly never as much a Cinderella part of the undergraduate curriculum as it has been in the United Kingdom, rheumatology teaching for medical students is now being stepped up. Additionally, in an attempt to standardise the quality of rheumatology specialists, and to bring training into line with that in other European countries, consideration is being given in Sweden to a specialist examination in rheumatology.

The doctor-patient relationship

Apart from generous funding and a uniformly high level of organisation, another possible explanation for the apparent smooth running of all departments I visited may rest in patients' attitudes to their doctors. Brahams [3] has recently commented that in Denmark 'doctors' attitudes remain generally paternalistic, and most patients are unquestioningly compliant'. While I saw nothing as obvious as this in any Scandinavian country, it is certainly true that nowhere in Scandinavia is medicine (or, indeed, society) in as much of a ferment as it is in the United Kingdom. The patients I encountered seemed uniformly satisfied with the treatment they received and, as far as I could tell, with the explanations they were given. There was never any sense of hurry, and their frequent questions about diet and alternative treatments were handled sympathetically. Nevertheless, it is generally accepted that the State will provide for health, and with this acceptance comes a certain passivity and willingness to be directed which is fast disappearing in Britain. The long-established and hitherto successful social welfare governments of Scandinavia are, however, starting to face significant rumblings of discontent about punitively high taxation and the cost of social services. It is difficult to say how this will develop, but it appears likely that private medicine along British lines will become more widespread as the State becomes increasingly unable to provide for all expectations.

The future

I received an insight into a likely future role for Scandinavian rheumatology at the 23rd Scandinavian Rheumatology Congress at Tampere, Finland's second

city. Virtually all sessions at this excellent meeting were in English, which led to the attendance of a sprinkling of British delegates, and large numbers of rheumatologists from Eastern Europe enjoying what for most was their first international congress since they were allowed to travel freely. Discussion still continues within the Danish, Swedish and Norwegian rheumatology societies about whether English or Swedish should be used at these biennial congresses, but many, particularly the Finns, prefer the use of the international language of science to a Scandinavian language. Additionally, all Scandinavians recognise that English provides a vehicle for spreading their influence and expertise to the former Eastern bloc, strengthening their proven role as a diplomatic, and now a rheumatological, bridge between East and West.

How has this visit coloured my views about the future of my own unit and of the NHS reforms as far as rheumatology is concerned? I believe that, despite the uncertainty surrounding the future of rheumatology as a core specialty in the new-model NHS, British rheumatology is in a healthy state of innovation and debate and that we are well served by the British Society for Rheumatology in helping to plan for the future. My own department, as many others, has recently suffered severe bed cuts; use of five-day wards and day hospitals, as in Scandinavia, may allow greater use of remaining beds, but some form of generally agreed protection for the interests of those with chronic illness is required if any rheumatology units in the United Kingdom are to retain their ability to provide comprehensive care for inpatients and outpatients. I was impressed by what can be achieved by the use of high technology information systems in hospitals, but it is clear that these systems take years to develop and that accounting (and accountability) cannot proceed without them. I do not believe that the hospital services of the NHS can be modernised without fundamental reform of the 42-year-old NHS system, but I doubt that internal competition is the whole answer. I was impressed by the apparent strength of local organisation of health services in Scandinavia; I feel that similar local funding and accountability of services would produce a rapid return on investment and effort. Most effective, however, would be a reasoned, bipartisan approach to the identification and solution of problems facing the Health Service, unclouded by the political hyperbole and insults that characterise our current debates.

Acknowledgements

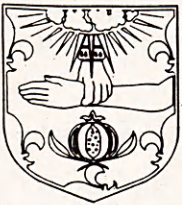
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References

- 1 Haslock I. Working for patients? *Br J Rheumatol* 1989;28:185-6.
- 2 Liang MH. Cost containment in health care and quality assurance: some American experiences. In *Measuring performance in clinical rheumatology*. Conference Proceedings Number 7 (eds DL Scott and K Bailey) pp 95-101. London: Arthritis and Rheumatism Council, 1989.
- 3 Brahams D. Round the world. Denmark: compensation for iatrogenic injury. *Lancet* 1990;i:1518.

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