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THE COMMUNITY HOSPITAL MODEL IN NORTHERN SWEDEN

Mante Hedman

Akademisk avhandling

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Fakultetsopponent: Associate Professor Torsten Risør,

Institut for Folkesundhedsvidenskab, Københavns Universitet, Øster Farimagsgade 5 Og. Q1353 København K

Department of Public Health and Clinical Medicine

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Author
Mante Hedman

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Abstract
Rural community hospitals (CHs) are vital in delivering healthcare services in sparsely populated regions such as northern Sweden. In Sweden these facilities act as primary care units, staffed by general practitioners (GPs), nurses, and other healthcare professionals. They provide hospital beds, emergency care, and basic diagnostics. The CH model, with GPs responsible for hospital care has not been studied earlier in Sweden. This thesis aimed to examine the role and practices of the Swedish rural CH model within the healthcare system and the local community. Furthermore, to investigate the perspectives of rural doctors in Sweden and New Zealand (NZ) working within their respective hospital models.

Four original papers form the basis of this thesis. In study one, hospital register data from Region Norrbotten and Region Västerbotten were analysed, focusing on hospital admissions of patients enrolled at CHs 2010-2014. We compared CH admissions with general hospital admissions, examining factors such as age, sex, and diagnoses. CH patients were older than those in general hospitals (median age 80 vs. 68 years), and women had a higher likelihood of admission to CHs compared to men. Common diagnoses in the elderly, such as heart failure and pneumonia were more likely admitted to CHs than to general hospitals. Study two utilized hospital register data from Region Västerbotten to describe registered care measures carried out in rural CHs during episodes of hospital care for patients with heart failure 2015-2019, in comparison with a general hospital. CHs showed documentations by fewer individual doctors, more frequent nursing documentation, and fewer blood tests compared to general hospitals. Radiology, including echocardiography, was performed in general hospitals only but in a minority of cases. Documentation by physiotherapists, occupational therapists, and dietitians was limited in both hospital models.

Studies three and four involved interviews with rural hospital (RH) doctors in New Zealand (NZ), and rural GPs in northern Sweden, respectively, to explore the role of their RH/CH. In both countries, doctors emphasised advantages with proximity and holistic, patient-centred care for elderly, multimorbid, and end-of-life patients. Their RHs/CHs were described to play a central role in rural patients' healthcare journeys, utilizing small, multidisciplinary teams and collaborating with general hospitals and municipal caregivers. Reported challenges for doctors in RHs and CHs included limited resources and inexperience in handling life-threatening, rare cases, and ethical dilemmas unique to rural practice. Despite this, RH doctors considered RH patient safety similar or better than that in general hospitals. CH doctors prompted the idea of expanding the CH model to urban areas.

We conclude that CHs admit elderly and multimorbid patients elsewhere common in general hospitals. Care for patients with heart failure at CHs showed more nursing notes, greater doctor continuity, and less biomedical examinations. Our results suggest potential for further development in the multidisciplinary care in both hospital models. Rural generalist doctors in Sweden and NZ emphasise the central role of CHs/RHs, their proximity to patients, and their holistic, generalist approach, and they suggest advantages in the RH/CH care for the elderly compared to general hospitals. In Sweden, the importance of relational continuity was stressed, as rural GPs are familiar with their CH patients from primary care.

Keywords
Rural health service; health services research; hospital; rural; inpatient; health services for the aged; geriatrics; generalist medicine

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