



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

Governance and finance of long-term care

Swedish National report

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1 Key contextual factors

Health, medical care and Care of elderly people hold a central position within the Nordic and Swedish welfare model. In an international perspective Nordic elder care is characterized by comprehensive, high quality public services available to all citizens in accordance with their needs rather than their personal finances. Highly autonomous municipalities and extensive public home help services are also considered to be specific Nordic phenomena (Szebehely, 2005).

Health, medical care and Care of elderly people are one of the issues in society that the Swedish people are most concerned about. Swedish Health, medical care and Care of elderly people are based on the principles that care should be provided on equal terms and according to need that it should be under democratic control and financed on the basis of solidarity. Health, medical care and Care of elderly people are to be characterised by high quality and good accessibility in which the patient comes first (Swedish Government , 2006b) The provision of elder care in one's own home is a central policy goal in all the Nordic countries (Szebehely, 2005)

The Ministry of Health and Social Affairs works to meet the objectives set by the Riksdag (Swedish Parliament) and Government. The objective of health and medical care policy is to improve the quality of care, increase accessibility and create diversity. The policy area of health and medical care encompasses government agencies and state efforts devoted to health and medical care, dental care and pharmaceutical (medical) products. The Ministry monitors and analyses health and medical care, drafts legislation and other guidelines, a move forward policy issues and negotiates with the bodies responsible for organising Health and medical care in Sweden. In Sweden these bodies are the county councils and the municipalities (Swedish Government , 2006b).

There are 280 municipalities, 18 county councils, and 2 regional authorities in Sweden. County council election and municipal election are held every fourth year in conjunction with the general election The municipalities and the County Councils are today entitled to choose their own organization and are free to participate in various form of collaboration. The responsibility of the county councils are to provide health services such as hospitals, health centres and other institutions, whilst the responsibility of the municipalities covers all other aspects of care, including social care, nursing homes and home care (Fukushima et al., 2010).

From the early 1980s In Sweden as in the other Nordic Countries, health and social care have increasingly adopted market based approaches to reform, with a growing emphasis on choice and competition as a means of improving standards and controlling costs. Thus, while there remains a strong commitment to publicly funded, comprehensive and universal services in many areas of the welfare state, such support is often provided in practice by a much more mixed economy of public, private sector providers. The market-inspired re- modelling trend – has had an impact on elder care in Sweden, but to different extents in different parts (Szebehely, 2005).

Responsibility for health and medical care in the Swedish health system is divided between the state, county councils and municipalities.

They have the right to levy taxes. This, according to Johansson and Borell makes the specialization of services an economic as well as an organization matter (Johansson, 1999), County Council election and municipal election are held every fourth year in conjunction with the general election (Fukushima et al., 2010).

Unlike many countries in continental Europe, adult children in the Nordic countries have no legal obligation to provide care or financial support for their parents. Instead, the formal responsibility for the welfare of elderly people lies with public elder care. In the Nordic perspective, well-functioning elder care is considered a welfare resource not only for elderly people requiring assistance but also for their close kin who thereby have the possibility to combine caring responsibilities with employment. Furthermore, the elder care sector is an important labour market where a considerable number of people, most of whom are women, find employment (Szebehely, 2005).

In all the Nordic countries the traditional care institutions (nursing homes, residential homes) have been replaced, to a greater or lesser extent, by various kinds of assisted dwellings for elderly people. These dwellings go by different names, for example service housing, dwellings for older persons, housing for care and services (Szebehely, 2005).

2 Governance and financing of long-term care services for older people

According to the Swedish Association of Local Authorities and Regions (SALAR).

- The expenditures of Swedish health care were 230 Billion SEK in 2008 that is equal to approximately 10 % of the Swedish GDP. The costs for the activities in the municipalities were 475 Billion SEK in 2008. Of these costs elderly represent 20 % (95 Billion SEK) (National Board of Health and Welfare 2008).
- The main expenditures of the Swedish Health care is financed to 63 % of taxes that the county council levy, 8% are from municipality taxes, 8% are patients fees, 15 % are a subsidy from the state (National Board of Health and Welfare 2008).
- The financial situation of municipalities and county councils remains troubling, despite vigorous cyclical support from central government in 2010. The exceptionally weak economic situation and lower employment will severely curtail income growth in the local government sector this year and next year (Swedish Association of Local Authorities and Regions 2010a).

Two legal frameworks have a prominent role in the Swedish health care system. These legal frameworks are:

- Swedish Health and Medical Services Act
- Social Services Act

The Social Services Act is designed to give county councils and municipalities considerable freedom with regard to the organisation of their health services. The state is responsible for overall health and medical care policy (Swedish Government, 2006b).

The 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 (Swedish Government, 2006b).

The Social Services Act states as follows: Public social services shall, on basis of democracy and solidarity promote peoples economic and social security, equality of living conditions and active participation in the life of the community. Regarding the municipalities responsibilities the Social Service Act states that each municipality is responsible for social services within its boundaries. and that each municipality are ultimately responsible for ensuring that persons staying within its boundaries receive the support and assistance they need (Socialdepartementet, 2001).

These two legal frameworks of laws are also reflected in the organization of health and social care. Responsibility for health and medical care in the Swedish health system is divided between the, county councils and municipalities. The Health and Medical Services Act sets out the respective responsibilities of county councils (e.g. acute care, GPs and rehabilitation). The Social Service Act sets out the respective responsibilities of municipalities (e.g. Social care home help in regular housing, home care, special housing nursing homes, day activities). Companies, trusts or cooperatives can provide services but the local authorities remain the ultimate responsibility to supply and maintaining the level of care even when private organizations supplement some of their responsibilities (Fukushima et al., 2010).

The organizational politically governed bodies that are involved with medical care and social care e.g. county councils and municipalities, each body have different but important roles in the welfare system of Sweden. They are represented by directly elected political bodies and have the right to finance the activities by levying taxes and fees within the frameworks set by the legal framework (Swedish Government, 2006b).

The Swedish state has since the early 90 s increased the ambition to govern health care (compare to the relative autonomy of county councils and municipalities). These efforts to govern have not been expressed in an increased legalization, more it has been expressed by different subsidiaries and agreements between different stakeholders. This development is not without problems because the agreements and subsidiaries are often based on short terms and it creates a felling of uncertainty among the stakeholders

The problems with this form of governance are concluded as follows.

- It's uncertain why one way of governance is used instead of another.
- The diversity of different forms of governance do not contribute to a clear accountability between the state and main principals
- It's not obvious to the main principals which areas are prioritized by the state

- The increase of other forms of governance than legalisation often contributes to a short term governance and that the ambition of the state also appear as short termed (Swedish Government 2011).

3 Key barriers to joint working

3.1 Structural

Better care of aged with co-existing diseases requires cooperation and responsible caregivers. As suggested above, services for older people in Sweden are fragmented between different health and social care systems, each with different legal and financial frameworks, geographical boundaries, accountability mechanisms and cultures. The boundaries are within different organizations e.g. within county councils, hospitals and Primary care and rehabilitation but also between organisations e.g. county councils and municipalities. The discussion about these boundaries is often referred to discussion about the chain of care e.g. hospitals, rehab, care in the municipalities.

A study by Bengt Ahgren states that the chain of care development has a high priority in Swedish health care. However, regardless of the high official priority and several years of experience, chain of care development is making slow progress. Seven out of ten county councils regard themselves as unsuccessful in developing and implementing chains of care. All the county councils declare that they will continue to develop chains of care. This faith in chains of care can to some extent be explained by the crucial role they have as links in the ongoing development of local health care. This is an upgraded family- and community-oriented primary care, supported by flexible hospital services. Many politicians and policy makers are convinced that such an integrated system will assure both high quality and a cost-effective health care (Aghren and Axelsson, 2007).

3.2 Procedural

Without a well functioning care of elderly in the municipalities the care are not able to be delivered with high quality and efficient use of resources, if the care in the municipalities not are functioning I doesn't matter if the primary care and the hospitals works well. This is essential when it comes to people with LTC Needs. Add to this that cooperation between different bodies often is insufficient.

Many of the people who come into contact with the healthcare system and the social services have complex needs that require the co-ordination of the efforts and activities of the local authorities and county councils. Far too often, however, the healthcare system and the social services act as fragmented sub-systems and fail to communicate adequately with each other. This can lead to poor care and healthcare, a lack of safety and security and higher costs than necessary (Dahlén, 2007).

The problem of non co-operation can be described as follows: The chain of care for several patients/diagnose groups needs care from different organisations with separate budgets, professional boundaries for instance. The single organisations often just have their own perspective in mind and do not see the big picture. The single organisations have their own organisational goals to fulfil.

The two legal frameworks that have a major impact on the Swedish Health Care system – the Swedish Health and Medical Services Act and the Social Services Act – have different starting points that sometimes in day to day business creates problems when the legal frameworks are needed followed parallel. People can at the same time be a patient and a client depending of the needs and in which legal framework these needs are governed by. In those cases that often applies for people with LTC needs the suggested treatment or services needed are far from obvious, this raises demands of an elaborated and functioning care plan process. Different stakeholders e.g. patient/user, informal cares and the profession needs to collaborate regarding the patient/client (Dahlén 2007). Furthermore there are different IT solutions regarding for example medical records and access to these depending on organisational and professional boundaries. For example the municipalities do not have access to medical records at the hospitals, and the nurses within the municipalities do not have access to the medical records held by Primary care (Dahlén, 2007).

3.3 Financial

Health and social care both have separate budgets. Therefore, patients that generate higher costs than the reimbursement the producers of care receive tend to generate issues regarding displacement of accountability between different organisations, departments etc. These circumstances also led the government to decide that the local authorities have to pay for “bed-blockers” in hospitals after a certain number of days and after certain conditions are fulfilled.

3.4 Professional

Top-down approaches are obstructing the chain of care e.g. co operation between hospitals, primary care and rehabilitation and the elderly care in the municipalities). Negative response emanates mostly from professional values of the body of physicians. Conversely, if a chain of care project is initiated locally by dedicated professionals, there is a good chance of a successful outcome. The legitimacy of the development work among colleagues and stakeholders is of vital importance to the success of the work. It also applies to confidence among participating organisations and authorities. These attitudes include giving space for prime movers and also trust between the participants (Ahgren and Axelsson, 2007).

3.5 Issues of status and legitimacy

The hierarchical bureaucratic structure that previously prevailed changed in Sweden after the Care of the Elderly Reform (Ädelreformen) in 1992. Old-age care had until then been administered by the central government, but through the reform, the role of the government became restricted to that of a legislating, facilitating and controlling body, and all detailed planning, funding, and allocation of resources henceforth became the responsibility of the municipalities together with the county councils (Fukushima et al., 2010).

However, the reform in 1992 led to a diversification of the activities provided by the municipality and, on the other hand, a specialization of services for the county councils. Although the responsibilities of the municipality account for about 90 percent of all elderly care and no formal hierarchical order between the two authorities exists, the county councils have de facto power over the municipalities as they are higher up in the care-chain and have the final say of whom to send to the care of the municipality (Fukushima et al., 2010).

4 Key enablers

4.1 Shared vision

In recent years there have been a movement towards creating agreements between different organisations/stakeholders, these agreements purpose is to create a set of rules and it seems that the rules often are concerning ways of collaboration between the organisations and creating forums for meetings between staff. These meetings are assumed to generate a climate of cooperation willingness. It seems like strategic decisions regarding for a example a joint budget could enable co operation further (Wånell, 2007).

4.2 Clarity of roles and responsibilities

Many of the people who come into contact with the healthcare system and the social services have complex needs that require the co-ordination of the efforts and activities of the local authorities and county councils. Far too often, however, the healthcare system and the social services act as fragmented sub-systems and fail to communicate adequately with each other. This can lead to poor care and healthcare, a lack of safety and security and higher costs than necessary (Wånell, 2007).

4.3 Appropriate incentives and rewards

A key barrier has been that most policy, budgets, incentives and rewards operate on a single organizational basis. This has begun to change with a development of different projects and an development of different quality indicators that cross organizational boundaries (National Board of Health and Welfare, 2006a).

The normative incentives are also often promoted and they can be concluded as follows.

- Co-operation is benefiting the user and reduces the risk for the user to be “forgotten” between organizations.
- A single stakeholder (organization /authority cant single handed solve users needs, because the needs are often multiple.
- The efficiency are likely to increases if stakeholder co operate and thereby the quality of life will increase to a lower cost
- By co operation each organization will broaden their knowledge meanwhile they are integrating the knowledge to the a better understanding of the “big picture” (Swedish Government, 2007b).

4.4 Accountability for joint working

The county councils and the local authorities within the municipalities have a joint responsibility to promote different forms of co-operation that benefits the patients. Several stakeholders have in their agendas joint working as a prioritized area of development for example the Association of Local Authorities and Regions provides regional comparisons, some witch are relevant for LTC.

As of 1 January 2010, the local authorities are required to draw up an individual plan for each care receiver that clearly states each step of the required treatments and services. The plan must also disclose the name of the person that is officially in charge of the case and clearly specify which authority to be responsible for each component of service and care offered.

5 The funding of long-term care services

The future care of older people to meet future needs requires that available resources are used as efficiently as possible. Today it's a large difference between the local costs of care for the elderly. Cost differences in ordinary housing for example vary a lot between different municipalities. It is not possible to explain if the differences are due to differences in efficiency or quality.

Institutional care costs approximately SEK 30,000 per year and per person over 65 years. The corresponding cost of home care per individual over 65 was SEK 19,000 in 2007. Dividing the total cost by the number of care recipient, the same care amounted to SEK 513,000 per institutional care recipient in average, and 220,000 per person for home care recipient. The total expenditure on LTC for individuals over 65 was SEK 168 billion in 2006, which accounts for approximately 3.5% of the GDP. Less than 5 % of the total cost of LTC is financed privately while the rest is covered by public funds, mainly raised through tax. The cost of LTC for the municipalities and the county council was about SEK 80 billion each in 2005 (Fukushima et al., 2010).

Charges for care of the elderly are regulated by the Social Services Act and designed to protect the individual from excessively high fees. Each year the government decides a maximum fee the service provider may charge an individual. The fee, which in 2007 corresponded to SEK 1612 per month, is fixed and charged irrespectively of the individual's income. Nevertheless, the fee may be reduced if the monthly income does not exceed the minimum costs of living, the reserved amount, also set annually by the government. In 2007, the reserved amount was SEK 4346 per month for a single elderly and SEK 3640 per person and month for a couple. Within the frameworks of these rules, each municipality decides its own system of charges and the fee paid by the individual (Fukushima et al., 2010).

6 Financial sustainability

With an ageing population and rising expectations, the current system in Sweden is widely perceived as financially unsustainable. With the same level of ambition that Sweden have today, health care can be hard to finance after year 2015. The reasons for this is that the tax base are decreasing, due to at the population in the workforce levels out, at the same time as the needs are expected to increase in its turn due to the overall all demographic development (Calltorp et al., 2006).

7 Good practice

In Sweden it's a continuously ongoing debate of how to improve LTC and health care in general. In a proposition, the Swedish government identified six areas of development on the care of the elderly. They are: better care for the once with most needs, security/Safety in your home, Social care, national equivalence and local development of care, Prevention efforts and assuring staff ratios and their educational level.

There is a development at the national board of health and welfare and other stakeholders to develop quality indicators regarding LTC.

Furthermore there are a lot of national, regional and local projects regarding these matters. Just to illustrate this with one example there is a new form of organization in Norrtälje. In 2006, the healthcare company TioHundra was founded in Norrtälje. Normally the county councils are responsible for nursing and hospital care, while municipalities are responsible for social care. What distinguishes TioHundra from other healthcare providers in the country is that they have major contracts from both the county and the municipality. This gives a unique opportunity to take a holistic view where the customer is central. In that way they have been able to create an organization in which co-operation and the exchange of knowledge are at the core of all activities. This may seem like a natural and obvious idea, but nevertheless represents a new and radical way of thinking within healthcare in Sweden (Ahgren and Axelsson, 2007).

In other areas there are many projects that are aimed to improve the chain of care for different patients groups, the success of them vary.

8 Ongoing tensions

In Sweden such as in all other countries, health- and social care is subject of high complexity compared to other "industries". It's possible to look at the healthcare system in the light of two axes, the uniqueness of "customer" segment served (the number of product lines times the number of major "customer" groups. On the other axe you find the political complexity, defined as the number of Stakeholders (patients, informal carers, citizens as members of society, citizens as tax payers, professional groups, managers, county and municipality elected politicians, the state and suppliers of services and goods). All Stakeholders together contributes to the complexity and tensions that are to be identified in the Swedish system.

Studies of elderly people's preferences have generally arrived at the same conclusion; namely that most elderly people do not wish to be dependent on care provided by the family – especially not when it comes to extensive, long-term or intimate assistance. They prefer the public home help services to help provided by the family or by private or voluntary organizations. Thus, it is hard not to interpret the shift towards more informal care in Sweden as an involuntary, forced situation (Szebehely, 2005).

In Sweden there is increasing political interest in the role of voluntary organizations in elder care. At the State level, there is an interest (partly rhetorical) in voluntary organizations as contracted alternative providers of welfare services in a care sector that has been opened to competition. At the municipal level, there is an increasing interest in unpaid volunteer work, for example as friendly visitors and in day centres, or as a support for informal carers. Voluntary organizations such as the church and pensioner associations have long been engaged in such activities; what is new is that the volunteers are now being regarded more and more as substitutes for a public sector that is underfunded. Here, there is a striking parallel to the increasing caring responsibilities of relatives. Researchers, like the voluntary organizations, have criticized the increasing demands that municipalities are placing on voluntary organizations to take over responsibilities from the public elder care. However, the relationship between voluntary organizations and the public elder care is a field that needs more research (Szebehely, 2005).

The development in the Swedish demography is that the number of elderly people increases, due to great numbers of births in the 1940: s that in combination with the medical/technological developments leads to possibilities to better treat and cure diseases. These two factors are interacting and together they create a tension and a challenge (Calltorp et al., 2006).

The advances in medical fields give opportunities to treat more diseases among different patient groups and not at least within the field of LTC. The medical profession are keen to use these advances in their work and cure more people. The well informed citizens wants these advances in the medical field to be available, this have an impact and on demand of care, some researchers say that this phenomena have more impact than the demographical development (Calltorp et al., 2006).

The citizen's values and attitudes are changing towards to a more individualistic view, ad to this a new cultural mindset on matters of sickness and health. Furthermore there are an increasing numbers of single households and often they have long distance to kin, these together effects the demands on the public system and due to the demographic development. The limitation and decreasing work force does not correspond to the identified increasing need (Calltorp et al., 2006).

9 Embedding good practice in everyday practice

Improving the level of collaboration between the two authorities has been debated since the 1970s. For instance, in an attempt to make the division of work more conspicuous, a law was enforced in 1990 to emphasize the 'planning of care' (vårdplanering) by the authorities when the initial assessment of need is conducted. In 1993 a new law made the interpretation of the responsibility of care expenditure more defined. Despite the law enforcements, the government's own calculations indicate that only two out of three care receiver have a written individual care plan.

Starting 1 Jan 2010, local authorities and county councils are required to draw up an individual plan in accordance to a given format for each care receiver. The plan should clearly state what treatment the individual requires, which authority to provide for what sort of care, specification of care if provision of

care is required by any other than the local authority or the county council, and the name of the authority that has the principal responsibility of the health of the individual (Fukushima et al., 2010).

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