Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Developing and ensuring quality within long-term care

Swedish National Report

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Table of contents

1 Introduction

In Sweden live approximately 9 million people. The publicly financed health and social care constitutes a major ingredient in the Swedish welfare system. The public responsibility for health and social care are explicit in legalization and other national policy documents.

Every four years, the Swedish people go to the polls to elect their representatives in the Parliament (Riksdagen). The Parliament, Riksdagen is the supreme political decision-making body in Sweden the Riksdagen appoints a Prime Minister who is given the task of forming a Government. The Government Offices comprise the Prime Minister's office, the twelve ministries and the Office for Administrative Affairs. The ministry that is responsible for healthcare is The Ministry of Health and Social Affairs. The areas of responsibility of the Ministry of Health and Social Affairs relate to social welfare: financial security, social services, medical and health care, health promotion and the rights of children and disabled people.

To the Ministry of Health and Social Affairs several agencies are subordinated, these agencies are responsible for the “day to day” business within the sphere of Swedish government.

The National Board of Health and Welfare is a government agency under the Ministry of Health and Social Affairs, with a very wide range of activities and many different duties within the fields of social services, health and medical services, environmental health, communicable disease prevention and control and epidemiology. The Government determines the policy guidelines for The National Board of Health and Welfares work.

The majority of The National Board of Health and Welfare activities focus on staff, managers and decision makers in the above mentioned areas. The National Board of Health and Welfare give support, exert influence and supervise in many different ways.

1.1 Independent powers of taxation

Municipalities, county councils and regions are entitled to levy taxes in order to finance their activities. Taxes are levied as a percentage of the inhabitants' income. Municipalities, county councils and regions decide on their own tax rates. The average, overall local tax rate is 30 per cent.

Approximately 20 per cent goes to the municipalities and 10 per cent to the county councils and regions. Tax revenues are the largest source of income for Sweden's municipalities, county councils and regions and account for approximately two-thirds of their total income. In Sweden, the local authorities do not levy property taxes - these revenues go to the State.

Local government has a long tradition in Sweden. The country's municipalities, county councils and regions are responsible for providing a significant proportion of all public services. They have a considerable degree of autonomy and have independent powers of taxation. Local self-government and

the right to levy taxes are stipulated in the Instrument of Government, one of the four pillars of the Swedish Constitution.

Municipalities and county councils are also together with the government are responsible for supplying welfare services to their citizens. Most of the tasks of municipalities and county councils are regulated in special legislation (e.g. the Social Services Act and the Health and Medical Services Act).

1.2 Regions, County Councils and Municipalities

Sweden is divided into 290 municipalities, 18 county councils and two regions (Västra Götaland and Skåne). There is no hierarchical relation between municipalities, county councils and regions, since all have their own self-governing local authorities with responsibility for different activities. The only exception is Gotland, an island in the Baltic Sea, where the municipality also has the responsibilities and tasks normally associated with a county council. (The Swedish Association of Local Authorities and Regions 2011).

1.3 The County Administrative Board Länsstyrelsen

The County Administrative Board is a government authority that exists in close proximity to the people in each county. The County Administrative Board has a unique position in the Swedish democratic system.

The County Administrative Board is an important link between the people and the municipal authorities on the one hand and the government, parliament and agencies on the other. The work of the County Administrative Board is led by the County Governor. The County Administrative Board works with issues that extend across the whole of society and therefore has a wide variety of specialists at its disposal. The County Administrative Board is charged with a range of tasks, including: implementing national objectives, co-coordinating the different interests of the county, promoting the development of the county, establishing regional objectives and safeguarding the rule of law in every instance.

The County Administrative Board ensures that children, the elderly and the disabled are well taken care of in the counties. The County Administrative Board also has a supervisory role with regard to compliance with the Alcohol Act and the Tobacco Act. The County Administrative Board ensures compliance with laws. The County Administrative Board is responsible for supervision and follow-up of the various bodies that come under the Social Services Act and the Support and Service for Persons with Certain Functional Impairments Act.

The County Administrative Board controls that the municipal authorities and private care providers in the county comply with laws and regulations. The County Administrative Board duties also include ensuring the development of social services within the municipal authorities. The County Administrative Board issues permits for private enterprises i.e. care homes for children, young people and adults as well as residential facilities for the elderly and the disabled which are run under private auspices. The County Administrative Board also provides information and advice to the general public and authorities on social matters.

1.4 Three levels of organisation

In Sweden the responsibility for formal care and social services is divided between tree levels; the national level, the regional level, and the local level. On the national level there is the Parliament and government which outlines the policy declarations and legalization. Responsibility for health and medical care is found on the regional level e.g. within the county councils. On the local level municipalities are, according to law, obliged to meet the care and service needs of their citizens (Jegermalm 2005).

Municipalities, county councils and regions may procure services from private companies. Activities carried out by private companies on behalf of municipalities, county councils or regions are financed using public funds. Privately run activities that are financed using tax revenues must offer citizens services on the same conditions as those which apply to similar public services. This means, for example, that citizens pay the same for a service irrespective of whether it is provided by the public sector or by a private company. In some areas, such as refuse collection, public transport and dental care, it has long been common for municipalities, county councils and regions to procure services externally. It is only recently, however, that private companies have begun to run preschools, schools and care facilities (The Swedish Association of Local Authorities and Regions 2011).

The Swedish municipalities have an extended level of autonomy concerning standards for the care and service provided. This tradition of local independence applies to all the Scandinavian countries (Jegermalm 2005).

2 Organization and resources of the health service

Health and medical care in the Swedish health care system is the shared responsibility of the state, county councils and municipalities. The state is responsible for overall health and medical care policy.

The national Health and Medical Services Act (hälso- och sjukvårdslagen) regulates the responsibilities of county councils and municipalities in health and medical care. The Act is designed to give county councils and municipalities considerable freedom with regard to how their health services are organized.

2.1 County councils

There are 18 county councils in Sweden, with responsibilities that are common to large geographical areas and often requiring considerable resources. Their most important task is health and medical care. County councils are responsible for organizing their services so that all citizens have access to adequate care (Goverment Offices of Sweden Organisation and resources of the health service 2012).

Some 71 per cent of county council services are financed by county council taxes. County councils also receive revenue from patient charges and the sale of services. State support is in the form of general central government grants. The state also gives targeted grants to increase access to care and to pharmaceutical benefits. The major portion of county council budgets, 89 per cent, goes to health and

medical care and dental care (Goverment Offices of Sweden Organisation and resources of the health service 2012).

2.2 Municipalities

Municipalities are responsible for care of the elderly and support and service to those whose medical treatment has been completed and who have been discharged from hospital care. Municipalities are also responsible for housing, employment and support of people with psychiatric disabilities (Goverment Offices of Sweden Organisation and resources of the health service 2012).

A freedom of choice system will be introduced to help develop elderly care that more clearly responds to the needs and desires of the individual. In order to make an educated choice, the elderly and their family need information on how elderly care works. The Government is working for the development and follow-up of quality with national open comparisons, improved statistics and a more efficient supervisory body (Swedis Governement Offices Elderly care 2011).

2.3 The main components In LTC

The main components in long-term care (LTC) are acute care managed by the county council. Rehabilitation and GPs also sort under the county councils. Many of the Swedish municipalities are responsible for home care and nursing homes. In some areas in Sweden, the counties are responsible for the basic home care. The services can be provided by the public sector or by a private company.

In the municipality you quite often find a needs assessment function i.e. one or several persons that will assess the needs of the municipality's population, if a need of services or institutionalization is anticipated. In a perfect world, when a person is referred home after he or she has been admitted to hospital, the hospital calls for a care planning meeting. Those who are called could be relatives; the municipality's needs assessment function and other relevant stakeholders. Then the needs assessor together with the stakeholders defines the need and the relevant provider is contacted.

There are additional ways of contacts between the needs assessment function and the municipality's population. Other ways can be that relatives and the GPs contact the needs assessment function. The role of the needs assessment function is vital to provide care to the municipality's elderly population e.g. the amount of home help, nursing homes etc.

Some limitations in this system are that it requires close co-operation between acute care, GPs and the needs assessment function and staff in the municipalities.

3 Legalisation, Taxes and Grants

Swedish municipalities, county councils and regions are responsible for providing a significant proportion of all public services. They have a considerable degree of autonomy and have independent powers of taxation. Two major frameworks of laws regulate Swedish Health and medical services and the Social Services Act.

3.1 The Swedish Health and Medical Services Act

The Swedish Health and Medical Services Act states as follows: Health and medical services are aimed at assuring the entire population of good health and of care on equal terms. Care shall be provided with due respect for the equal worth of all people and the dignity of the individual. Priority shall be given to those who are in the greatest need of health and medical care (Health and Medical Services Act, 1982: 763). (Swedish Governement Offices Health and medical care in Sweden 2007).

3.2 The Social Services Act

The Social Services Act states that, the municipal authorities are ultimately responsible for ensuring that the residents of a municipality receive the support and assistance they need. Despite that there is in some areas a framework that regulates the responsibilities within the family, for instance the marriage Act states that within families there is a mutual responsibility such as married couples have responsibility to individually according to their own capability contribute to supply of means that are needed to meet their individual and families needs. Although this do not mean that you are responsible for giving informal care within the families. This is a major difference compared to several countries in Europe. The obligation by law to provide informal care was excluded from the Social Services Act in 1956.

3.3 The right to levy taxes

Municipalities, county councils and regions are entitled to levy taxes in order to finance their activities. Taxes are levied as a percentage of the inhabitants' income. Municipalities, county councils and regions decide on their own tax rates. The average, overall local tax rate is 30 per cent. Approximately 20 per cent goes to the municipalities and 10 per cent to the county councils and regions. Tax revenues are the largest source of income for Sweden's municipalities, county councils and regions and account for approximately two-thirds of their total income. In Sweden, the local authorities do not levy property taxes - these revenues go to the State (Swedish Governement Prop 2005/06:115 2006).

3.3.1 Grants

Grants from the State are either general or targeted. General grants are paid per inhabitant. Each municipality, county council or region can use this money on the basis of local conditions. Targeted grants must be used to finance specific activities, sometimes over a specific period of time (Association of Local Authorities and Regions (SALAR) 10100 2011).

3.3.2 Income

There are major variations in the average income of the inhabitants of Sweden's municipalities, county councils and regions. The cost per inhabitant, for providing the services to which they are entitled, also varies. In order to ensure fairness, a system has been introduced with the aim of providing equitable conditions in all municipalities, county councils and regions. This is the local government equalization system, which entails redistributing the revenues of the municipalities, county councils and regions on the basis of their tax base and level of expenditure. The equalization system is managed by the State (Association of Local Authorities and Regions (SALAR) 10100 2011).

3.3.3 Fees

Municipalities, county councils and regions may charge users for their services. A non-profit principle applies, however, which means that fees may not be higher than the costs relating to the service concerned. If the municipalities, county councils and regions are obliged to provide a service, they may only charge for the service if specifically permitted to do so by law (Association of Local Authorities and Regions (SALAR) 10100 2011).

4 Regional Comparisons (Öppna jämförelser)

Quality and Efficiency in Swedish Health Care – Regional Comparisons, was published in October 2008 it's a series that compares healthcare quality and efficiency in the 21 Swedish county councils and healthcare regions by using a set of national performance indicators.

The first report was published in 2006 and the second in October 2007. The purpose of publishing comparative data about healthcare performance is twofold. First, the comparisons are a way of informing and stimulating public debate on healthcare quality and efficiency. The public, as both patients and citizens, has a right to know about the results of the healthcare services that are available to it.

The second purpose is to stimulate and support local and regional efforts to improve healthcare services in terms of clinical quality and medical outcomes, as well as patient experience and efficient resource use. In county councils and healthcare regions, political representatives, managers and staff of primary care clinics and hospitals can use the comparisons to locate and pinpoint the strengths and weaknesses of their healthcare systems. Comparisons are a powerful way of driving performance improvement.

This series of healthcare comparisons is a joint, long-term project of the Swedish Association of Local Authorities and Regions (SALAR) and the Swedish National Board of Health and Welfare (NBHW). Future publications are planned based on the original set of indicators but modified or expanded with respect to the areas of health care that are covered (The Swedish National Board of Health and Welfare & Association of Local Authorities and Regions 2008).

5 Quality Registries

Health and social services are developing and changing rapidly in Sweden, as in other nations. The organization and management of these services has been similar and stable for many years. At the general political and administrative level the focus has been on financial and staffing issues, i.e., the framework for providing services. The content of health services has been determined mainly by the various groups of healthcare professionals, while the dynamics of change have been heavily influenced by new treatment options generated through research. The traditions of health and social services

explain why we have the types of management systems that we do. In health care, we have well-developed and functioning systems to monitor economic and human resource activities.

Corresponding systems have not been developed for working with patients, although this is the actual core and the ultimate aim of provider organizations. The traditional patient record systems have not facilitated the compilation and analysis of data needed for quality improvement. Although increasingly more records are electronic, they essentially continue to be note pads that individual caregivers use for memory support in treating individual patients.

The National Quality Registries have been developed to fill the gap left by the lack of primary monitoring systems. The quality registries collect information on individual patient's problems, interventions, and outcomes of interventions in a way that allows the data to be compiled for all patients and analyzed at the unit level.

Since the registries are national, the entire country is in agreement on what indicates good care. This also makes it possible to compare different units. Executive Committee for National Quality Registries

In the areas where National Quality Registries have been established, the tools are available for any unit that wants to participate to continuously monitor their effectiveness and the benefits that they create for patients.

The successful development of the Swedish National Quality Registries is explained largely by their decentralized nature. Caregivers that have the greatest use for the data also have the main responsibility for developing the system and its contents, and the databases are spread out among different clinical departments throughout Sweden.

Registry content is continually validated in different ways by registry managers and units that use the registers. This is complemented by annual quality control, represented by the annual reports and grant applications submitted for central funding. Data quality in the National Quality Registries is sufficient for use in clinical research. A system of national quality registries has been established in the Swedish health and medical services in the last decades. There are about 70 registries and four competence centres that receive central funding in Sweden.

The national quality registries contain individualized data concerning patient problems, medical interventions, and outcomes after treatment; within all healthcare production. It is annually monitored and approved for financial support by an Executive Committee.

The vision for the quality registries and the competence centres is to constitute an over-all knowledge system that is actively used on all levels for continuous learning, quality improvement and management of all healthcare services.

5.1 Competence Centres

Three competence centres for the National Quality Registries have been established (one is under construction). In a competence centre, several registries share the costs for staff and systems that a

single registry could not bear. Hence, a continued development of the registries can be assured although the system follows a decentralized model, i.e. each register is governed by a professional collaboration.

Competence centres aim to promote the development of new registries, create synergy effects by collaboration among registries (e.g., in technical operations, analytical work, and use of registry data to support clinical quality improvement), and helping to make registry data beneficial for different users (Association of Local Authorities and Regions Nationella Kvalitetsregister 2011).

6 Guidelines

The guidelines developed by the National Board of Health and Welfare can be divided in to three types of guidelines.

- Firstly, there are national guidelines that provide decision makers and professionals with recommendations within a certain area, for example within the area of a disease.
- Secondly, there is support for decision making within the field of Health Insurances
- Thirdly the National Board of Health and Welfare also gives recommendations regarding HIV prevention and Disease Control (The Swedish Board of health and Welfare, Nationella riktlinjer 2011)

Table 1 Development of National Guidelines in Sweden

Preliminary Guidelines	Guidelines being produced	Finalized Guidelines
Lung cancer	Update of Breast, colorectal and prostate cancer	Schizophrenia
Methods of prevention	Update Heart disease	Dementia
Dentistry	Palliative Care	Depression and anxiety
Musculoskeletal Disorders		Diabetes
		Stroke
		Heart disease
		Abuse and dependence
		Breast, colorectal and prostate cancer

Source: National Board of Health and Welfare: (The Swedish Board of health and Welfare, Nationella riktlinjer 2011).

7 Quality Indicators

The Swedish Board of Health and welfare are responsible for the development of National quality indicators. The development of the Quality indicators is based on a model that was developed by Stockholm County Council. The models that have been used in the Stockholm County Council have similarities to the models that are used in Holland and UK.

Working with the model is a process that has it start in gathering information about the specific area of interest e.g. disease from guidelines and/or care programmes. And then the indicators are discussed and defined in expert groups and other stakeholders.

The indicators shall have scientific reliability/validity; the indicator should also be relevant and important and the indicator should be possible to measure. The indicators should be based on the best evidence possible.

Table 2 illustrates an example of how to construct indicators according to the model.

Table 2 Structure of Quality Indicators

Measure	Description	How to measure	Data source	Source of error	How to Display results	Stakeholders
Proportion or means	Definitions. Numerator and denominator	Ex: care-documentation, survey	Ex: registries, medical records	Factors that influence the outcome.	Ex: Yearly or time series	Patient/clients, management at different levels.

Source: (The Swedish Board of health and Welfare, Nationella riktlinjer 2011)

7.1 Quality Indicators of co operation

In a study by the Region of Skåne it shows clearly that co operation works better if there is an assigned function within acute care to work with co operation with the municipalities. The study also shows that the co operation seems in general to work better between acute care and municipalities then primary care, even though acute care and primary care formally are the same organization (Jansson , Björn; Tegle, Stig 2009).

A method that strengthens co operation is that the responsible GP visits his/her patient when the patient is subject of acute care, but this never occurs in daily practice in Sweden. But in many other countries the numbers of these sorts of visits are an indicator of the co operation and continuity (Jansson , Björn; Tegle, Stig 2009).

A measurement that is used in Sweden is the number of bed blockers in acute care. This is the number of patients that are considered as ready for discharge and waiting for referral to their “home” or other care (Jansson , Björn; Tegle, Stig 2009).

8 Examples of good practice

8.1 Webcare

The need for information and good communication when a patient is referred from hospitals back home is quite often extensive. To support this need of information and communication the Stockholm County council and the municipalities have developed a system, IT application to facilitate communication

about individual patients which makes the administrative process about referrals easier; easier in the way that WebCare includes a link to an official electronic list of all participating providers and whom to contact at the providers, e.g. who is responsible for the patient in the municipalities and primary care. WebCare also includes information about the patient's care plan.

The need of information and good communication when a patient is referred from hospitals back home is quite often extensive. So the rationale behind the development of WebCare was that it addressed several problems. For instance a lot of time-consuming work where needed to get in touch with responsible person in the different organizations. Furthermore, contact details were not organized and scattered, and information was sent by fax to providers and there was a risk that the information about the patients was sent to a non-authorized receiver. It was not unusual for a nurse to spend about two hours to find the right receiver. There was also a problem to know if the receivers had read the information.

WebCare is an IT application. Information about the care planning process between the county councils and the municipalities is documented in WebCare.

If an elderly is admitted to hospital and the doctor suspect that the patient will be in need of continued care after discharge they must notify the social assistant officer in the municipality and the district nurse and GP about the admission. This is the first step in the legislation to ensure that continued care will be available for the elderly after discharge. The following steps are; call for care planning, date for discharge, and finally actual discharge. This process was handled by facsimile transmission earlier but it proved to be a very time-consuming task. It was difficult to find facsimile numbers and name of the receivers. It was not unusual for a nurse to spend about two hours to find the right receiver. There was also a problem to know if the receivers had read the information.

The process is initiated by hospital staff when the doctor has decided that it is possible that continue care will be needed. The nurse will then register the patient in WebCare on the page called admission. The responsible receivers in primary care and municipality will appear automatically and when the nurse press "send" will be available on their computer. On the first page in the system will now appear two symbols in the column for admission – one for primary care unit and one for municipality, in form of a closed envelop, similar to mail symbol. As soon as the receivers has open the form the envelope will appear opened and in that way show the sender that information has been read. They will now give an answer weather the patient is known to them by putting a tic in an answer box. The social assistant officer will also let the hospital know if the patient has a nursing home bed.

The information in WebCare is mostly administrative information. A few basic medical data is included to enhance understanding before meeting for care planning. No information is distributed without the patients consent. The actors using the information are doctors and nurses on admission wards, GP and district nurse in primary care, social assistant officer in the municipality.

WebCare is divided into five pages to support the process of care planning, each page shared by the three organizations, hospitals - primary care units and municipalities. Each organization also owns their part in the page where they can submit information to be shared by the others. The partners can only

read the information, never alter or change what has been written. WebCare thus give each organization a concise picture which has not been possible before.

The legislation in Sweden has very strict stipulations on who is allowed to read the content in a patient act. Everything is being logged, and the log files are supposed to be checked regularly. Each actor has a unique identification through the official electronic list how also distribute safety cards for the users.

The development of WebCare started as a bottom up project. It has been managed and driven by committed individuals who did see the need for communication and reliable transfer of information to different care providers.

The development of WebCare started parallel to another development of a national common care provider register. The national register was needed to develop WebCare, because the register was a way to actually know which care providers are involved with each patient.

The costs of developing WebCare have been fairly low. All together the Stockholm County Council has granted The WebCare group approximately 315 000 Euros since the end of the '90s. This is the actual grant that has been set aside to develop the system, on the other hand there are additional costs of implementing and maintaining the system, but that has not been calculated.

WebCare is today implemented within the Stockholm County Council and the island of Gotland situated in the Baltic Sea.

8.2 Joint Care Planning model

A model that is widely spread in Sweden is the joint care planning model. When a patient is referred from acute care there is a care planning meeting. Representatives from the acute care and the municipality's needs assessment function meet with the patient and, if there is, an informal carer, and rehab resources. They meet and plan the future care together.

8.3 EQ-5D

EQ-5D is a standardized instrument for use as a measure of health outcome. Applicable to a wide range of health conditions and treatments, it provides a simple descriptive profile and a single index value for health status. EQ-5D was originally designed to complement other instruments but is now increasingly used as a 'stand alone' measure (EuroQol Group What is EQ-5D 2011).

In order to measure the change in health status in Sweden, the generic health-related quality of life instrument, the EQ-5D, was included in the 1998 (n = 4,950) and 2002 (n = 49,914) cross-sectional postal Public Health Surveys, a representative sample (21–84 years) of the Stockholm County population, with response rates about 63% in both years. The EQ-5D provides data on five dimensions of health as well as an overall index value (1 = full health; 0 = dead). Results: Over time the health index decreased. Women had significantly more health problems in 2002 in four out of the five dimensions, with the largest increase in the dimensions anxiety/depression and pain/discomfort. The health index was significantly lower in all age-groups for women. Men had significantly more health problems 2002 in two

dimensions, and the largest increase in anxiety/depression (Burström, Johannesson och Rehnberg 2007).

So far there are more than 200 units using/have been using the web application for EQ-5D in Stockholm and they have registered several thousands of patients' altogether. The patients fill in an EQ-5D form at the first visit to the care giver and a second at the last visit. Sometimes even a third measurement is performed. Many rehabilitation units in Primary care have to use EQ-5D as a part of their contract. So far, they are told to test the instrument and they can choose any patient group they want. Neurology patients are the most frequent group, for example stroke rehab. The plan is that every unit will use their own results to make local improvement work. The purchasing office also plans, in the future, to make comparisons between units using results from EQ-5D.

8.4 National Surveys (Nationell patientenkät)

For the first time a national patient survey has been performed all over Sweden. More than 160,000 questionnaires were randomly sent out to patients that had visited a primary care physician. The aim is to give the patients the possibility to rank and tell about their experiences. It deals with, among other things, acknowledgement, involvement, confidence, and information.

Later on other sectors of the health care will be addressed, as well as other care professionals. This national survey is mainly focused on primary care. During 2010 the surveys will be extended to cover inpatients in acute care and psychiatric care for in and out patients.

There are also user surveys to investigate the quality of home-help services and nursing homes from a user perspective within the municipalities... The User Survey 2008 was the first national survey that covered all municipalities in Sweden. The results are expected to be used for several purposes important to users, residents and responsible decision-makers at various levels. The basis for the survey was that: User surveys shall comprise the aspect of quality that is called results in the research and pertains to the operation's effects on users

The areas of quality inquired about were chosen considering the objectives of social services and elderly care outlined in the Social Services Act and the regulations of the National Board of Health and Welfare. This involves users' opinions with regard to personal treatment, influence, information, etc (Songur 22-24 June 2009).

8.5 Äldreguiden

In recent years the discussion about client empowerment has aroused. There is an emerging movement towards more openness. The national Board of Health and Welfare provides for instance a guide on elderly care (Äldreguiden) where people online can compare different quality indicators for nursing homes and short stay homes. Some of the indicators are about support to family and educational level for staff (The National Board of Health and Welfare 2011).

8.6 Examples of developing and ensuring quality within long-term care

Good and structured examples of developing and ensuring quality within long term care that are built on the criteria's of INTERLINKS are quite hard to find. Different projects have started with the purpose of establishing teams between different provider organizations, several of these projects has been short-lived and unfortunately the results has not been evaluated to any major extent (National Board of Health and Welfare 2007). The following examples are a project that has received acknowledgments in Sweden but there are of course other projects that have been working with these issues.

In the beginning of 2006 a political suggestion was proposed to change the status for Norrtällje Hospital from a hospital with acute care to a "community hospital" with fewer resources for acute care. The propositions meet public resistance and therefore it was decided to keep the acute care status for the hospital, although it was still requested to downsize the budget. To be able to downsize but still keep the acute care status for the hospital a new organization hospital and primary care and the community care became partners with a joint board (Association of Local Authorities and Regions (SALAR) 10100 2011).

The focus of the project is to meet the citizens with care needs in a coordinated way where boundaries between different levels of care are secondary. New departments have been established, for example for family and youth psychiatric and rehabilitation was established. This is a department that focuses more on the patient process in the system rather than the responsibilities within different fields.

To create a basis for this cooperation it has been necessary to decision makers to work in pragmatic and consensus oriented manner. The future challenge of this project/new organization is to develop and define horizontal measurements and goals (Association of Local Authorities and Regions (SALAR) 10100 2011).

Esther is a project designed to create co-operation between acute care, primary care and community care, with focus on elderly patients. The project was designed according to the method of Health Care Re engineering (HPR/BPR). Several processes have been re-designed to fit the needs of elderly patients. One process that has been developed is that the information (IT) should follow the patient's process trough the boundaries of different organizations and providers (County Council Of Jönköping. The Eshter Network 2011).

9 Empowerment

9.1 Patients' committees (Patientnämnden)

Every county council and municipality has a patients' committee that, based on patients' views and complaints, is to support and help individual patients and contribute to quality development in the health care system, by:

- Helping patients to get the information they need to safeguard their interests,
- Promoting contact between patients and health care staff,

- Helping patients to get in touch with the appropriate agency,
- Reporting any irregularities that are significant to patients to care providers and care units.

The number of cases reported to patients' committees has increased in recent years. About 15 per cent of all cases have to do with reception, communications and information (Swedish Government Health and medical care 2011).

9.2 Medical Responsibility Board (HSAN)

Patients who believe they have received the wrong treatment from a public or private health care professional may turn to the Medical Responsibility Board. The Board makes its decision after conducting a thorough investigation. If the professional is found to be blamed, the Board may impose a disciplinary punishment (Swedish Government Health and medical care 2011).

9.3 Patient insurance

A patient who is injured in connection with treatment or a comparable health care measure (including dental care) can seek compensation for the injury from the patient insurance scheme. All care providers are required by law to take out patient insurance. Such insurance does not cover injuries caused by pharmaceutical products (Swedish Government Health and medical care 2011).

9.4 Pharmaceutical insurance

Pharmaceutical insurance is a voluntary, unregulated, collective insurance for injuries caused by pharmaceutical products supplied in Sweden by members of the Swedish Pharmaceutical Insurance Association. The insurance is provided to members either in their capacity as Swedish manufacturers or as importers of pharmaceuticals manufactured abroad. Virtually all pharmaceutical enterprises manufacturing or importing pharmaceutical products to Sweden are members of the Association (Swedish Government Health and medical care 2011).

9.5 International dimensions

Today Swedish health and medical care is greatly influenced by EU cooperation. Even though responsibility for organizing and funding health and medical care is mainly a national concern, the number of patients seeking care in another Member State has increased in recent years. The number of professionals working in health care in another Member State has also increased. This development can bring great advantages both for the individual and for health care systems. Sweden is participating actively in cooperation in the EU to improve accessibility in health care, to cooperate on highly specialized care, to improve patient safety in all Member States and to enhance patient influence and information to patients. In the pharmaceuticals area, Sweden is also an active participant in working groups for matters including information to patients and the relative effects of pharmaceuticals. Increasingly discussions on health care are also being conducted outside EU cooperation, mainly in organizations like the WHO, OECD, the Council of Europe and the Nordic Council of Ministers. Many of the challenges facing Swedish health care are shared by other countries. This applies, for example, to issues of accessibility, quality, efficiency; demographic challenges; and the funding of health care, to mention a few areas (Swedish Government Health and medical care 2011).

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