

Freedom of choice and dignity for the elderly

Host Country Report

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Facts about elderly in Sweden

The elderly population

Over 17 percent of the Swedish population, or about 1.6 million people, are 65 years old or older. Population projections show that in the next 30 years, the largest part of population growth will be among people aged 65 and older. By 2035, the greater part of population growth will be in groups that are not of working age. The very oldest part of the population has increased since the mid-20th century and the number of people aged over 80 is projected to almost double between now and 2050.

Number and percentage of people in the population aged 65 and older

Year	Number aged 65+	Percentage aged 65+	Of whom women, per cent
2005	1,565,000	17.3	57
2020	2,056,000	21.2	54
2030	2,303,000	22.9	53
2040	2,464,000	23.9	53
2050	2,478,000	23.6	53

Source: Statistics Sweden 2006, *Population projections*

In 2005 average life expectancy in Sweden was 78 years for men and 83 years for women. On retiring at 65 men can expect to live for another 17 years and women for 21 another years. Mortality is falling more for men than for women. For this reason more women in particular will be able to retain their partner when they get older.

Average life expectancy for women is expected to rise from 83 years to 86 years in 2050 with an increase for men from 78 years to 84 years.

The ageing population will lead to greater demand for health care and social care, but probably only to a limited extent over the next ten years. Many of the pensioners will still be aged 65-70 years during the period. At those ages the need for health care and social care is relatively small. This need primarily increases after the age of 80 years.

A great majority of the elderly in Sweden (about 93 per cent) live in ordinary homes with or without home care services. The housing conditions of older people do not differ significantly from those of the population as a whole; the general standard of housing is high.

Funding and expenditure

In 2005 the cost of the elderly care at municipal level amounted to SEK 80.3 billion (special housing accounts for 64 per cent of this amount, care in ordinary housing for 34 per cent and preventive activities for 2 per cent). Care for a person in special housing is approximately twice as costly as care in ordinary housing. If health care services provided for the elderly at county council level (i.e. hospital care and out-patient care) are included, the cost doubles to approximately SEK 160 billion.

Municipal health care and social care services for the elderly are mainly (more than 80 per cent) financed by taxes levied by municipalities on their residents. A smaller part of this elderly care is financed by government grants to the municipalities. About 4 per cent of the costs are financed by charges.

Elderly with home care in ordinary housing or living in special housing

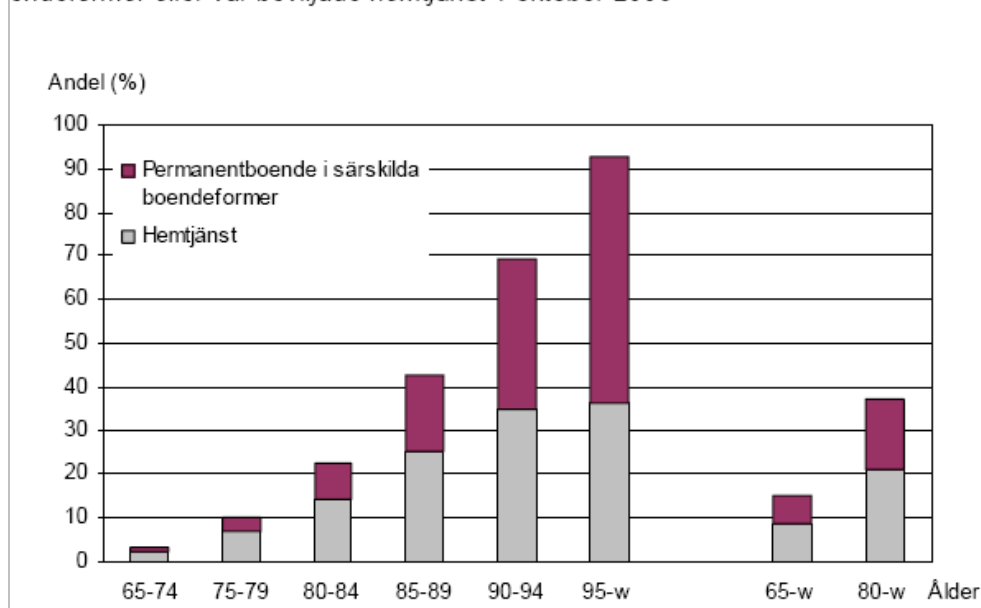
The need for assistance from elderly care rises with increasing age. This means that persons aged 80 or above account for the bulk of help recipients in elderly care. On 1 October 2006 almost 239 000 people aged 65 and above were living permanently in special housing or had been granted home care in ordinary housing; this corresponds to about 15 per cent of the population in this age group. The total number of places in special housing has decreased in recent years, while the number of people receiving home care has increased by almost the same extent.

About 140 300 people (about 8.6 per cent), have been granted home care services in ordinary housing and around 98 600 people (about 6.4 per cent) have been granted special housing.

Diagram A. Proportion (per cent) of the population living permanently in special housing or granted home care on 1 October 2006.

Proportion (%)
 Permanent residents in special housing
 Home care
 Age

Diagram A. Andel (procent) av befolkningen som bodde permanent i särskilda boendeformer eller var beviljade hemtjänst 1 oktober 2006



Among people aged 65-74 years some 3 per cent had home care in ordinary housing or were living in special housing, while the corresponding proportion in the oldest group (aged 95 and above) was around 93 per cent. In the age group 80 years and above some 37 per cent either had home care or lived in special housing.

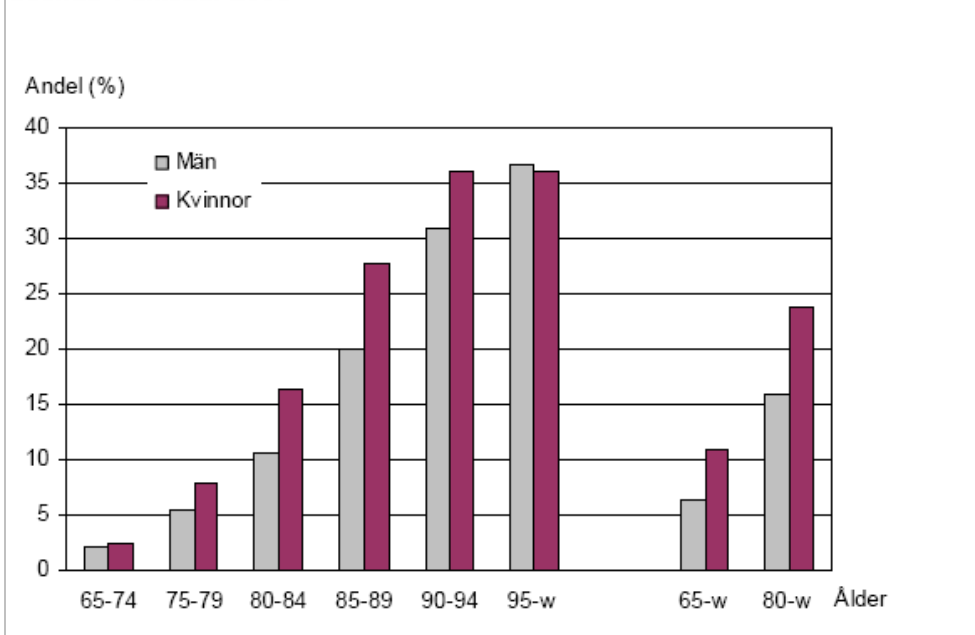
Home care

The municipalities reported some 4 362 200 granted hours of home care in October 2006, an increase of some 21 per cent since 2000. Just over 140 300 elderly people living in ordinary housing had been granted home care, an increase of about one per cent of the population aged 65 and above. The number of persons with home care in the 80 and above age group has increased each year since 2000.

Diagram B. Proportion (per cent) of the population granted home care in ordinary housing on 1 October 2006.

Proportion (%)
Men
Women
Age

Diagram B. Andel (procent) av befolkningen som var beviljad hemtjänst i ordinärt boende 1 oktober 2006



In the age range 65 to 94 years a higher proportion of women than men have home care. Among the oldest persons – aged 95 and above – the difference between the proportion of men and women was marginal and in the other direction.

Of all persons aged 65 years and above granted home care on 1 October 2006 some 39 per cent had been granted between 1 and 9 hours of assistance per month, 22 per cent had between 10 and 25 hours of assistance and 3 per cent had 120 hours or more. Among women aged 95 years and above the proportion of people with a relatively large number of home care hours, i.e. 120 or more, was much higher than for the other groups. Men aged 95 years and above and men and women aged 65–74 years also had a larger proportion of people with a relatively large number of home care hours than other groups.

The percentage distribution of all persons aged 65 years and above with home care has been broadly unchanged in the period 2000–2006.

Form of management

Some 11 percent of all persons aged 65 years and above granted home care mainly received services provided by the private sector. This refers to home care services that the municipality has ultimate responsibility for but that are provided by some other party than the municipality, such as a company, trust or cooperative, on behalf of the municipality and for payment by the municipality. In 2000 the corresponding proportion was about 7 per cent. Some 12 per cent of the

granted/estimated hours of assistance reported by the municipalities for October 2006 were produced by private care providers. The corresponding proportion for October 2000 was about 7 per cent.

Municipal home health care in ordinary housing

In 2005, 145 municipalities were responsible for all or part of home health care in ordinary housing and in day care (not for work by doctors). Around 48 600 elderly persons were registered as recipients of home health care on 1 October 2006 irrespective of whether or not they received care on that particular day. Some 70 per cent of those who received care were 80 years or above and most were women – some 65 per cent.

Table C. Percentage distribution by age and sex of persons aged 65 years and above who were registered recipients of municipal home health care on 1 October 2006.

Age years Men (%) Women (%) All (%)

<i>Tabell C. Procentuell ålders- och könsfördelning bland personer 65 år och äldre som var registrerade som mottagare av kommunal hemsjukvård 1 oktober 2006</i>			
Ålder	Män (%)	Kvinnor (%)	Samtliga (%)
65–79 år	13	17	30
80–w år	22	48	70
65–w år	35	65	100

Around 71 per cent of the 48 600 elderly registered as recipients of home health care had also been granted home care.

Short stay accommodation/short-term health care

Short stay accommodation/short-term health care refers to temporary accommodation in special housing combined with treatment, rehabilitation and nursing for purposes including respite care, recurring periods of respite care or treatment and aftercare. On 4 October 2006 around 9 000 elderly persons were in short-stay accommodation. This corresponds to about one half of one per cent of the population aged 65 and above and is an increase of about 600 persons compared with same period in 2000. About 55 per cent of the persons in short stay accommodation were women. The number of resident days in short stay accommodation amounted to 255 500 in October 2006. A comparison of the number of resident days in October 2003 and October 2006 shows that the number of resident days in short stay accommodation has increased by about 16 per cent.

Day care

In this context day care refer to support provided on an individual basis, under the Social Services Act or the Health and Medical Services Act, during daytime in the form of occupational therapy, socialising with other people, treatment, rehabilitation, etc. for people with, for example, dementia or mental or physical disabilities. "Open activities", i.e. activities that people can take part in without having individual decisions, such as café activities and other forms of meeting points, are not included. Around 12 800 elderly persons had decisions on day care on 1 October 2006. Most of them were women – about 64 per cent. As shown in table E the number of people with needs-tested day care decreased gradually between 2000 and 2005 but increased by 5 per cent from 2005 to 2006.

Table E. Number of persons aged 65 and above with decisions on day care, 1 October 2000–2006. Rounded figures.

Year Men (%) Women (%) All (%)

<i>Tabell E. Antal personer 65 år och äldre med beslut om dagverksamhet 1 oktober 2000–2006. Avrundade tal.</i>			
År	Män	Kvinnor	Samtliga
2000	5 500	10 000	15 500
2001	5 100	9 200	14 300
2002	4 600	8 300	12 900
2003	4 500	8 200	12 700
2004	4 400	8 100	12 500
2005	4 400	7 800	12 200
2006	4 600	8 100	12 800

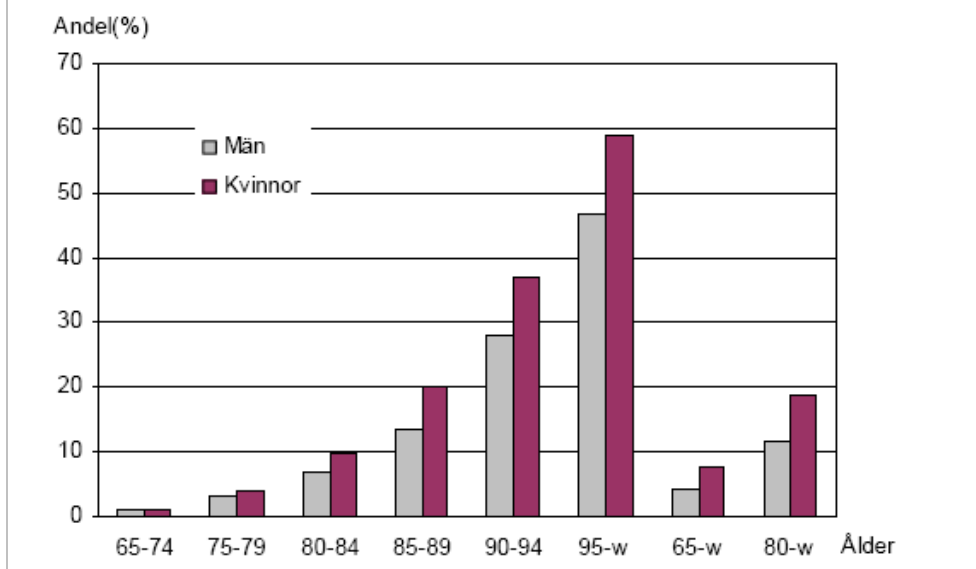
Residents in special housing

The number of residents in special housing has decreased by about 17 per cent since 2000. In relation to the population aged 65 years and above this means a reduction of the proportion from about 8 per cent to about 6 per cent, and in the 80 and above age group from about 20 per cent to about 16 per cent compared with 2000. Some 81 per cent of residents on 1 October 2006 were 80 and older and some 70 per cent were women. The diagram below illustrates how the proportion of people living permanently in special housing increases with rising age as well as the differences between men and women.

Diagram D. Proportion (per cent) of the population living permanently in special housing on 1 October 2006.

Proportion (%)
Men
Women
Age

Diagram D. Andel (procent) av befolkningen som bodde permanent i särskilda boendeformer 1 oktober 2006



Form of management

Special housing can be run both by the municipality and by private health care and social care providers such as companies, trusts or cooperatives. The funding and supervision of elderly care are municipal responsibilities, regardless of whether the services are run by the municipality itself or by private health care and social care providers. On 1 October 2006 Some 14 percent of all special housing residents were living in privately run housing.

Housing standard

At the same time as the number of places in special housing has decreased, there has been an improvement in the housing standard. For instance, the number of residents in rooms without cooking facilities, a WC and a shower or bath decreased from almost 6 900 persons in 2003 to just over 5 000 persons in 2005, or by more than 27 per cent. At the same time, there has been a reduction in the number of multi-bed rooms and the number of people sharing a room with someone other than their spouse, partner or other family member. Out of the approx. 98 600 elderly persons living permanently in special housing some 56 per cent had 1-1½ rooms with cooking facilities, a WC and a shower or bath. After that the most common types of housing were 1 room without cooking facilities but with a WC and bath/shower (about 19 per cent) and two rooms with cooking facilities and a WC and bath/shower (just over 16 per cent). Around 5 per cent, or some

4 600 persons, lived in 1 room without cooking facilities, a WC or a bath/shower. Around 1 800 persons, or almost 2 per cent of residents, shared a dwelling with someone other than their spouse or partner or another person close family member. This data includes residents sharing all forms of housing, i.e. a share of a flat, a shared multi-bed room, etc.

Pensions and housing supplement

Sweden has a politically stable pension system that automatically follows economic and demographic developments. This gives long-term stability irrespective of developments and with no risk that the cost of income-based pensions will be shifted on to future generations. It is a system that also puts Sweden in a good position to be able to provide long-term basic security in an acceptable manner.

Anyone who has not earned an adequate pension through the public pension system is assured of a top-up guarantee pension. This compensation is financed via the central government budget. The guarantee pension can be paid from the age of 65 at the earliest to people born 1938 or later. Residence in Sweden for 40 years is required for full guarantee pension.

The Maintenance Support for the Elderly Act came into force in 2002. Maintenance support for the elderly is intended for people aged 65 years and older whose basic maintenance needs are not satisfied through other benefits in the national pension system. Most of those entitled to this support are elderly persons who have not lived in Sweden long enough (40 years) to qualify for a full guarantee pension. This support is a means-tested benefit.

The housing supplement for pensioners is an important part of the basic social protection provided to pensioners with a low economic standard. Just less than half a million pensioners receive housing supplement. The guarantee pension and maintenance support for elderly persons are adjusted upwards in line with the price base amount.

Care of the elderly in Sweden

National objectives for policy for the elderly

In Sweden, policy for the elderly aims at enabling older people to live independently with a high quality of life. Older people in need of health care and social care are entitled to help of high quality. Elderly care is provided in accordance with democratic principles and is mainly financed from tax revenue.

The Riksdag (the Swedish Parliament) has defined the following objectives for national policy for the elderly.

Older people are to:

- be able to lead active lives and have influence on society and their own everyday lives;
- be able to grow old in security and retain their independence;
- be treated with respect; and
- have access to good health and social care services

One of the most important principles of Swedish policy for the elderly is that public action is to be framed in such a way that older people can continue living in their own homes for as long as possible, even when in need of extensive health care and social care. An accessible society, good housing, transport services and home-help services are examples of important action to realise this principle.

Responsibility for care

Overall responsibility for care of the elderly in Sweden rests with the State. The Government and the Riksdag legislate and formulate guidelines for care of the elderly and who is to provide the various services involved. The general principles of the Swedish welfare state regarding care of the elderly are the same throughout the country, namely that social care and health care for the elderly are primarily public sector tasks and that care is to be provided by trained and qualified staff.

Sweden's first-tier units of local government, the 290 municipalities, are responsible for the social services and health care in special housing and day care (not for work by doctors). Health care is run by the regional units of local government – the 21 county councils. Half of the municipalities are responsible for home health care in special housing and in day care. In the other half it is the county councils that have this responsibility.

Swedish municipalities and county councils have a high level of autonomy by international standards. Local politicians are directly elected at general elections and both municipalities and county councils levy taxes. The legislation on social services and on health care allows the municipalities and the county councils very great freedom to plan and organise their own services and levy taxes in order to finance them. Thus, services for the elderly are organised and prioritised differently in different parts of the country. The work of both municipalities and county councils is regulated by national legislation.

The Social Services Act

A new unified Social Services Act came into force in 1982; a revised Social Services Act has been in force since 2001. This legislation is a framework law that emphasises the right of the individual to receive municipal services. People who need help to support themselves in their day-to-day existence have the right to claim assistance if their need "cannot be met in any other way". The services provided by the social services are based on assessment of the individual's needs of services and care. The needs assessment is carried out by a care manager employed by the municipality. A person who is not satisfied with the decision can appeal against it to an administrative court. Charges for the care of the elderly are levied under the Social Services Act. The national rules are designed to protect the individual against high costs.

The legislation indicates what expenses, over and above housing costs, are to be met out of the individual's reserved amount under the Act. Within the framework of these rules, each municipality decides its own system of charges and the specific charge payable by the individual. The individual has right to appeal the decision concerning the charge payable to an administrative court if he or she is not satisfied with the decision.

The Health and Medical Services Act

In 1983, a new Health and Medical Services Act came into force. Under this Act, health care has to be available to all members of society, thus ensuring a high standard of general health and care for everyone on equal terms.

Since 2003 people everywhere in the country have been entitled to freedom of choice in health care. Free choice means that patients can seek out-patient care anywhere in the country on the same terms as in their own county council area. When a county council decides on a course of treatment, such as hospital care, the patient is free to choose a hospital anywhere in the country.

The 1992 reform of elderly care (Ädelreformen)

Background

Public resources for health care and social care were expanded substantially in the 20th century. But right up until the 1970s the very great bulk of this expansion related to the building of institutions. The expansion of long-term medical care and old people's homes meant that elderly persons were looked after in institutions to a much greater extent than previously. The prime reasons for the substantial expansion of the number of places in old people's homes and in long-term care medical care were the large increase in the number of elderly people in society and the queues to places in institutions. But the relatively poor housing situation of elderly people was also of importance.

Responsibility in health care and social care of the elderly was divided up so that county council primary health care dealt with health care in ordinary housing while the municipal social services were responsible for the social care. The county councils were responsible for the nursing homes. The division of responsibility between the authorities responsible for care services meant that municipal nursing assistants did work of a social character and county council assistant nurses carried out health care in the individual's home. As social home care services and home health care were expanded in the 1970s and 1980s it became more possible for older persons to stay on in their ordinary homes and receive the health care and social care needed there. The division of responsibility became more and more blurred when large numbers of persons with extensive needs of health care and social care could stay on in their ordinary homes.

The persons being cared for in nursing homes at that time had complex care needs that varied over time or were persons with mental problems such as confusion, depression and memory loss. Many of them did not have access to any home other than the nursing home. The housing standard was low; most of the places were in two- or four-bed rooms and individuals were forced to share a room with people they did not know.

Many persons were being cared for at long-term clinics but did not need the resources available in conjunction with their clinic such as advanced resources for diagnosis and treatment, resources for emergency care and treatment, etc.

Many older persons also stayed for a long time at the psychiatric care facilities. There were special wards for persons with dementia. There were also persons with schizophrenia at the psychi-

atric care facilities. They often had long treatment periods and had therefore acquired institutional damage.

Patients in emergency medical care whose treatment there had been completed were obliged to remain in too resource-intensive a form of care because there was a lack of places in other forms of care. The opposite was also true with long waiting times at home before accommodation could be arranged in service housing, old people's homes or group housing. In 1990 a large number of people with dementia were still living in long-term psychiatric or physical in-patient care, at the same time as more and more people were being given the opportunity to live in group housing. Trials of day care and group housing for people with dementia were started in the 1980s in cooperation between the municipality and the county council.

All in all, the division of responsibility between municipalities and county councils concerning public care for the elderly was in need of clarification and reorganisation.

The reform

In 1992, a major national reform of policy for the elderly came into force. The purpose of the reform was to create clear lines of accountability and an organisational structure better suited to implement the objectives established by the Parliament. Financial resources and staff were transferred from the county councils to the municipalities.

Under this reform, the municipalities were given overall responsibility for social care and health care for the elderly and disabled. The municipalities were given overall responsibility for special housing accommodation (nursing homes, elderly homes, group housing and service homes) and daytime activities.

Under the reform it became the duty of municipalities to provide health care in special forms of housing and in day care but they were not given responsibility for the work of doctors, which remains under the county councils. The county councils are responsible for providing home health services, but can transfer this responsibility to the municipalities if agreed.

One important component of the reform was the transfer of financial responsibility for patients in county council hospitals and geriatric wards, whose medical treatment had been completed, from the county councils to the municipalities. The municipalities were given payment responsibility for patients whose medical treatment has been completed and who were staying in long-term physical care. This had the effect of greatly reducing the number of elderly "bed-blockers" in county council institutions, at the same time as municipal housing capacity for elderly in need of health care and social care was expanded.

Evaluations of the 1992 reform show three major outcomes related to the reform.

1. The possibility for the elderly to live at home has been reinforced even if the elderly need extensive care, by for example providing home care around-the-clock.
2. The former problem of "bed-blockers" in hospital care has been reduced.

3. Both the volume and the standard of special housing for the elderly have increased considerably.

Evaluations also show some deficiencies in the achievement of targets; for example, the supply of physicians in care of the elderly and the cooperation between municipalities and county councils.

Staying on at home

The main concept guiding the care of the elderly in Sweden today is that the elderly are to be enabled to continue living in their own homes for as long as possible.

Most elderly persons in Sweden, 93 per cent, live in ordinary housing. The general standard of housing is high. Grants for housing adaptation make it possible for elderly persons with disabilities to undertake the individual adaptations to their homes that they need in order to stay on in their own homes. Common adaptations include removing thresholds and rebuilding bathrooms.

Home care services

The services that are most important in making it possible for older persons to stay on in their own home are home care services. The municipal social services are responsible for the home care services that provide assistance with shopping, cleaning, cooking, washing and personal care to elderly persons living in ordinary housing who cannot cope on their own.

To enable elderly persons to continue living in ordinary housing, other forms of service are often provided in combination with home care services. Most municipalities offer meals services, security alarms and adult day care.

Even persons with extensive needs of health care can remain in their own homes, because home care services can be offered round the clock. Elderly persons are increasingly remaining in their own homes until the end of their lives, and even the severely ill receive health care and social care in their homes.

Adult day care

In recent decades, adult day care units have been established for both persons with dementia and elderly persons with somatic diseases. Many elderly persons with care needs live at home and are looked after by their families. The day care units for these elderly persons can therefore play an important role in giving the elderly supervision and care they need while allowing the family some respite. The number of elderly in these units at any one time is limited and care is provided by specially selected staff.

Personal safety alarms

Elderly and disabled persons can obtain personal safety alarms.

Short stay housing

Short stay housing/short-term care complements home help services and is an intermediate stage between regular housing, special housing and medical care, which allows people to remain in their own homes longer. Short-term housing and short-term care are used for rehabilitation, nursing after a hospital stay, home health care and a respite for family members (usually a spouse who is an informal carer).

Home health care

Half of Sweden's 290 municipalities are responsible for home health care in regular housing (not for work by doctors). In the other half it is the county councils that have this responsibility.

Assistive devices

The authorities responsible for health care – the municipalities and county councils – are required to provide assistive devices for the disabled. These services are regulated by the Health and Medical Act.

Home adaptations

Grants for housing adaptation make it possible for elderly persons with disabilities to undertake the individual adaptations to their homes that they need to stay on there. Common adaptations include removing thresholds and rebuilding bathrooms.

The municipalities provide grants for certain measures needed to enable disabled persons to use their homes efficiently. People can apply to the municipality for grants for home adaptations. The grants cover the entire cost, regardless of the applicant's income. There is no price ceiling for home adaptation grants.

Transportation services

Elderly and disabled persons who cannot use regular public transport are entitled to transportation services. The most common form of transport is a taxi, but special vehicles are sometimes included.

Users who have to travel outside the range of the local transportation services can be approved for national transportation assistance.

Special housing

Under the Social Services Act alternative forms of housing have to be available for people who are no longer able to live in their own home. Since 1992 the municipalities have been responsible for all types of special housing, a responsibility that includes social care as well as health care.

The most common forms are group housing for persons with dementia and nursing homes. There are also places for short-term care in special housing.

Family carers

Family members do a very great deal of work in health care and social care, and their contribution increased in the second half of the 1990s. The Social Services Act contains a provision that social welfare committee should assist, through support and relief services, persons caring for people close to them who are suffering from long-term illness, are elderly or have functional impairments. An incentive grant has been available to the municipalities for several years to assist them in developing new forms of support.

In 2006–2007, central government is providing 125 million SEK (EUR 1 = approx. 9.20 SEK) per year to enable municipalities to develop support for family carers, mostly a wife who cares for her husband.

Some municipalities provide financial compensation for family members providing help and care. In certain cases family members can be employed by the municipality and in other cases the person in need of assistance can obtain a family carer grant to pay a family member for the work done.

Service for the elderly

In 2006 a new Act authorising municipalities to provide practical services for older persons came into force. The Act is intended to prevent injuries among elderly due to falling accidents, etc. The Act stipulates that municipalities can supply services for elderly persons such as changing curtains, cleaning and washing without any further needs assessment. Charges for the services are decided by the municipalities but must not be higher than the municipality's costs. Many municipalities provide these services free or at a very low cost.

Health care and long-term care

In the Swedish health care system responsibility for health care is shared by the State, county councils and municipalities. The county councils operate the hospitals and out-patient clinics, while the responsibilities of municipalities include health care in special forms of housing.

Since 2003 people everywhere in the country have been entitled to freedom of choice in health care. Free choice means that patients can seek out-patient care anywhere in the country on the same terms as in their own county council area. When a county council decides on a course of treatment, such as hospital care, the patient is free to choose a hospital anywhere in the country.

Dental care

In 2002 dental care protection for the elderly was improved. New protection from high costs came into force for people aged 65 and older.

Client choice in elderly care

Since the early 1990s more and more municipalities have chosen to make all or parts of elderly care subject to competition. Initially this was primarily done through tenders for contracts. In the past ten years various client choice models have been introduced as an alternative or complement to tenders for contracts. In December 2006, 27 municipalities had introduced client choice or some similar activity and the same number again were planning to introduce it. Client choice primarily applies to social home care in ordinary housing, including practical services.

A handful of major actors operate all over the country and dominate the market for tenders, in particular special housing and social home care services. As more and more municipalities introduce client choice in social home care services, small business will also have the opportunity of competing with the nationwide companies. The Public Procurement Act does not contain any specific rules for the procurement of services with suborders according to the client choice model. The municipalities that apply the client choice model appoint their providers either through public procurement or through certification. Then certification is based on a number of pre-determined quality criteria for the provider.

The providers all receive the same payment in the client choice system, with the exception of supplementary services where the providers themselves set the price. As the price is given, the providers have to market themselves on the basis of their service quality instead. In contrast to the situation in a tendering system, providers in the client choice system have no “guaranteed” clients and must rely on old clients staying on with them and on being able to recruit new clients. Most clients come from the local area. Many users receive information about the various providers from their neighbours, friends and acquaintances, which means that the provider's reputation is important for the choice made by the user. In most cases the user's contact with the provider is through the home care staff carrying out the services, and the user's perception of the care staff will therefore characterise his or her assessment of the provider. In other words, it is important to match users and staff when the companies have to enhance their good reputation and establish a close relationship with users. Another way of strengthening the user's perception of quality is for the provider to try to meet the user's wishes for free services over and above the assistance included in the support decision.

Summing up, client choice means that the user is more able to influence how the services granted are provided, but also to obtain services over and above those included in support decisions, either for payment or free of charge. However, this choice presupposes the existence of several providers to choose between. Reports from the municipalities that have introduced client choice show that even small municipalities can meet the requirement of a choice between several providers even though the range is limited.

Client choice also presupposes that the user has the ability to assess and choose between different providers, but this is not always so. This is why it is important that the municipality does not just take decisions on measures but also makes sure that users who cannot choose by themselves also receive the support they need to transform the support decision into a measure that has been provided. Under the Chapter 3, Section 3 of the Social Services Act (2001:453) measures within social services shall be of good quality. The Committee has the same responsibility for developing and securing services whoever is the provider.

An inquiry has recently been appointed to investigate the conditions for, and present proposals on, how to increase freedom of choice concerning health care, social care, support and service, including special housing.

Dignity

An inquiry chair has been appointed to present proposals for a dignity guarantee for health and social care for older women and men. The dignity guarantee is intended to make clear to everyone what elderly care has to offer and what the older persons and their relatives can expect when they need elderly care.

Ageing with dignity

The development of health care and social care for older people is one of the Government's highest priority areas in welfare policy. Security, accessibility and a holistic view of the needs of the individual have priority. The Government's development work will be guided by the perspective of the individual.

The Government wants to:

- increase security and dignity by clarifying the content of elderly care;
- increase accessibility in health care and social care, especially for persons with extensive needs;
- support the development of forms of housing for the elderly;
- develop support for family members;
- work for better information about the quality of elderly care to both citizens and decision-makers
- support diversity among providers and freedom of choice for the elderly
- stimulate systematic reviews of medication prescribed for older people
- support the development of dementia care
- stimulate health promotion and preventive action
- reinforce developments by providing support for research on older people and ageing
- stimulate the development of new assistive devices wanted by older people and their family members.

Incentive grants for municipalities and county councils

Incentive grants amounting to SEK 1.35 billion (EUR 1 = approx. SEK 9.20) are paid to municipalities and county councils to increase the quality of health care and social care for older women and men. The priorities are access to doctors both in special types of housing and in ordinary housing, medication reviews, preventive work, dementia care, rehabilitation, diet and nutrition, and the social content of care.

Better access to doctors

Many older people with an extensive need of health care and social care in their home meet a doctor far too rarely.

Improving access to doctors for this group is an important measure to enable individuals and their family members to feel security. When doctors make home visits, are accessible and take part continuously in the health and social care of the older person, acute action can be avoided. This is needed to avoid unnecessary hospital admissions.

Medication reviews

Many older women and men use several pharmaceuticals that can, for example, result in them falling and injuring themselves. More frequent and regular medication reviews need to be carried out for older women and men living both in special housing and in ordinary housing. The government incentive grant is intended to support the county councils and municipalities in this work.

Preventive work

Preventive home visits are an important method of also reaching groups who are otherwise difficult to reach with health and lifestyle information. During home visits individuals can be given information about what opportunities are available in the municipality, such as local meeting points, activities in voluntary and community organisations, exercise for seniors, walking groups, the possibility of offering to do voluntary work or of receiving volunteer assistance, etc.

Falling accidents among the elderly are a major problem that causes human suffering and leads to major costs for society. A falling accident can have considerable consequences for the people affected, for their relatives, for municipal home care services and for health care. There are major possibilities of preventing falling accidents through preventive work.

Dementia care

It is important to have cutting-edge skills in dementia care in order to retain, develop and spread knowledge about dementia diseases, about good nursing and about the needs of dementia patients and their family members. Places that have dementia nurses, dementia care developers, other staff with specialist training in dementia care or dementia teams also have good conditions for joint working and for good dementia care. It is important for people with dementia diseases to be given a diagnosis as early as possible.

Rehabilitation

Rehabilitation in the health care and social care of older women and men needs to be developed in areas including cooperation in the planning, development and delivery of rehabilitation services. A rehabilitative approach needs to be developed and health care and social care staff need to be given guidance in various rehabilitation methods.

Diet and nutrition (nutrition science)

Competence is needed in nutrition issues so as to secure the whole process from planning to the enjoyment of food during the meal and so as to be able to monitor the result. Well-structured, specially customised action programmes can counter nutrition problems. Improved procedures and a clearer division of responsibilities need to be developed to better meet the nutrition needs of more and more very old frail people.

Social content

More attention needs to be given to the social needs of older people. Participating in various activities can break their isolation and provide valuable social contacts and togetherness. In order to be able to live an active life it is important to get help in maintaining contacts with relatives and friends, to be escorted to activities, to get help go out for walks and get fresh air, and to take part in cultural activities. Voluntary organisations can make a major contribution in, for instance, helping for older women and men to break their isolation and opening up possibilities for them to have contact with other people.

Open comparisons

Open comparisons of the quality, costs and efficiency of elderly care will be carried out annually, starting this year. Citizens, staff and decision-makers have to be able to compare different municipalities and county councils. The National Board of Health and Welfare has been instructed to develop, together with the Swedish Association of Local Authorities and Regions, a national system for open comparisons between municipalities' health care and social care of the elderly and between the home health care provided by different county councils. Quality indicators will be produced and the statistics and documentation in municipalities and county councils will be improved. Over and above this, national user surveys will be developed and the sample used in statistical surveys will be expanded so that the elderly are better represented.

Delegation on Elderly Living

The Delegation on Elderly Living has been tasked by the Government with proposing how more older women and men are to gain access to homes in intermediate housing. The Delegation will also review and follow the effects of the investment grant for special types of housing and follow and analyse the need for special housing for the elderly.

Investment grant for elderly housing

Financial support of SEK 500 million per year has been introduced as of 2007 for the construction of and conversion to special types of housing for the elderly. The grant available per square metre is SEK 2 600 for new construction and SEK 2 200 for conversion. The grant is available for up to 35 square metres per dwelling unit and 15 square metres per dwelling unit as regards common areas.

Dignity guarantee

An inquiry chair is to propose a dignity guarantee for health and social care for older people. This will clearly set out what all elderly care will have to offer and what the elderly and their family members can expect. The inquiry chair is to consider proposals for service or quality levels that must always be met. Special consideration will be given to the frailest people, those who are unable to make their voices heard on their own.

Free choice in elderly care

The conditions for greater freedom of choice in health care and social care are being investigated. The starting point for the proposals to be made by the inquiry chair is to increase freedom of choice for older women and men in need of social home care services and special housing and to promote diversity among providers. The inquiry chair is to present proposals for the design and regulation of a system of freedom of choice in publicly funded health care and social care of older people that gives individuals the opportunity to make their own choice from among a more diverse range of providers. The inquiry chair is also to present proposals on how to handle the approval of providers in a simple and efficient way and is to consider legislation requiring the municipalities to provide information about the choices available in its area.

Support for family carers

Family carers make very substantial contributions in health and social care. The participation and involvement of family members is often a precondition for effective health and social care. The Government is allocating some SEK 115 million in 2007 to stimulate municipalities to develop the support for family members providing care and assistance. The Government considers that the support for and assistance to family carers needs to be developed and strengthened, in part by regulating it more clearly in the legislation.

Technology for older people

In 2007–2009, SEK 22 million per year will be allocated to stimulate the development of assistive devices and services for the elderly. More information and greater accessibility of practical assistive devices and services will increase the ability of older people to find assistive devices and services in the market. Development areas can include equipment in the home for handling personal hygiene, help with planning or “memory aids”, the telephone, TV or other means of communication, smart guides, reliable automatic devices, simple remote controls or an attractive sup-

ply of services. For family members, an increased supply of new combinations of mobile services for the provision of both goods and services is important.

Research on the elderly

The Swedish Council for Working Life and Social Research has the task of providing financial support for research on the elderly and ageing. The Council is tasked with promoting the long-term development of broad and vigorous research in this area. The funding from the Government gives the Council the opportunity both of supporting earlier initiatives and of starting new initiatives. Examples of areas where more knowledge is needed are the organisation, governance and management of elderly care, health and social care for people with dementia and potential differences between men's and women's need of health care and social care.