RIKSREVISIONEN
The Swedish National Audit Office

RiR 2009:10 Summary

Psychiatric services and the effectiveness of central-government support

Summary

Caring for people with mental illnesses is a public undertaking. Responsibility is shared among several actors, above all county councils (regions) and municipalities, although the central government has the overall regulatory responsibility.

Mental illness often first develops at a young age. Untreated mental illness and poor mental health will lead to a poorer quality of life and a lower capacity for work, both for those directly affected and for those who are close to them. Further, mental illness is one of the leading causes of absence from work due to illness and of early retirement (sickness pension), thus giving rise to high costs both for the central-government budget and for the national economy.

The audit presented here by *Riksrevisionen* (the Swedish National Audit Office, SNAO) deals with two types of central-government measures in the field of psychiatric services: the temporary financial subsidies given to county councils in this field during the 2001–2007 period, and medical training with specialisation in psychiatry. Our main question is whether these measures have been effective and efficient against the background of the central government's duties in the field.

Central-government subsidies to psychiatric services in 2001–2007

The central-government subsidies covered by the audit are those linked to the following:

I – The national healthcare action plan, 2001–2004;

II – Further agreements, 2005–2007;

III – Special projects in the fields of psychiatric and social services, 2005–2006;

IV – Subsidies for child and adolescent psychiatry, 2007.

The SNAO's audit of these subsidies consists of analyses based on earlier follow-ups. The issues we have examined relate to the form and content of the subsidies, their traceability and effects, and their follow-ups and the use to which they have been put. The analysis yielded discouraging results, especially as regards the traceability and effects of the subsidies.

The effects of the subsidies were difficult to trace

The audit shows that subsidy types I and II did not function as policy instruments. The county councils were not bound by the agreements entered into between the Government and the Federation of County Councils, and the money was paid out as part of the general central-government subsidy. The follow-ups carried out by the National Board of Health and Welfare could not paint a clear, overall picture of the effects of the central-government subsidies because of a lack of uniformity in county councils' reporting. In fact, the Government had not requested uniform reporting.

The project-related subsidies for psychiatric and social services (type III) also turned out to have had uncertain effects. Some of the 'county projects' had already

been planned by county councils and municipalities, and would probably have been carried out even without the central-government subsidies. Other project were more improvised in nature and less well linked to regular operations. The projects that had strong links with regular operations were not as dependent on additional central-government subsidies. It is difficult to tell how the *overall* operations of psychiatric and social services were affected by the projects funded by the central government.

The effects of the 2007 subsidies for child and adolescent psychiatry (type IV) are difficult to distinguish for other reasons – follow-up was performed at a very early stage and there was a lack of suitable follow-up methods.

The subsidies did not entail any major resource increases

None of the subsidies examined added particularly large resources to psychiatric services; the amounts corresponded to 2–4 per cent of county councils' own net costs of specialised psychiatric care during the years in question. The county councils' own efforts in the fields of primary care and specialised psychiatric services increased by about as much, in proportion, as their efforts in other healthcare fields. In other words, the allocation of resources decided by county councils themselves was not clearly affected, positively or negatively, either by the shortages of resources identified by a governmental commission of inquiry, or by the central-government priorities as manifested in the special subsidies to psychiatric services.

The subsidies may have made it unclear what were the responsibilities of the central government

While the central-government subsidies have indeed attracted attention, it has not been possible to trace any major effects. Even so, the Government presented the subsidies as if they were extensive and important. There is a risk that this may have restricted county councils' own efforts in exactly the field that the central-government policies were intended to reinforce.

The SNAO's overall conclusion is that the provision of additional central-government funds in such a way as in the cases examined can be of only marginal importance to the resources of psychiatric services. The decisive factor in this respect is the allocation of resources decided by county councils themselves. The achievement of more significant effects will require other types of central-government measures that support psychiatric services without diluting county councils' responsibility for them.

Staff and skills requirements of psychiatric services

Both the National Board of Health and Welfare, the commission of inquiry into the national coordination of psychiatric services and a number of stakeholders commenting on the commission's report have pointed out that psychiatric services suffer from staff shortages and recruitment problems.

There is a great deal of flexibility in how staff are used in psychiatric services, with certain categories of staff being able to substitute for each other to some extent. However, physicians have a key role because of their long training and their special competence. Staff shortages in psychiatric services have long been the most severe

as regards specialist physicians (psychiatrists), particularly in regions outside the Stockholm area. The SNAO considers that the Government should take measures to increase the supply of physicians with specialist qualifications in psychiatry.

The training-related part of the SNAO's audit focuses on the training of physicians, but that must not be construed to mean that the other categories of staff are less important. In the SNAO's opinion, the staff and training problems of psychiatric services should be the subject of a more thorough analysis than has been possible in the present audit.

Psychiatry in medical training

Psychiatry is given limited space in medical training. Basic training for physicians and surgeons (which lasts 5.5 years) includes ordinarily little more than four weeks of psychiatry studies, and the subsequent general internship needed to qualify as a registered physician (which lasts 18–21 months) must include at least three months' service at a psychiatric ward. This volume of training comes across as very small considering the disease patterns of the general population.

If all trainee physicians were given increased knowledge of psychiatry, they would be better equipped to handle the mentally ill patients that they will encounter in the course of their work. The SNAO finds that there are several opportunities available for the central government to increase the attractiveness of psychiatry to future physicians and to improve the skills of those who have completed specialist training in psychiatry. The SNAO considers that those opportunities should be made use of.

Organisation of medical training and number of students

The audit shows that the central government's influence over medical training is unclear, that there are shortcomings as regards the number of students admitted and that county councils play a contradictory role in medical training.

Divided responsibility

Responsibility for medical training is divided among several parties. At the first stage, basic training, universities bear principal responsibility while county councils exert some influence given that the clinical elements of the training take place at hospitals run by them. The next two stages (internship and specialist training) mainly consist of services funded by county councils and governed by objectives set by the central government. Certificates of registration as a physician (after completion of the internship) and as a specialist (after completion of specialist training) are issued by the National Board of Health and Welfare.

Many factors determine the number of student places on medical programmes

A large number of factors determine the number of students admitted to basic medical training, including central-government appropriations. There are several other factors of importance, not least the local supply of supervision resources for the clinical component of basic medical training in the county councils that run university hospitals. The long-term planning documents drawn up by the National

Agency for Higher Education and the National Board of Health and Welfare, however, are less important when it comes to the number of student places.

The number of physicians trained in Sweden has long been too small. The proportion of physicians trained abroad has increased strongly, from 25 to 65 per cent of newly registered physicians during the 1997–2007 period. The increase in the number of places on medical programmes decided by the Government in recent years has been strongly delayed compared with the planning documents previously presented by the National Agency for Higher Education. The National Board of Health and Welfare has also found there to be shortages of physicians, especially of specialists in psychiatry and family medicine. To the extent that there is a general shortage of physicians in Sweden, it will be particularly marked in those two medical specialities.

No long-term planning for individual medical specialities

The number of physicians training as specialists in various fields depends on the number of positions as specialist trainees established by county councils. However, the number of such positions in the various specialist fields is not always governed by long-term priorities of healthcare policy.

The audit also indicates that county councils' duty to provide supervisors for future registered physicians and specialists is unclear.

Each county council has overall responsibility for the supply of medical specialists to healthcare services throughout its geographical area – i.e. not only as regards the healthcare services actually run by the county council but also as regards privately run healthcare.

There is also a conflict between the long-term and short-term interests of the individual county council when it comes to training. Training is an investment which consumes supervision resources during the period of training and only later yields a return in the form of trained staff. Some county councils (though not all) can reduce their training costs by recruiting fully qualified staff from other county councils or from abroad. This will also reduce their interest in long-term training planning. Instead, regions with net emigration will be burdened with increased training costs and/or a more severe shortage of physicians. To balance this, there would be a need for stronger planning responsibilities at the national level. The present type of 'national planning support' developed by the National Board of Health and Welfare will not solve the problems.

The SNAO's recommendations

- The SNAO is of the opinion that the Government should consider reallocating the support it provides for the development of healthcare services for the mentally ill. Temporary increases in resources should be replaced by long-term measures within the remit of the central government that support psychiatric services without diluting the responsibility of county councils. Such measures, including the expansion of training and research in the field of psychiatry, can be expected to be more effective and efficient than temporary contributions of resources to county councils;

- The SNAO is of the opinion that the Government should consider strengthening medical training in psychiatry. Above all, the SNAO wishes to emphasise the importance of ensuring a larger psychiatry component in basic medical training. Expansion of research activities could also make psychiatry a more attractive field to future physicians. The SNAO recommends that the Government should see to it that measures are taken in this area;

- The SNAO considers that the organisation and funding of basic medical training should be reviewed to ensure greater transparency as regards responsibilities, student numbers, direction and monitoring. The duties of county councils in relation to specialist medical training should be clarified, as should the role of the National Board of Health and Welfare in relation to 'national planning support'. The SNAO recommends that the Government should see to it that a review is performed of these issues.