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Nursing Abroad: A Comparison of Healthcare in Italy, Sweden, and the US

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Abstract

No healthcare system is perfect, nor does one system work for all populations. History and culture have dictated the mindset of people for generations. It is the ever-changing mindset of patients and providers that will continue to expand and improve international healthcare by first changing daily practices. Nursing in Italy, Sweden, and the United States look very similar but also have a number of differences. Each country's healthcare system works for its population, but efforts for international collaboration could still prove beneficial. Whether it be universal or private, centralized or localized, a patient centered focus is the driving force behind quality healthcare outcomes. Similarities and differences in structure, monetary allotment, licensure, education, and care throughout the lifespan combine to show the strengths of each system. Learning from each other can result in insights that lead to better support of patients as they seek to identify the best course of action for their health.

Relevance

During the fall semester of 2021, I had the privilege of studying abroad in Rome, Italy through the Nursing Across the Lifespan program at the University of Arkansas Rome Center. During this time, I was able to learn about not only nursing in Italy but also the structure of their healthcare system and how the country's culture influences health decisions and practices. I was best able to see this while completing clinical course work at Gemelli University Hospital, where I interacted with Italian nursing students as well as native health care providers. Gemelli University Hospital is the number one ranked hospital in Italy and the 37th best ranked hospital in the world. This hospital is an international leader in research and innovation (Gemelli, 2022). It was during this first study abroad experience that I developed a significant interest in global health care and how it differs between countries.

To further explore this concept, I participated in a second study abroad experience during the summer of 2022 in Sweden. The Health Teams Abroad interdisciplinary program allowed me the opportunity to explore Sweden's healthcare system, including nursing and other related professions. Combined, these experiences abroad have laid the foundation for exploration into international healthcare. These experiences will remain with me, informing my future nursing practice and serving as a reminder to always be an advocate for meaningful exchange of ideas.

Overview

Healthcare systems in Italy, Sweden, and the United States (US) are each unique. In Italy, every citizen is entitled to care automatically through the country's universal healthcare coverage (Odone & Azzopardi-Muscat, 2019). With all services being provided by tax revenues, the cost for the patient is limited to small copayments for only a few specialty visits or if they desire to seek private healthcare (Odone & Azzopardi-Muscat, 2019). Care in Italy is decentralized, meaning each region is autonomous in its delivery of care, however funds and national policies are managed by the central government (Odone & Azzopardi-Muscat, 2019).

Sweden, similarly to Italy, also has universal healthcare coverage which is funded by taxes and regulated by national policies, however, the funding for each region mainly comes from the taxes within that region (Burström et al., 2017). A rising percentage of Swedish citizens are enrolling in supplemental private health insurance (Burström et al., 2017). The Swedes are feeling the need for dual insurance because it allows them shorter wait times and more personal reimbursement. If a person needed to make an appointment in Sweden, they would first be screened to ensure you are matched with the correct professional. For example, if a person has knee pain, they may need to see a physical therapist, not a medical doctor (MD). Dependent on

the number of physical therapists available, the wait time could be significant, however with private insurance, the population of available physical therapists will increase.

In the US, on the other hand, 8.5 percent of the population has no insurance of any type (Dieleman et al., 2020). Of the 91.5 percent of the population that does have healthcare coverage, 34 percent have some form of public coverage such as Medicare, Medicaid, or military insurance, while 67 percent have private insurance (Dieleman et al., 2020). While this may sound like a high percentage of the population that has healthcare expenses covered, out of pocket costs in 2021 topped $491.6 billion, or about $1,650 per person, in the US (Muoio, 2022). On average, American's also pay a monthly insurance premium of $928, that is over $11,000 a year. Most of these plans do not cover but about 75% of costs and have high copays (Masterson, 2022).

Considering the culture behind the numbers and policies, each country is once again unique. Italy is a country rooted in family. This is seen in a lack of elder facilities and extended expenses on comfort care with terminal illness. In general, Italians are keener to spend the time they have left in the home with family (Ferre et al., 2014). This is in stark contrast with the Swedes, a very individualistic population who believe family is the one you create yourself and caring for a loved ones should not be at the expense of your own identity (Burström et al., 2017). Geographically Sweden is closer to the northern pole, therefore parts of the country experience 24 hours of darkness during winter. During the times of no sunlight people suffer from vitamin D deficiencies which correlates to higher rates depression and alcohol abuse. In the US due to the sheer size of the population, the "norm" differs greatly depending on which state or even region of the state being considered. The population in the US known as the "melting pot" for a reason, only 59.3% of the US population identifies as white alone, not Hispanic or Latino (2021). The

diverse population reflects the multi-cultural impact on various methods of coverage, perspectives on care, and willingness to seek help.

Structure

Italian healthcare is available to all because of universal healthcare which is provided by the Servizio Sanitario Nazionale (the National Health Service in Italian). The delivery of care is decided and enforced by each region. The Ministry of Health is the main overruling body that dictates structure regulations and the logistics of care while the Agency of Regional Health Services keeps each region in check and works alongside the Ministry of Health (Ferre et al., 2014). The division of power and regulation throughout various organizations allows for continual proposals and conversations of ways to better healthcare.

In Sweden, all levels of the government are involved in healthcare. They too have a Ministry of Health and Social Affairs which is responsible for healthcare policy. This branch works with many different national agencies composed of both elected officials and health care professionals (Moore et al., 2016). This combination of expertise gives multiple perspectives to provide the most fluid delivery possible. Once again, each region is responsible for the delivery of care and the decision of how to spend their funds.

The US has national governing bodies as well, such as the Food and Drug Administration (FDA), Center for Disease Control (CDC), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (Royner, 2019). However, a large portion of policy is decided by state governments and state boards, including a nurse's scope of practice.

Monetary

Universal healthcare comes at a cost to each and every individual taxpayer. This can take a large portion out of a person's salary, but it also always guarantees care without bankruptcy. In

Italy and Sweden, high income taxes cover medical expenses. However, in the US, public insurance covers only a small portion of the population. Qualifying for coverage is very difficult, and even those who qualify do not often get complete financial coverage. Private insurance is an option in both the US and Sweden, however in the US, it can be very costly and still only pay around 75% of medical costs, and this is only after a deductible of several thousand dollars is met (Masterson, 2022). US insurance companies also often cap the number of therapy visits, refuse to pay for certain treatments, and have a maximum amount of coverage.

A procedure in Sweden or Italy that is completely free to the patient could bankrupt someone in the US. For comparison the percent of taxes that people in Italy and Sweden pay are comparable to the percent people in the US pay, the difference is how the funds are federally allocated. The US is a world power and uses more tax dollars on its defense system than any other category, while Italy and Sweden spend their tax dollars on their people via health care and infrastructure (Wager et al., 2022). It is also important to note most hospitals in Italy and all public hospitals in Sweden are not for profit while many hospitals in the US and private hospitals in Sweden are for profit organizations. This is yet another example of the difference in allocation of resources.

Pay for nurses covers a wide range between the three countries. . In Italy an average yearly salary for a registered nurse is around 30,000 USD. In Sweden it is around 45,000 USD, and in the US average yearly salary for a registered nurse is 75,000 USD (PayScale, 2022).

Licensure Requirements

In order to work as a nurse in any of the countries, one is required to have a license or the equivalent. In Italy, nursing schools are run by the hospitals. Each hospital trains its nurses and dictates if they have reached competency by a final exam (Pagnucci et al., 2021). If a nurse

decides they wish to work for a different hospital, they will have to pass the exam of the new hospital even if they have been working for years. The curriculum on the exam is determined by the respective instructors at the hospital.

In Sweden, each university is responsible to granting full nursing privileges to each student once they have completed their studies via an end of the program exam (Moore et al., 2016). This provides the new nurse with a license that is valid all over the country, that never expires. For both Italy and Sweden, a decentralized license allows each program to assess the strengths and weaknesses of the students of a given cohort and adjust where needed.

In contrast, the US uses a centralized license which unifies a nurse's scope immediately out of school. Similar to Sweden, students in the US complete the training for their license in an independent university setting. However, when their education is complete, US students must pass a national licensure exam called the National Council Licensure Examination for Registered Nurses (NCLEX-RN or NCLEX) (Wasserman et al., 2019). In 39 states or territories there is a National Licensure Compact (NLC) that allows nurses to practice in any other NLC area (Wasserman et al., 2019). This license also allows nurses to practice in any other state or territory with the appropriate endorsement. As long as the nurse keeps actively practicing, they will not need to test again.

Education and Funding of Education

In Italy, both primary and higher education, including nursing school, are free of charge to individual and paid from tax revenue (Pagnucci et al., 2021). Students in Italy go through a three-year program consisting of lectures and shifts in the hospital. The title of student nurse is an official position within the hierarchy of the hospital. The students are paid for the shifts they work. Students could, for example, have lectures on Monday, Tuesday, and Wednesday, then

work in the hospital Thursday night and Friday night. It is most common for a shift the be eight hours (Pagnucci et al., 2019). If a nurse wants to further their education, they can go back to school and obtain further degrees which expands their scope of practice.

In Sweden, nursing school is also three years and is completely free to the individual as it is covered via country wide taxes (Burström et al., 2017). Students can take out loans for personal expenses that will be paid back after their education: they can spend this money on rent, food, or anything of their choosing. For the three-year program loan totals on average amount to around 24,000 US dollars (USD) (Burström et al., 2017). In contrast to Italy, Swedish nursing students focus more heavily on lectures and the reasoning behind processes and assessments, while focusing less on clinical experience. When Swedish students do have clinicals, working hours rarely exceed six hours at a time. Also, if a nurse wishes to expand their scope of practice, they can complete a certification of sorts in which they learn a new skill and are declared competent by the hospital at which they work. This competency allows them to perform the skill in various settings.

Nursing school in the US is longer than the other two countries. Nursing school in the US is offered in different options: the Bachelor of Science in Nursing (BSN) and the associates degree in Nursing (ADN). For training as an ADN nurse, students complete approximately 2 years of training, both didactic and clinical, but with a heavy focus on clinical experience. Both BSN trained nurses and ADN trained nurses are eligible to be licensed as a Registered Nurse (RN) by taking and passing the NCLEX. Training in Italy and Sweden is more equivalent to the BSN degree in the US so the BSN will remain the focus for the rest of this paragraph. In order to obtain a BSN, students must complete two years of general studies at the university level and then two years of nursing school, totaling four years, or approximately 120 credit hours, for the

degree (Wasserman et al., 2019). Throughout the nursing program, students will complete about half of their education in didactic courses and half in clinical experience. Clinical hours for a nursing student in the US are between 8 and 12 hours at a time, usually two or sometimes three days a week. Nursing school can be funded by scholarships based on merit or loans for financial need or privately by the student and/or their family (Wasserman et al., 2019). The average cost of a BSN in the US is around 100,000 USD and this does not include students living expenses (Wasserman et al., 2019). If a nurse wishes to expand their knowledge in the US, they can go back to school such as in Italy to obtain more degrees or they can get certifications in specialties similar to in Sweden.

Care Throughout the Life

From birth to death a person receives medical care in all three countries. In Italy, many people will be seen at the same hospital throughout their entire life. Healthcare is very centralized in that one campus will house all the services most people will need (Odone & Azzopardi-Muscat, 2019). There are few specialty clinics and even fewer elder facilities. Even with terminal diagnoses, it is highly common for Italians to refuse treatment and be placed on palliative care in the home setting. A strong sense of family is deeply rooted in Italian culture which is evident in the way most Italians plan end of life care. In general, Italians value quality of life more than quantity of life and would prefer to spend valuable time with those they love at home.

In Sweden, care is also centralized but in a different way. Each specialty is more likely to come see the patient than having to schedule separate appointments. In fact in order to make an appointment you must call and describe your symptoms. For example, if someone was having knee pain, they may go see a physical or occupational therapist and never see a physician

(Westerlund et al., 2020). Elder care is more common in Sweden but is vastly different from the US. Patients stay in the home until it is absolutely not possible for them to be safe anymore and then they become eligible for a facility. Of course, at any point they can deny this service, but in a facility, they are allowed to come and go as they please and maintain as much dignity as possible while being safe (Ridelberg et al., 2016).

In the US, healthcare is primarily decentralized. Each specialist can have a different building in a different part of town and the responsibility to make sure the patient sees all the appropriate specialists mostly falls on the patient themselves. Interdisciplinary collaboration is very difficult because of the geographic and corporate separation of specialties. Elder care in the US is very common and can differ greatly depending upon the facility. Some facilities are funded by the federal government and have very specific qualification criteria while others are private pay (Dieleman et al., 2020). In most cases when a patient goes into an elder care facility, they do not come out of it. Also, all of their assets such as their house or their car can be taken as payment by the facility.

Each country's cultural beliefs, practices, and priorities throughout the life are reflected in its nursing care model. Italy uses a primary nursing model in which each nurse cares for a given patient the entire time the patient is needing care (Pagnucci et al., 2021). This allows for continuity of care and better trust and cooperation between the patient and provider. Sweden uses the team nursing model where all specialties work together as a group to provide care for the patient (Ridelberg et al., 2016). The US uses a functional nursing model in which a charge nurse, several RNs, and other assistive personnel take care of the patients as a group (Bakhamis et al., 2019). This method allows for the highest turnover of patient for hospital.

Implications

Collaboration and sharing of ideas between the healthcare systems of each of the three countries would be beneficial to each system, but large scale change requiring policy change is typically slow, especially when it involves healthcare due to the varied interest groups and influential parties involved (Iglehart, 2002). Systemically, when it comes to policy and collaboration, centralized legislation with regional autonomy combines to give power to the people on the front lines to make the best decisions for their people while keeping the continuity of care throughout the country. Collaboration between countries can lead to better systems and care of the citizens. Population size and geographic spread can be a challenge for change but by intercountry exchange of ideas and day-to-day practice we can learn from each other, advance research, and impact global health.

As a future nurse, I am eager to implement many of the lessons I have learned from my experiences in Italy and Sweden into my personal practice. Nurses must respect their patient's wishes and never push their own beliefs onto the patient but to determine the patients' personal desires and goals of care. I believe that these experiences have opened my eyes to accept that even when I do not understand why a patient is making certain decisions, I can understand where the patient is coming from and help my colleagues do the same. I have experienced being the only person in the room that does not understand the language being spoken so can now empathize with patients in that situation. When it comes to end-of-life care, I will be better able help advocate for my patient regardless of their decisions. Seeing these different approaches to healthcare has made me a passionate advocate of patient-centered care and the importance of self-determination for patients.

Conclusion

No healthcare system is perfect, nor does one system work for all populations. Universal healthcare provides care to all but is not without drawbacks. Individuals needing medical care can receive it without worrying about the associated financial burden. However, those who do not use medical services very often will still be accessed for the taxes to fund healthcare for the citizens of their country. For US citizens without access to universal healthcare, this may be comparable to the government mandate to obtain health insurance (at the individual's expense) and then not needing it.

The cost and time of education can vary dependent upon country, but regardless, nurses in Italy, Sweden, and the US are highly trained and irreplaceable members of the healthcare team, even if their salary is not always reflective of their value. History and culture have dictated the mindset of people for generations. It is the ever-changing mindset of patients and providers that will continue to expand and improve international healthcare by first changing daily practices.

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