

Sweden 2007

# Freedom of choice and dignity for the elderly

Minutes



On behalf of  
**European Commission**  
DG Employment, Social Affairs and Equal Opportunities



## Freedom of choice and dignity for the elderly

Stockholm, 13-14 September 2007

*The Peer Review was hosted by the Swedish Ministry of Health and Social Affairs.*

### Day 1

#### Welcome addresses

Welcoming the participants to Stockholm, Gunilla Malmberg (Ministry of Health and Social Affairs, Sweden) reminded them that Sweden has one of the highest life expectancies in the world, with more than 17% of the population aged 65 or above. A further sharp rise in this percentage is expected over the coming ten years. So it is not surprising that the ageing society and the care of the elderly are high-profile issues in Sweden. More research and development are needed if high-quality, cost-effective care for the elderly is to be enhanced or even maintained. Greater knowledge is required about a number of fields, ranging from adequate, well-functioning care systems to top-of-the-line dementia care. As in most European countries, the proportion of elderly people in the Swedish population is increasing. Undoubtedly, this is creating huge demands. Ageing is often seen as a threat to society, and older people continue to be regarded as a marginalised, vulnerable, resource-dependent, non-productive group. But of course, this is not true. Older people are a great asset to society. One challenge in the years to come will be to increase labour market participation and life-long learning among elderly people. It is a matter of survival for our society that it should make the most of older people's knowledge and experience. Investment in healthy ageing, and efforts to prevent early retirement, are productive contributions to economic growth. Over the last decade, Swedish government policy has been aimed at making it possible for older people to continue living in their own homes for as long as possible, even if they are in need of extensive care and social services. Over 90% of the elderly in Sweden live in their own, ordinary homes. Special housing is generally seen as an option to be used only when all alternatives have been exhausted. Over 70% of those living in special housing suffer from some kind of dementia. The emphasis on remaining in one's own home will help to meet the challenge of rising demand. In recent years, there have been ongoing discussions in Sweden about quality problems in care for the elderly and the lack of respect and understanding for individual needs. The elderly and their families need to know that they will be treated with respect if they become ill or otherwise care-dependent. And it is even more important to ensure that the most vulnerable receive respect for their dignity and rights. Obviously, people suffering from dementia must be a particular focus group in this regard. For the Swedish government, protecting and caring for elderly people is not just a social and medical issue, it is a moral one. The future system of care for the elderly must take account of the full range of opinions, both in Sweden and abroad. For this reason, the Swedish hosts were really looking forward to the Peer Review, and to hearing the visitors' suggestions for improving their system.

Roland Bladh (European Commission, DG Employment, Social Affairs and Equal Opportunities) thanked the Swedish ministry, on the Commission's behalf, for the invitation to conduct a Peer Review about freedom of choice for the elderly, regarding the care services and the security they might need, and how to ensure dignity for the elderly when they are receiving care. These are two very important and interesting visions which the seminar participants need to know more about. He hoped that the Peer Review would provide valuable input both to the Swedish participants and to

those from other countries and organisations. It was also important that it should provide input to the work of the Commission, within the Open Method of Coordination (OMC), on issues concerning social services of general interest, as well as work on more specific issues that are emerging about abuse and maltreatment in long-term care. The Commission would be organising some activities on this topic during the winter. Further national reports would be presented to the Social Policy Committee in 2008 and would form the basis for Commission working documents, which could also include inputs from this Peer Review. He thanked participants who had already contributed to the review by providing national papers, together with the thematic and network experts and the organisers of the event.

### Introduction to the Swedish policy

The care system for the elderly in Sweden differs from that in other parts of Europe, Karin Hellqvist (Ministry of Health and Social Affairs, Sweden) pointed out. Some peer reviewers had already noted this in their papers.

First, she outlined the governance structures in Sweden. There are three levels: national, through the elected parliament which decides on the formation of the government; regional, through 20 elected county councils and 1 local authority; local, through 290 elected municipal councils. At the national level, responsibility for care for the elderly rests with the Ministry of Health and Social Affairs as well as several national bodies, including the National Board of Health and Welfare. The responsibilities at this level are legislation, supervision, evaluation and follow-up. The 20 county councils and 1 local authority are responsible for organising and providing health services to all residents, as well as promoting public health. At the third level, the municipalities are responsible for care for the elderly and disabled. About half of Sweden's municipalities have integrated care, which means that they are responsible for both health care and care services for the elderly. The regions and the municipalities have a high degree of autonomy, although there are rules setting the framework for their decisions. So care services are not the same all over the country, and there are some inequalities. Care of the elderly is almost totally financed by taxes. The user only pays a fraction of the cost, 4 per cent. The largest share of the cost, about 80 per cent is covered by local taxes. National taxes cover the remaining cost of care for the elderly, about 10-15 per cent. The cost for the elderly care in 2005 amounted to SEK 80.3 billion at the municipal level. If health care of the elderly at the county council level (i.e. hospital care and out-patient care) is included the cost doubles to approximately 160 billion SEK.

The national authorities – the National Board of Health and Welfare – Socialstyrelsen - (focusing health care issues) and the 21 County Administrative Boards - Länsstyrelser - (focusing social services issues) – are responsible for: supervision, follow-up and evaluation of municipal and county council caring services. The County Administrative Board supervises both municipally and privately run services. The County Administrative Board has the right to inspect all social service activities in the county, whether they are municipally or independently run.

Two important regulations affect care for the elderly. One is the Social Services Act, which came into force in 1982. It states that the elderly have the right to receive public service and health at all stages of life. Anyone who needs help in order to support themselves in their day-to-day existence has the right to claim subsistence if their needs cannot be met in any other way. The social services may not take individual financial situations into account. So it does not matter how much money a person has. Under the Social Services Act, a person who is not satisfied with a decision has a right of appeal to an administrative court. The fees payable by users are also regulated by the Social Services Act.

Municipalities can charge different fees, but only within the limits set by the Act. The other is the Health and Medical Services Act, which also protects users against high costs for health care. This Act further specifies that there is freedom of choice in health care. For example, patients can choose a hospital anywhere in the country.

The aims of health care for the elderly in Sweden have, for decades now, been guaranteed finance, security, good housing and service, and care according to needs. Public supervision is to guarantee high standards of care, and all elderly persons are to have equal access to these welfare products, regardless of age, sex, ethnicity, place of residence and purchasing power. If spending by the county councils on elderly people is taken into account, the total amount spent on care for the elderly in Sweden today is about SKR 160bn.

The policy is that, if elderly people wish to stay in their own homes, they should be able to do so, and the necessary support should be available. About 93% of elderly people do opt to continue living at home. This evolution from living in institutions to living at home has been going on for a number of years now in Sweden. Technical means have been developed to assist this, and the health of elderly people in Sweden is now much better than it was 20 years ago. The Government is financially supporting the sector with 2 billion SEK (211 million euro). One area covered by the government's contribution is technology and housing improvements. The government wants to make it possible for the elderly to live independently in their homes. To increase the quality of health care and social care for older women and men the Government pay incentive grants (SEK 1,35 million) to municipalities and county councils.

Seven fields have been identified for quality improvements:

- **Better access to physicians** for the elderly, whether they are living in their own homes or in special housing. People should not be obliged to go to hospitals in order to see a doctor. So the priority is to get more doctors to make house calls.
- **Development of dementia care.** In particular, the earliest possible diagnosis of dementia is important, both for the person concerned and for the relatives.
- **Rehabilitation.** Cooperation on the planning, development and delivery of rehabilitation services is needed.
- **Nutrition.** The competence of nutritionists must be fully used in the care of the elderly.
- **Prevention.** Home visits are an important form of contact with groups who are otherwise difficult to reach, and provide them with information on health and lifestyle. They can also help to prevent falling accidents, which can be very dangerous for elderly people.
- **Supervision of pharmaceutical products.** More frequent and regular medication reviews need to be carried out for older women and men in order to prevent accidents, as elderly people often have a number of medicines to take. The government incentive grant is intended to support the county councils and municipalities in this work.
- **Social life.** Elderly single women in particular often suffer from isolation, which can be very depressing. Social contact is important, and voluntary organisations can play a vital role in this.

Research is another area supported by government funding. The Swedish Council for Working Life and Social Research is given the opportunity both to support existing initiatives and to launch new ones. The organisation, governance and management of care for the elderly and of health and social care for people with dementia are among the research topics.

Family carers should be supported, but nothing in Swedish law says that children should take care of their parents, or that spouses should be responsible for each other's medical care. That is society's duty. But of course, a lot of people do want to take care of each other. Recently, Swedish legislation has been drawn up to provide support for family carers, but this is quite a new policy. The government has allocated funds to stimulate the municipalities to develop support for family members providing care and assistance. This year, the total is about SKR 125m. The government believes that support for family carers needs to be developed and strengthened, in part by regulating it more clearly in the legislation, and work on this is currently in progress.

A Freedom of Choice Commission has the task of stimulating more providers of services and care for the elderly. The Swedish government wants to increase freedom of choice in order to strengthen elderly people's ability to influence their own everyday lives. This is also a matter of dignity, and another commission has been established by the government to explore the possibilities for developing a national guaranteed standard of service and care for the elderly. Both Commissions will report in March 2008.

In 2005-2007, SKR 1bn have been provided to the municipalities in order to enhance staffing and improve services, through a scheme called Steps for Skills. This aims to improve the skills of staff engaged in caring for the elderly.

As a consequence of the policy of helping the aged to remain in their own homes whenever possible, those who are in special housing these days are more frail and dependent, in terms both of functional and of cognitive capacities. This has increased the pressure on municipal services caring for the elderly. Currently, there is a debate in Sweden about whether the principle of staying on at home has gone too far. A consensus has been reached on the need for more special housing, and the new Centre-Right government has announced that such provision will be increased, as well as other private and public housing alternatives for the elderly. To stimulate more building of housing for the elderly by the municipalities and the regions, the government has decided to award SKR 500m annually in state grants over the coming years.

### Questions and answers

**Gijs Adriaansens** (Ministry of Health, Welfare and Sport, Netherlands) asked who owns the special housing and whether residents pay rent. If so, are the care and the rent billed separately or together? Do issues of affordability mean that better-off people have greater access to special housing? **Kent Löfgren** (Ministry of Health and Social Affairs, Sweden) replied that everyone in Sweden is entitled to a home and special housing is no exception to that rule. Special housing is rented, but on the basis of a needs assessment. The municipalities, who rent out the housing, ensure that residents have access to staff round the clock, so that adequate help is always available within a very short time. Everyone can afford the rent, because people on low pensions can get a household grant, which is available to people renting any kind of housing, but also an additional grant to pay for special housing. **Gijs Adriaansens** asked if a variety of special housing is available to meet different wishes (for example, as regards the size of the accommodation). **Kent Löfgren** answered that special housing is fairly standardised. So do many people prefer private nursing homes, **Gijs Adriaansens**

enquired. No, Kent Löfgren replied, there is not much of a market for private, self-financed care. Almost all provision in Sweden is based on needs assessment, which gives access to financing. There are private providers who work under contract to the municipalities, but the financing is still public.

Clemens Tesch-Römer (Thematic Expert - German Centre of Gerontology) asked about quality control and comparability within care for the elderly. Minga Orkan (Ministry of Health and Social Affairs, Sweden) replied that the Swedish government has commissioned the National Board of Health and Social Welfare to develop special quality indicators. This work is being done in close cooperation with the Swedish Association of Local Authorities and Regions, which in the summer of 2007 published the first review of indicators in the area of care for the elderly. At the end of 2007, the National Board will publish the first report. At the same time, there is a drive to collect statistics on each individual – an essential task if true quality indicators are to be developed.

Martin Schenk (Diakonie Österreich, Austria) wanted to know more about the Swedish social security reforms of 1992. Had they helped to bring care services and health services for the elderly closer together? Isabel Borges (AGE, European Older People's Platform) asked how the continuum of care is handled – for example, if an elderly person is in hospital and then goes home again. In many countries, these situations tend to lead to a disruption of care. How are the health care and social budgets coordinated in Sweden? What are the benefits that the Swedish government has decided to give to family carers – are they cash benefits, training, respite care, or a pension? Will a growing reliance on family carers mean a return to a more Mediterranean system of caring for elderly people? Is the Steps for Skills programme open only to healthcare professionals, or is it also available to informal carers? Philippe Swennen (AIM - International Association of Mutual Benefit Societies) asked if any figures are available on differences between the Swedish regions in terms of care for the elderly. If such differences exist, how might they be decreased? He also asked for more details of the Steps for Skills programme. Jane Carolan (Health Services Executive, Ireland) asked if the cost of care to the users is the same whether they are in special housing or they stay at home.

Karin Hellqvist explained that, under the Social Services Act, needs assessments must be individual for every person. This means that the care manager must listen very carefully to each user and take account of their wishes. If an individual is dissatisfied with the care manager's decision, an appeal can be lodged with the administrative court. Minga Orkan added that the reform of 1992 was the most comprehensive public administration in modern time in Sweden. Responsibility for up to 40,000 beds had been shifted from the county councils to the municipalities. The cost of this transfer had amounted to more than SKR 20bn, in 1992 figures. At first, many county councils had not wanted to lose this area of responsibility, and many municipalities had been afraid of taking it on. Kristina Jennbert (Swedish Association of Local Authorities and Regions) said that, although the transfer from the county councils to the municipalities was politically difficult at the time, it had to be done once more elderly people started deciding to stay in their own homes. The task is not yet finished, because there is still a need to achieve more integrated care by ensuring that the municipality has complete responsibility for health care and district nurses. Minga Orkan added that the government contributed SKR 3bn towards the cost of transferring the responsibilities and to help the municipalities in building new special housing for the elderly. She explained that the term "special housing" covers nursing homes, residential homes for the elderly, service houses and group housing. In particular, group housing for people with dementia began to develop in the 1990s after the reform. Considerable emphasis was also placed on the need for information, training and education. Government grants were also given for these tasks. Niclas Jacobson (Ministry of Health and Social Affairs, Sweden) said that the government initiative had concentrated on improving the skills of the less highly trained care staff, rather than the medical staff. SKR 1bn were earmarked for this, and all municipalities were

eligible to apply for training grants. Quite a large organisation was built up within the ministry to contact, help and support the municipalities in this respect. This proved quite successful. Almost all of the 290 municipalities sought and received grants for this training. It is a little too early to evaluate the success of the training courses themselves, but there has certainly been more concentration on the competences of care staff. The themes for which the municipalities sought grants were highly relevant to questions of dignity and ethics. Philippe Swennen asked if Sweden plans to introduce accreditation for care staff. Niclas Jacobson replied that there is currently a discussion going on about this, but no decision has been taken.

Regarding the cost of care to the user, Kent Löfgren explained that the size of pensions varies greatly in Sweden. They can often be quite low. Instead, the welfare system is based on income protection, or more precisely on what is called "high cost protection". In the case of rent, it is possible to obtain a household allowance that will cover up to 93% of SKR 5,500 per month. That is the highest household allowance available, and it is means-tested. At the other end of the scale, the last SKR 1 of household allowance does not disappear until the person's pension reaches the level of SKR 12,000 – 14,000 per month. This is an important element in the Swedish system, making it financially possible for everybody to carry on living in their own home. For care services, high cost protection also exists. The rule is that a person must have at least SKR 4,300 per month available for spending on his or her own needs, not including rent. Below that threshold, no care fees are payable. About 19% of those using home care services are on low incomes, so they do not pay any fee. For the others, the fee varies up to a maximum of SKR 1,600 per month, regardless of how much care is needed. Even if the care is provided 24 hours per day, the fee cannot rise above that maximum. Meals supplied to pensioners by the municipality are charged at cost price. The monthly charge varies between SKR 1,200 and about SKR 3,500. Municipalities can lower this charge for needy cases, but not all of them do so. High cost protection also operates for medical care. The maximum charge is SKR 900 per year. For hospital care, the maximum that can be charged is SKR 80 per day, including meals. The maximum charge payable for medication is SKR 1,800 per year.

### Presentation of the Discussion Paper

Clemens Tesch-Römer pointed out that EU Member States are committed to three goals in terms of long-term health and social care. In the European Commission's Joint Report on Social Protection and Social Inclusion (2007), they are defined as:

- **Access for all to adequate health and long-term care**
  - The need for care should not lead to poverty and financial dependency
  - Inequities in access to care and in health outcomes should be addressed. *(He suggested that as well as being addressed, they should be mitigated).*
  
- **High quality in health and long-term care**
  - Adapting care to changing needs and preferences of society and individuals. *(This, he emphasised, means that services have to adapt to the needs of individuals and society, rather than the needs having to adapt to the services).*
  - Developing quality standards reflecting best international practice. *(This is an important task, and many Member States, including Sweden, are already engaged in this process).*
  - Strengthening the responsibility of health professionals and of care recipients. *(Social care should, he explained, strengthen the freedom of choice and the dignity of the elderly. This also means strengthening their autonomy. Hence the need for both, care recipients and health professionals, to take responsibility).*

- **Affordability and sustainability of adequate health and long-term care**
  - Promoting rational use of resources (e.g. coordination between care systems).
  - Promoting healthy and active lifestyles.
  - Maintaining and encouraging good qualified staff for the care sector. (*What is left out of this list, he commented, is the need for Member States to put enough money into the system. This is one of the points under discussion in, for example, the German government's current proposal for reform of the legislation governing the long-term care system*).

At the European level, he emphasised, health care and social care are combined. So these goals apply to health care as well as long-term care. And in old age, both are needed if adequate care is to be provided.

He and those who had helped him to compile the discussion paper had looked at issues of transferability. Seen from Germany, Scandinavia is a social policy paradise, and Sweden is at the centre of that paradise. So Germans can see many elements that might usefully be transferred from Scandinavia into their own system. Indeed, the German Health Minister was planning to visit Sweden in order to learn from the Swedish example.

He suggested five possibly *transferable elements of the Swedish system*:

- **Healthy ageing – avoiding (and accepting) dependency.** There is an emphasis on prevention, starting early in life, and a conviction that the promotion of a healthy lifestyle up to old age is necessary and meaningful. This also means that health care should be accessible to all, whether young or old and whether they have less or more money. However, when dependency starts in late life, this is accepted in Sweden and there is a very good infrastructure for dependent people. This balance between the promotion of healthy ageing and the acceptance of frail ageing could be a role model for other countries.
- **Access to care services – reducing inequalities.** Care service access is high in Sweden, both for home care and for residential care (known as “special housing” in Sweden, but he found this term unfortunate). There are waiting lists, but this could be related to the general attitude in Sweden that it is good to promote the use of care. In Germany for example, residential care would be seen as the last resort, whereas in Sweden it is accepted that it is possible to live well in “special housing”. The cost to the individual of using the Swedish services is rather low, and it is affordable for all. There appear to be no poverty risks connected to long-term care in Sweden. There are national frameworks for mitigating regional disparities in Swedish care. This is important in a system where the responsibility for care rests mainly with the municipalities.
- **Consumer direction – supporting freedom of choice.** People in need of care certainly should have freedom of choice. However, the choice alluded to in Sweden is very often one between public and private providers, and he was not sure if this is what is most important to old people. The choice between home care and residential care is perhaps more relevant to them. A situation should be avoided in which people are pressed to continue living at home when in fact they might prefer residential care. In Germany, although there is also an emphasis on care at home, the proportion of those opting for residential care has increased significantly over the past ten years, since insurance for long-term care was introduced. But the most important element of choice, in his view, is choice within the care process (“I don’t

want to have my hair washed today. I'll call you tomorrow.”) This freedom is very important to people in need of care.

- **Qualified staff.** Competent and motivated people are the backbone of good care. Sweden supports continuing staff education with a variety of qualification programmes, of which Steps for Skills is one example.
- **Financial sustainability – mediating between different claims.** He had been impressed by Sweden’s ability to create a society for all generations. This includes a rather high level of spending on long-term care, which appears to be based on a high societal consensus.

These are the positive aspects of the Swedish experience. He also pointed to four *open questions*:

- **Quality of care – defining, measuring, and allowing public access to quality indicators.** Ensuring a high quality of care is a problem in many EU Member States. A basic issue here is how to define “good care”. The second report on the quality of long-term care in Germany, which had been published just before this Peer Review, actually showed that it had improved. But coverage in the popular press had nonetheless been headlined “Care Shock”. This was because the report stated that 10% of residents in Germany’s long-term care and residential care facilities are not adequately cared for, according to the standards set by the German health insurance funds. This is, of course, completely unacceptable. However, the definition of “adequate care” used is a very narrow one. Feeling that it needs to be broadened, he suggested that a reference could be made to human rights. We need to think about how we would like to live when we are old and frail. On the other hand, it should not be too broad, because nobody can actually be guaranteed a good life. The definition needs further discussion and work. But definitions alone are not enough. There need to be regular checks on the care, whether residential or at home. The periodicity of these checks – yearly, every other year, every three years – is open to discussion. But they do have to be regular. These quality checks must be transparent and there must be public access to the results. He cited the approach taken by the American website [www.medicare.gov/NHCompare/home.asp](http://www.medicare.gov/NHCompare/home.asp). Visitors to that site can type in a zipcode and call up details of all the residential care facilities within a 10-mile (16 km) radius. Then all the relevant outcome quality indicators are available for each facility – for instance, the percentage of residents with pressure sores.
- **Guaranteeing a continuum of care – making health and social care services cooperate.** There are still open questions about this, even in the Swedish system and in other European countries as well. Two possible ways of achieving integrated care are case management and care management. Case management is more oriented towards the needs of each person, while care management is more concerned with bringing the systems together. One approach used in Germany is to combine funds from different sources into personal budgets. But no good solution to this problem has been found yet.
- **The family and the State – crowding out or crowding in?** What is the relationship between the family and the State? Are they rivals? Probably, we need to find a solution in which there are “mixed responsibilities” between formal and informal care. Formal services and families should each do what they can do best. Families can provide the better emotional support, while the better professional care will probably come from the State. Supporting

family carers is also an important task for the future. Most such carers are women, although sons are also now taking on more of the responsibility for caring for elderly parents.

- **The role of technology – using intelligent tools in an intelligent manner.** The care sector often regards technology with some suspicion, as care is communication between people. If used intelligently, however, technology could in fact leave more time for communication and human interaction. The documentation process, for instance, can be supported by technology. Communication with people living at home, and security, can be improved. So what are the barriers to using technology? Attitudes are not the only problem. The cost of technology can also be hurdle, as can the fact that technology is not always usable by everybody. Technology needs to be developed that is equally usable by old people and young people, and people with and without disabilities. So the development of assistive devices is an important task for the future.

### General discussion

Henk Nies (Vilans – Centre of Expertise for Long-Term Care, Netherlands) asked how equality of care for all citizens can be ensured right across a country. Sweden too is struggling with this problem whereas, in his view, the Netherlands has too much equality. The reverse side of equality is standardisation, without any tailor-made care. Countries that decentralise the responsibility for long-term care, devolving it to the municipalities, have to accept that there should be democratic control and that the care should be tailored to regional and municipal circumstances. Why should it be a matter for concern that there are inequalities across the country in a decentralised system? Does democracy not work at local level? On the other hand, how can we ensure that the differences are not too big, because we do need some kind of minimum level? So can a certain kind of equality be ensured while at the same time seeing to it that local government shoulders its responsibilities and provides tailored care to the region concerned? In caring for older people, we do not want uniformity, but we do want standards. So, where should the balance be struck? Clemens Tesch-Römer replied that his paper was not necessarily a plea for equality. He believed that both equality and variety are needed. Specific interventions are needed for individuals, who are all different. For this reason, it is a good idea to give a large measure of responsibility to the municipalities, who are best placed to know where the problems are. However, whenever individuality leads to unjustified and unjustifiable differences in quality, we have a problem. The risk of individualisation is that the system as a whole would no longer be accepted, if it provides much lower standards of care in some places than in others. If we guarantee equality at a high level, this is at least a step in the right direction. And this is the case in Sweden. The uniformity in Sweden is uniformity at a high level. Everybody gets good care. If rich people need more, he trusted their money and skilfulness to find a solution.

Fernanda Rodrigues (Coordinator, National Plan for Social Inclusion, Portugal) felt that, at some point, the discussion would have to be conducted on a different basis, given the very varied circumstances of the countries taking part. In Portugal, for instance, equality still plays a very important role. Only if there are basic standards can specificities be taken into account. After all, the main specificity in human services is human beings. The southern countries are a different world, of which she is part. They still have a long way to go in order to ensure that equality is important right across Europe. Specificity can lead to the abandonment of some of the pillars of quality. Ideally, there should be both specificity and quality, but this is a question of priorities. In her view, national if not European or international standards are needed if quality is to be ensured. Clemens Tesch-Römer added that the second report on the quality of long-term care in Germany, both at home and in residences, enables comparison of different groups of facilities: those that are more costly and those

that are cheaper; those run by welfare associations and churches and those run by private business; those that have a certified quality management system and those that do not. Interestingly, no differences emerge between cheap and costly institutions. So the idea of a minimum standard of quality is an issue. But in many countries, there are also more basic questions to be tackled. Björn Halleröd (Network of Independent Social Inclusion Experts and Department of Sociology, Umeå University, Sweden) distinguished between equality of outcomes and equality of choice. In Sweden, municipalities' ability to offer equality of choice varies greatly, not least because the biggest local authority has more than 700,000 inhabitants while the smallest has about 2,500.

Jane Carolan (Health Services Executive, Ireland) pointed out that Ireland has been moving in the opposite direction, by centralising everything in order to reduce inequality. In 2005, a large-scale reform of the Irish health and social services established one body for delivering all of them. Although the Republic of Ireland has a population of just over 4 million people, they had been experiencing very different standards of service, depending on where they lived. The present centralisation may be only temporary, however. Once equality has been established, the trend may be reversed, because there is an awareness in Ireland that local delivery is better. It is difficult to strike the right balance between maintaining some local responsibility and making sure that a clear policy is interpreted in the same way everywhere. 68% of Irish institutional care is provided by the private sector and 32% by the public sector. This is another huge challenge, particularly as the private sector has been financed by tax incentives which have not been tied to where the need is. So there are institutions, particularly on the western seaboard, where nobody lives, whereas there is a real scarcity of choice in Dublin, where most of the population lives. In terms of quality, the private facilities are currently inspected but the public ones are not. This is because the Health Services Executive, which runs the public facilities, is also in charge of inspections. This is about to change. Under the reforms, a wholly independent body has been set up to verify quality across all health care and social services. In 2008, it will start inspecting both the public and the private facilities. Ireland has been developing a lot of quality standards in this field. So she would be very interested to learn about the Swedish ones and to compare them with Ireland's draft Charter of Rights for Older People, which is currently out for consultation. Two years' work has gone into this Charter, including a lot of consultation with stakeholders. Philippe Swennen asked if the Irish private providers are for-profit. Mostly for-profit, Jane Carolan replied. There are a few not-for-profit private providers, but they are a very small minority. There ought to be more. Philippe Swennen asked if the rates charged to the user are the same in the public and private sectors. Not at present, Jane Carolan said, but a new system to be introduced in January 2008 will equalise the charges. Are standards higher in the public or the private sector, Philippe Swennen asked. The public perception in Ireland is that the public sector care is better and that private is bad, Jane Carolan answered. However, an objective comparison will not be possible before 2008, when measurements in both sectors will begin. Generally, the public sector takes care of the most highly dependent older people. The private sector is often unwilling to do so. Isabel Borges asked if there are waiting lists in Ireland. There are long waiting lists for public facilities, Jane Carolan said. Also for private facilities in the Dublin area. So people move 60 miles (about 95 km) out of Dublin when they need care. But in the West of Ireland, there are no waiting lists for private care. However, it is expensive. Are care charges means-tested, Isabel Borges asked. Currently, there is means-testing for both public and private care, Jane Carolan explained. For those needing private care, a grant is available, but it certainly does not cover the whole cost, particularly in Dublin. The new system will be means-tested and will be fairer, because the same charges will be payable in the public and private sectors, and the level will depend on the person's means.

Minga Orkan (Ministry of Health and Social Affairs, Sweden) pointed out that Sweden has two important mechanisms for reducing inequalities, which certainly do exist at the municipal level. The first is national directive supervision, through inspections. The other, which is now being developed, is open comparisons, similar to the US system mentioned by Clemens Tesch-Römer. The present Swedish government hopes that open comparisons will greatly reduce the differences between municipalities. One big difference at present is in the municipal costs for care. For example, costs for home help services are up to seven times higher in some municipalities than in others. This municipal cost gap is not caused by structural differences alone, according to a recent report from the National Board of Health and Social Welfare. The report concluded that there is still scope for improving the efficiency of these services in Sweden, and reducing the differences between municipalities in the process.

### Site visit to the Sofiero Senior Centre in Nacka

Welcoming the peer reviewers to the centre, its Director Marika Westerblom explained that it offers domestic care facilities as well as a centre where people can meet during the day. There are also residential facilities for the elderly. There are some 250 clients and a staff of around 100 people. The idea behind the day centre activities is that elderly people should be able to carry on living in their own homes for as long as possible. Generally, people arrive at the centre at about nine o'clock in the morning and stay until around three in the afternoon. They have breakfast, lunch and afternoon coffee at the centre. For the rest of the time, certain activities are planned for them. These include memory training, bingo and music. For people who need to break out of their isolation and achieve greater security, while receiving some assistance, the centre offers social activities and physiotherapy. This focus concerns the majority of the clients – some 40-60 every day, out of a total of 70-80 registered clients. They are people who need some domestic help while they are living at home. Another section is for people who have just recently been diagnosed with dementia but still have most of their faculties. They can still do the basic household chores, but they need some assistance. For those whose dementia has gone further, help and training are available for basic tasks such as domestic chores. For example, they may be able to lay the table, but they cannot complete the process without some guidance. The day activities are also open to those living in the residential facilities. They can come and go more or less as they please. There are 42 people in the residential facilities. The three levels of day activity take about 30 people per day – ten in each. A total of six staff work in the three day sections – one occupational therapist and five occupational therapy assistants. A physiotherapist comes in to give treatment and to make the various assessments needed. From 2007, all the activities have been client-steered. They are no longer the result of decisions made by local officials. The large number of domestic helps working in the area provide the initial information, but it is the centre's job to ensure that the clients really do want to attend the centre. Asked if the centre is open at night or at the weekend, she replied that it is not. The domestic services, which are separate from the day activities, are also client-steered. So it is up to the clients to decide what provision they want. When clients first come to the centre, an implementation plan is drawn up in consultation with them and with the domestic help staff, who are trained to assess the clients' needs. The result is an agreement setting out the clients' wishes and the measures needed to ensure that they can continue to live their lives in decent circumstances. To a question about the socio-economic background of the clients, she replied that there is a very broad spread. Asked about waiting lists, she said that there could have been waiting lists, but the centre tries to accommodate everybody who applies, if only for one day a week at first. However, she emphasised that the centre is simply a producer of services for the local authority. It is the local authority which decides on the dimensions of those services.

Greger Bengtsson (Director of Care for the Elderly, Municipality of Nacka) added that, in 2007, a customer choice model had been introduced for day care in Nacka. There are now three day care centres like Sofiero, all run by the municipality. But in the autumn of 2007, two private centres will also start offering day care. There will then be competition and the ones that produce the best results will get the customers. Asked if the advent of private day care in Nacka would lead to different provision for people with higher incomes, Marika Westerblom said the municipal facilities are very much accustomed to meeting customer expectations. Given the devotion and expertise of her staff, she was sure that she could continue working to the highest quality standards. Greger Bengtsson said that it is already, and increasingly, the case in Sweden that, while the State provides the care, people can buy extras with their own means. Marika Westerblom said that, as a municipal service, her centre is prohibited by law from competing with commercial interests. To a remark that commercial services are allowed to compete with the municipal ones, but not vice versa, she replied that this is a political issue.

*The peer reviewers then visited the centre's various sections.*

### Discussion with officials of the Municipality of Nacka

Greger Bengtsson and Harriet Holmgren (Assistant Manager of Care for the Elderly, Municipality of Nacka) explained that Nacka, situated in attractive surroundings between Stockholm and the Baltic, has a population of approximately 84,000. Within five to six years, that figure is likely to reach 100,000 and Nacka and Stockholm will be in the same conurbation. The population is quite young. The people moving into Nacka tend to be young couples with one or two children. It is not a typical Swedish municipality, as it is run and organised in a different way. One reason for this is political. The Liberal and Moderate parties have been running Nacka for 35 years, whereas most Swedish municipalities had Social Democrat administrations. This is reflected in the priority given to customer choice in Nacka, where it has become a basic value. That also applies to services for the elderly. Who knows best – the person who is receiving the social service, or the professionals? In Sweden as a whole, the attitude tends to be that the professional knows best. One advantage of Nacka's emphasis on customer choice is that it has stimulated discussion about how elderly people should be cared for.

The basic principles on which care is organised in Nacka are:

- **The separation of finance from production.** Municipal services are not assigned a budget at the beginning of the year. They are paid for the services provided, on the same basis and at the same rate as the payments made to private providers. So if a municipal service cannot provide value for money then, just like a private provider, it will have to close down.
- **Competition through customer choice or competitive tendering.** From chiropody in 1985 to day care for the elderly in 2007, customer choice has been gradually expanded. In each case, an analysis was first made of whether customer choice or competitive tendering was a better way of ensuring good services. Customer choice is not always appropriate. For example, it would be pointless in the case of the alarms provided to elderly people living at home. So the alarms are supplied by one private firm and the call response is provided by the municipality – both on the basis of their having put in the best bids.
- **Neutrality of competition.**

- The delegation of responsibility and authority to the lowest qualified level.

In care for the elderly, the first step in the process is assessment of, and a decision on, the support needed. In Nacka, this stage is conducted much as it is in the rest of Sweden. The care manager evaluates the needs, usually on the basis of an interview with the person concerned and sometimes also with relatives, doctors and nurses. In Sweden, children have no legal responsibility to take care of their parents. That is a municipal responsibility. The care manager decides both the kind of assistance to which the individual is entitled and the amount of time allotted for this service. If the person concerned does not agree with the care manager's decision, the matter can be taken to court.

An example: Sven, aged 87, needs help with cleaning his house, washing his clothes, taking a shower once or twice a week, and cooking. He might be assigned 15 hours of help per month. In Nacka, he will then receive a cheque for 15 hours, which he can take to any of the home care providers. His chosen provider then plans and executes the services. In the rest of Sweden, Sven's needs would be assessed in much the same way, but the care manager would then instruct the municipal provider to go and perform the services in Sven's home. If Sven was unhappy with the results, he could complain, but the provider would remain the same. In Nacka, on the other hand, he can change providers whenever he wishes. He can also decide, within reason, when he wants the work done. So this is a question of empowerment. Customer choice means that Sven himself has the power to decide what happens with him.

Roland Bladh asked how many providers there are in Nacka. There are currently 40 private providers plus the municipal services, Greger Bengtsson replied. The municipal service has about 25% of the market, and the rest is covered by private companies. Constança Paúl (University of Porto, Portugal) asked if both the private and the public services are evaluated by the municipality. Yes, they are, Greger Bengtsson replied, one of the reasons for this being that it is the municipality that finances the services. The time allocated by the care manager can be challenged in court if the person concerned is dissatisfied, so care managers know that they have to motivate their decisions. Asked by Philippe Swennen if people have a right of appeal against the court's ruling, he replied that this rarely happens. Jane Carolan asked if the municipality pays the money directly to the company or to the elderly person. Greger Bengtsson replied that the municipality would pay the company directly for the time actually spent working for Sven. Irrespective of the time allocated by the care manager, the municipality pays for the time actually worked by the provider, which is billed in minutes. This increases the possibility that Sven will actually receive the full work times allocated. The municipality pays at the same rate to all providers. That rate is set by the municipality once a year. Harriet Holmgren added that, when the bill comes into the municipality, it is checked before payment to see if it corresponds to the time allocated by the care manager. Constança Paúl asked if there are periodic reevaluations, in order to see if a person needs more care. Greger Bengtsson said that, in the case of people who do not yet receive a lot of care, a reassessment is made every two months. If something significant happens, such as an illness, Harriet Holmgren said, then of course a new assessment is made.

Bianca Rendl (Federal Ministry of Social Affairs and Consumer Protection, Austria) asked if there is a maximum number of care hours per week or month that can be allotted to a person. Harriet Holmgren replied that home helps will not stay permanently with a person but, according to needs, they may come in up to five or six times per day, including at night in some cases. Jan Lorman (ŽIVOT 90, Czech Republic) asked if there is a system for giving public information about the providers. A catalogue is compiled, answered Greger Bengtsson. This is available both on paper and on the Web. It describes all the providers, giving details of who they are, what their own mission

statement is, how many employees they have, and which areas they usually work in. So this will help Sven to make his choice. However, there is certainly a quality control problem, because care for the elderly been run by the municipalities for a long time now, and it has been supervised by the political system. And in Sweden, political supervision means that the quality has to be good. So not much thought was given to quality issues until the 1980s, when private providers began to emerge. Then a huge scandal broke, which in a way was the best thing that could have happened to care for the elderly in Sweden. A private provider had given low-quality service and the press went after the story. This led to a new concern about quality. Standards had to be defined, and work has been proceeding on this over the past 20 years. What is certain is that customer satisfaction with the services in Nacka is high and has been increasing. On a rising scale of 5, it was 4.0 in 2001-2 and 4.6 in 2006-7. Surveys of customer satisfaction have been a powerful instrument for quality.

Are there no waiting lists, asked Henk Nies. Is there more supply than demand? Yes, there is oversupply, Greger Bengtsson. More and more companies are asking to be registered as providers. Currently, 50 in all are registered, but 10 of them do not have any customers. The competition is too strong. So are some companies going bankrupt, Henk Nies wondered. So far, no companies have been kicked out of the scheme because of poor quality, Greger Bengtsson stated, but some have withdrawn because of a lack of customers. In other cases, people who simply wanted to provide care have found themselves running growing companies, and have decided to sell up.

Michael Murchan (Department of Health and Children, Ireland) asked if the service described in the case of Sven applies purely to home help, or if the municipality also pays for enhanced care packages, including nursing care. What percentage of the clients receive home help only, and what percentage receive enhanced care? Greger Bengtsson preferred to divide these services into three categories: cleaning, washing etc.; personal care; nursing, physiotherapy etc. Home help accounts for just 5-10% of the hours. 30-35% of the clients receive home help only. The biggest outlay is on the second category, care. The third category is not run by the municipalities. Health care is the responsibility of the counties. So, asked Michael Murchan, if Sven needed a public health nurse or a doctor to call round at his home once every six weeks, who would organise that? It would be the county's responsibility, Greger Bengtsson. He added that, in the Stockholm area, county services are beginning to apply the same customer choice principles as are followed in Nacka. So in a few years' time, private companies may also become involved in health care, on a similar basis. Harriet Holmgren said that the home help and health services do try to cooperate, but this is difficult because they are under different authorities. That being the case, Henk Nies wondered whether it might be better to make nursing a municipal responsibility. In a way, that might be easier, Greger Bengtsson agreed, but the bigger an organisation gets, the more problems arise for cooperation. A better way of dealing with the problem might be to introduce customer choice into the health services. That way, both municipal and county financing could go to the same companies, and this would increase cooperation on the ground. Henk Nies asked if the assessments of home care needs and health care needs are made separately. Yes, they are, Greger Bengtsson said. What happens in practice in Nacka, if an elderly person needs to take pills each day, is that the same company may take responsibility both for the home care and for giving the pills, but will be paid by the county for the time taken in administering the pills. Henk Nies asked if there are any plans to combine the two needs assessments. About half of Sweden's municipalities have responsibility for nursing, Greger Bengtsson replied. They might have such plans, but Nacka does not. Harriet Holmgren pointed out that home care and health care are covered by different sets of legislation.

Clemens Tesch-Römer wondered why there has been an increase in customer satisfaction. Is the national average satisfaction also increasing? He suggested that customer satisfaction is not the best way of measuring quality. If asked to rate their satisfaction on a 5-point scale, most people will usually give a rating of 3 or more. There is a natural human tendency to express satisfaction with services on which one depends. Are there any plans to add other, more objective quality indicators? And how is satisfaction measured for people who might be unable to use a five-point scale – in particular, for demented people? Greger Bengtsson did not know how customer satisfaction in Nacka compares with the rest of Sweden, because most other municipalities do not do customer surveys and those that do, conduct them in a different way. But the government and the associations of municipalities and counties have now taken big steps forward in the measurement of quality. One new development is that various authorities' customer satisfaction surveys will now be based on the same scales. So some comparable figures may become available in 2008 or 2009. He thought there are two reasons for Nacka's customer satisfaction rating of 4.6. One is that the municipal services, which previously did not always have high quality standards, have greatly improved. Also, the competition between the companies means that they have to perform many services beyond those paid for by the municipality, just to keep their customers. Clemens Tesch-Römer asked what is the range of customer satisfaction with individual companies. From 3.8 to 4.9, Greger Bengtsson replied. Philippe Swennen asked how the municipality sets the price paid for the services. And might the private providers form an association in future to further their interests? The critical factor will be size, Greger Bengtsson believed. If there are ultimately just a few big companies, they will be able to set their own price. But for as long as there are many providers, the municipality can decide the price. Once a year, the administration decides what it thinks would be a good price, but after that, there is always some lobbying from the companies, and the political decision-makers tend to raise the price slightly. The customer satisfaction surveys are sent out to all the customers, but in the case of clients with dementia, the replies may be provided by relatives.

Björn Halleröd asked if the introduction of competition had not put a lot of pressure on the people working within the system. Greger Bengtsson did not have any information on employee satisfaction within the private providers, most of which are rather small companies. But in the municipal services, employee satisfaction actually increased after the move to higher standards, and sick leave absences declined.

Are the companies under an obligation to accept all clients, Henk Nies asked. Yes, Harriet Holmgren replied, they have to accept everyone. And are the health authorities happy about working together with so many companies? No, she replied, but they have had to get used to it. Are the companies merging across the line between social and health care, Henk Nies wondered, so as to reduce the complexities? Not yet, Greger Bengtsson answered, but it is coming and it will be a good thing.

Jane Carolan asked if the physiotherapist who comes into the day care centre is paid by the municipality or by the health service. In the day centre itself, by the municipality, Harriet Holmgren said, but by the health service in the case of visits to a person's home. That is the national policy, Minga Orkan added – municipalities are always responsible for health care within day centres. But a doctor's visit, even to a day care centre, is the county council's responsibility.

As regards special housing, Greger Bengtsson reported that Nacka has rooms for about 500 people. Six special housing schemes are run by the municipality and six by private companies. The number of rooms per scheme varies between 20 and 114. Gijs Adriaansens (Ministry of Health, Welfare and Sport, Netherlands) asked what "run by the municipality" means. Does the municipality

build and maintain the accommodation? No, Greger Bengtsson replied, here too, financing and production are separated. The municipal special housing services are paid for what they actually provide. And, as for care services, the price paid by the municipality for special housing is the same – whether to the private sector or to the municipal services. The process of needs evaluation and decision-making is also the same as for care services. So, asked Gijs Adriaansens, what happens if Sven's assessment says he needs to go into a nursing home, but Sven says "no"? Then Sven stays in his own home, Greger Bengtsson replied. Karin Hellqvist confirmed that, under the Social Services Act, if Sven opts to stay at home, then that is the way it must be, even if the total cost to the public purse is greater. Greger Bengtsson added that, in practice, few people who really need residential care insist on staying on in their own homes. But the knowledge that they have a right to do so makes them feel more secure. They know that they can go back home if they really want to. The additional spending caused by this policy is not very great. In the Netherlands, Gijs Adriaansens said, the government insists that public funding of home help should not exceed the cost of caring for the person concerned in an institution. That is not a big issue in Sweden, Greger Bengtsson felt, although it may sometimes be privately discussed among politicians. In general, Swedes believe that society should pay for the services that people need, wherever they choose to live. But, insisted Gijs Adriaansens, even in Sweden there must surely be a point where a decision has to be taken that somebody must go into residential care, because they cannot be provided with the necessary level of round-the-clock care in their own home. When is that turning point reached? Greger Bengtsson replied that, once the number of visits by the home help reaches four or five per day during the morning and evening, and perhaps once or twice at night, then it will probably not be possible to increase the service further. Karin Hellqvist pointed out that the number of hours may vary from one day to another. Round-the-clock provision may sometimes be available. Also, it may be that a relative is living in the elderly person's home and can help out. If the situation becomes too difficult, it will be discussed with the person and perhaps their family, but nobody can be forced to move into residential care. Clemens Tesch-Römer suspected that there may be cultural differences here. In Germany, and perhaps also the Netherlands, elderly people see residential care as something to be avoided if at all possible. In Sweden, that may not be the case. Greger Bengtsson added that, in Sweden, people who are seriously handicapped are entitled to State-financed personal assistance for up to 24 hours per day. But this entitlement ends at the age of 65, when the system of care for the elderly takes over. The people concerned then expect the same level of care from the municipalities, but the municipalities cannot afford it.

Greger Bengtsson explained that, in the case of special housing, a decision is first taken on a person's need for support. Many residents in special housing have dementia or have very high needs. If it is decided that Sven is in need of support and special housing, then in Nacka he can choose his housing in exactly the same way as for home help or home care. The manager of the special housing that he chooses will then draw up a services plan, together with Sven. What the municipality pays the special housing provider, whether private or municipal, will depend on Sven's needs. The municipality of Nacka pays for each service except food and rent. These are paid by the resident. The rent depends on the size and quality of the accommodation, and ranges from SKR 1,200 per month to about SKR 6,000. The payment made by the municipality to the provider is determined by a points system which assesses the resident's physical and psychological status, change in mental age and medical needs. The maximum score (i.e. the heaviest needs) is 21 points. If, for instance, Sven has 15 points, then the municipality will pay the special housing provider SKR 1,300 per day for looking after him. If a permanent increase in his needs is noted, a new assessment will be made and if the number of points rises, the payment will be increased. However, if he scores fewer points than previously, the payment will not be reduced, because this will mean that the special housing provider has done a good job of training him to do certain tasks for himself.

**Gijs Adriaansens** noted that, under this system, the municipality pays for nursing when people are in special housing but not when they are in their homes. **Greger Bengtsson** confirmed that this is the case. In answer to a question from **Clemens Tesch-Römer**, he also confirmed that the points system is specific to Nacka and is not used nationwide. However, other municipalities near Nacka are beginning to adopt and adapt it. **Clemens Tesch-Römer** praised the pragmatism of the points system and said that he would call attention to it in Germany. **Greger Bengtsson** said that a big advantage of the points system is that it shows how many staff a resident needs. **Jane Carolan** asked if a tool exists for translating the points into staff numbers. Such a tool was included when the system was devised, **Greger Bengtsson** replied. But it is not used in that way anymore. Now, it is mainly just an instrument for determining the payments to be made. So how does the municipality check that a special housing provider has the right number of staff, **Jane Carolan** enquired. The municipality does not check this, **Greger Bengtsson** said. **Clemens Tesch-Römer** commented that translating needs into money and staffing is a problem in Germany. He wondered how the Swedes had tackled this issue. **Jane Carolan** added that Ireland faces the same problem. **Greger Bengtsson** explained that the special housing is subject to both national and municipal inspections, plus the customer satisfaction surveys. If all of these are positive, there is no need to look at staffing levels. In any case, more staff does not necessarily equal higher quality. It is more a question of how the care is organised. In Germany, **Clemens Tesch-Römer** said, there is a rule that 50% of special housing staff must be nurses. **Greger Bengtsson** replied that Nacka had formerly also had something like that proportion of nurses on its special housing staff. Then it had investigated how many of the 500 or so people in special housing actually need a nurse 24 hours a day. The answer was 7. So now, just one special housing unit has nurses on duty 24 hours a day. For the others, nurses can be called in within 30 minutes, which is enough.

**Henk Nies** asked how much choice **Sven** has within the special housing system. Can he choose where he lives? Can he choose which company provides the nursing or the food? **Greger Bengtsson** replied that the nursing and the food are organised by the company running each special housing site, so **Sven's** choice of accommodation will also determine who provides the nursing and food. Responding to a question from **Gijs Adriaansens**, he again stressed that inspections as well as customer surveys play a role in monitoring quality. So what authority do the inspectors have, **Gijs Adriaansens** asked. What do they do if they find something wrong? They make a report, **Greger Bengtsson** said, and the report always gets into the newspapers, which is an effective sanction. Apart from that, the company and the municipality receive copies of the report, and the municipality generally gives the company three weeks to fix the problem.

What does Nacka do to support informal carers, **Henk Nies** asked. **Greger Bengtsson** replied that when people caring for their husband or wife have a lot of needs, the municipality provides SKR 1,500 per month. Respite services and short-stay homes are also available, **Harriet Holmgren** added. These give informal carers the opportunity to take a break from time to time. One of the short-stay homes is in Majorca, **Greger Bengtsson** pointed out. **Henk Nies** asked if help and advice are also provided to informal carers. Yes, **Greger Bengtsson** replied, one of the care managers advises them. Social activities are also organised, to help informal carers to meet other people in the same situation. And more is now being done to contact elderly people's relatives and to inform them of the services available. **Gijs Adriaansens** said there is a lot of discussion in the Netherlands these days about how to stimulate people to do as much as possible for themselves, and what use to make of volunteers. How much should be done by the government, and how much by people themselves? **Greger Bengtsson** commented that Nacka tries to stimulate voluntary organisations by contacting them and contributing some money. For example, there are volunteers whom elderly people can call if they want to be taken out for a drive or be accompanied on a visit to the doctor. Not much is done to stimulate elderly people to do more for themselves, **Harriet Holmgren** said, because the

experience in Nacka is generally that they not seek help unless they really need it. Elderly people usually want to take care of themselves.

Greger Bengtsson asked if the peer reviewers thought that there was anything that Nacka should be doing differently. Clemens Tesch-Römer said that he had learnt a great deal from the visit, and would be taking some valuable insights back with him. Gijs Adriaansens suggested that it might be more rational if nursing in special housing and nursing in people's own homes were organised in the same way. Greger Bengtsson and Harriet Holmgren agreed. Jan Lorman asked if the decision on who is responsible for health care ultimately rests with the counties. Yes, Harriet Holmgren confirmed – unless it reaches an agreement to the contrary with the municipalities, the county retains that responsibility. But there is a continuing discussion about this in Sweden. Three regions will, she hoped, soon decide that the municipalities should have the responsibility for health care. Jan Lorman asked if any other municipalities in Sweden have similar policies to those in Nacka. This system started in Nacka in the 1990s, Greger Bengtsson recalled, and now every year, more and more municipalities are introducing similar ones. They are mainly in the more densely populated regions. In the remote rural areas, care for the elderly is mainly run by the municipalities. About 11% of Swedish municipalities now have customer choice, and the proportion is increasing each year. Legislation now in preparation is likely to speed up this process.

Jane Carolan wanted to know how Nacka works with the hospitals, to ensure that elderly people do not stay hospitalised for longer than necessary. This is a major problem in Ireland. By law, Greger Bengtsson replied, if a doctor certifies that somebody is fit enough to leave hospital then, after five days, the municipality has to start paying the cost of the hospital bed. This is a very effective stimulus. But effective for who, Jane Carolan retorted. In Ireland, health and social services are in the same organisation, so that particular financial sanction would not apply, but it is often suspected that elderly people leaving hospital are more likely to go into institutional care than to go home, because it is less complicated to provide care for them in an institutional environment. Is there the same risk in Sweden? Yes and no, Harriet Holmgren replied. Swedish hospital stays tend to be short, but the home help providers are under an obligation to start providing a service within 24 hours if it is needed. So they have to put in resources immediately. But of course, not everybody can go home immediately after leaving hospital, even though home help is available. So some go into short-term care. But as far as possible, the preference is for people to go straight home from hospital. Minga Orkan added that the doctor, the hospital and the municipality are required to agree on a care plan. The person concerned, or relatives, is supposed to take part in that meeting and have a say. There is some criticism in Sweden that hospitals try to get rid of patients too quickly. Responsibility for rehabilitation needs to be more clearly defined, she felt. This is perhaps the weakest link in the Swedish system. Harriet Holmgren pointed out that the primary health care system also has a say in whether somebody leaves hospital. If their family doctors say they cannot look after them adequately, then they have to remain hospitalised. Michael Murchan raised the issue of "bed-blockers" – patients who occupy acute hospital beds for longer than is medically necessary. This is a problem in Ireland, and particularly in Dublin where the pressure needs to be taken off the acute hospitals. So key strategic decisions have to be taken in Ireland. How can a quality home-based care system be devised? A pilot scheme for home care packages was introduced in 2005, and a government evaluation of that is now in progress. He had been interested to hear that the Swedish requirement that municipalities pay for bed-blockers has proved effective. Greger Bengtsson replied that it is effective in the sense that, in order to avoid this "fine", the municipality has to ensure that special housing, short-term care and home help are available. So the threat of the "fine" is a real incentive. Before this law was introduced in 1993-4, the hospitals were overflowing with patients. That is no longer the case. Jane Carolan said that a similar measure has been proposed in Ireland, but the

concern is that the old people themselves might suffer as a result, when this is really not their problem.

Fernanda Rodrigues (Coordinator, National Plan for Social Inclusion, Portugal) asked what are the political elements in the Swedish controversy over customer choice. One disputed point, Greger Bengtsson said, is the principle of allowing private companies into the care service system. Many Swedes still feel that it is not right to make a profit out of care. Another issue, already mentioned, is the question of who knows best. Should the municipality or the individual decide? A third argument sometimes made is that a customer choice system will cost more, due to overcapacity. In his experience, this is not true. As far as it is possible to compare the figures, Nacka is one of the most cost-effective municipalities in Sweden. Michael Murchan asked if any cost comparisons between the public and private sectors are available. Studies in Ireland had shown clearly that paying the private sector to produce public services is more expensive. Greger Bengtsson said that, when the private sector became involved in Nacka, costs went down quite considerably at first. But then things started evening out, and these days, he did not think that there is much of a cost difference between publicly and privately run services. The real point is that competition produces lower prices. Whether the competitors are public, private or non-profit does not really matter. But, Jan Lorman interjected, this is not really a case of the market setting the price. Nacka decides what price it wants to pay, and says "take it or leave it". In response, Greger Bengtsson described a situation that arose a few years ago in the field of special housing, when the private companies decided that, rather than selling their services to Nacka at what they felt was an unreasonably low price, they would sell them at a higher price to other municipalities. At the same time, the municipally run special housing found that it was having difficulty in making ends meet. The result was that Nacka raised the price by 10% that year. So in that case, market forces had an impact. But if just one company rejects the price, then certainly, it will be told to close down or hand the business over to somebody else. On the other hand, if everybody starts making very big profits, then Nacka will know that it has set the price too high. But in deciding the price, it also makes comparisons with prices elsewhere.

Philippe Swaenen asked if a private company from, for example, Estonia could come to Nacka and compete in care provision. No problem, Greger Bengtsson replied – as long as it has the qualifications needed and can speak Swedish. Asked if the pay gap between Estonian and Swedish workers would be an issue, he said that it would not – but the workers would be required to speak Swedish fluently. So he thought this situation was less likely to arise in care services than in some other sectors.

Greger Bengtsson wanted to comment on the earlier suggestion that it is unfair that the private sector can compete with municipal services, whereas the municipal services are banned from entering private sector markets. This is not specific to the care services, he pointed out. The law is really aimed at, for example, stopping the municipalities from using taxpayers' money to set up food kiosks in competition with privately run stalls. When the law was brought in, nobody imagined that there would one day be competition in social services. So, while the situation might be unfair, it was not deliberately created by the legislation. Henk Nies asked if the municipal services are allowed to make a profit. Yes, Greger Bengtsson replied. And does the profit go back into the municipal budget? No, they are allowed to keep it. They may use it for staff parties, or for training, or save it for a rainy day. Isabel Borges asked if the customer surveys show that older people are more satisfied with the private or the public services. They are still slightly more satisfied with the private sector, Greger Bengtsson said. But the gap has narrowed. It used to be much bigger.

Gijs Adriaansens suggested that Nacka might give individuals a personal budget to buy care wherever they want, and not just from the contracted providers. This approach has been tried in the Netherlands and works well, including in care for the elderly. Greger Bengtsson found this interesting. He and Harriet Holmgren might visit the Netherlands to take a look. Gijs Adriaansens also described a new system introduced in the Netherlands in July 2007, under which elderly people take care of their own housing and the State pays for the rest of the package that exists in residential care, i.e. care, food etc. This gives scope for more variety in housing for the same group.

Henk Nies asked what will look different in Nacka in 5-10 years' time. Greger Bengtsson thought that the quality of care will probably have improved, due to competition. And it is likely that providers of care for the elderly will also become involved in health care, so that the division of responsibilities will be less relevant. This will also lead to improved quality. Philippe Swennen wondered if Nacka will still be able to afford the same services in 10 years' time, as the number of elderly people to care for will be greater. Greger Bengtsson believed that, in 10-15 years' time, Nacka will be better at providing elderly people with safety in their own homes, so there will be proportionately less call for residential care. But the big issue then will be dementia. More effort will have to go into making people secure in their homes, so that they can have a high quality of life for as long as possible. He did not think that Sweden differs much from the rest of Europe in this regard – except, perhaps, that the generally good quality and accessibility of Swedish housing offers some advantages for elderly people who wish to remain in their own homes.

#### Feedback from the site visit

Constanza Paúl said that the Portuguese experience of care for the elderly would lead to rather different conclusions than those drawn by Nacka. Most of the Portuguese care has always been privately run, or run by the church. Older Portuguese people are often keen to move out of their own homes and into residential care. In part, this is because many people of that generation associate their homes with poverty and backbreaking work, and look forward to the relative comfort of residential care. But there is also another reason: private providers pick their residents. So people want to get into residential care while they are still reasonably fit, because they know that they may be refused a place when they become more of a burden. The Portuguese experience therefore does not confirm that private care necessarily means consumer choice. It may well be that more public provision is needed.

Michael Murchan's initial reaction was that the care services available in Sweden are very good and comprehensive. The public and private sectors seem to complement each other and provide a continuum of care. In terms of access, quality and financial sustainability, standards in Sweden are probably among the best anywhere. It is a comprehensive and impressive system, and every other country could learn something from it that might be transferable to their own case. The only point that he might raise, coming from Ireland where the same agency runs both health services and social services, would be that Sweden might wish to look at the possibilities for greater cooperation on the ground between the two services.

Henk Nies, when he arrived in Sweden, had expected to find a quite logical and simple system. Now, he was happy to learn that the Dutch are not the only ones with complicated structures. The other point that had struck him was that Sweden is probably the only country in the world to have a surplus of services for older people. In most other countries, there are shortages which give rise to real concern. In Sweden, there is so much supply that there is a possibility of real competition. He was

puzzled as to how the Swedes achieve this, and he hoped to dig a little deeper into this question. Greger Bengtsson said this is true as far as care at home is concerned. But in special housing, Sweden has experienced shortages. This has caused concern at times, because the Swedish system requires a good balance between care at home and special housing. Minga Orkan felt that, in fairness, it should be said that some elderly people in Sweden are not all that satisfied with the Swedish system. Some people want more help, but are not entitled to it under the needs assessment principle. Sweden can be quite proud of what it has achieved, but there are still improvements to be made. Considerable work is still needed in the fields of special housing and rehabilitation. While most people in Sweden are reasonably well off, we should not lose sight of the few who are not. Sweden should go a little bit further in bringing services closer to each individual. Kristina Jennbert felt that Swedes should be proud that they have managed to achieve this system, given the increasing number of older people. When older people are dissatisfied with the system, this is not so much about the services, it is about company, about having someone to hold your hand or drink a cup of coffee with you. But that is not the responsibility of the public sector. These needs must be met in other ways. Kent Löfgren said that Sweden is certainly not trying to hide its problems. It does not have all the answers. But what it has tried to do is to assign responsibilities to functional units. The municipalities are very functional units for long-term care. The dividing lines between county and municipal responsibilities and between hospital care and home care certainly do raise difficulties, but these lines are unlikely to disappear. And there are indeed shortages of special housing in some areas, leading to waiting times. But there are no very long waits. Socially, the problem is a small one, although it can be a terrible problem to the people concerned and their families. The situation can be eased by using the short-term accommodation and home care, but this is not an ideal solution. On the other hand, national surveys have shown that there are hardly any people in Sweden whose needs are not met.

While understanding that having a cup of coffee with an older person is not a public service responsibility, Isabel Borges emphasised that isolation is a serious problem for elderly people. It can lead to illness and depression, and so to extra costs. So she thought that there is nonetheless a role for public social welfare services in ensuring that older people have somebody to talk to. This is a form of preventive medicine. It helps to keep people healthy. Martin Schenk noted that Sweden invests more than 3% of its national product in care for the elderly, while the corresponding figure for Austria is between 1.8% and 1.9%. This difference in investment levels is reflected both in the variety of services that can be provided and in their affordability for the user. And, of course, if people cannot afford the services, then variety and choice become meaningless. Jan Lorman emphasised that consumer choice will not work in countries where people lack the necessary information on the quality of the services available. He had been very impressed with the Swedish system because in the Czech Republic, although people do receive money to buy care for the elderly, the problem is often how to spend that money legally, on good-quality services.

## Day 2

### NGO statements

#### AIM – the International Association of Mutual Benefit Societies

Philippe Swennen explained that AIM has 41 member organisations in 30 countries, mainly in Europe, but also in the Middle East, Latin America and Africa. All the members are non-profit organisations operating on the principle of solidarity and non-selection. In Europe, they cover social risks for more than 150 million people. They take part in the management of both compulsory and voluntary health insurance. They also deliver health and social services, either directly or through special organisations. Some AIM members deal with long-term care – for example, in Germany, Belgium and France. Recently, AIM has created a new group on long-term care.

Like the other participants, he had been impressed by what is happening in Sweden. He thought that a number of elements might well be transferable to other countries. These include:

- The overarching goal of the Swedish long-term care policy: “enabling older persons to live independently with a high quality of life”. Improving quality is, of course, always an ongoing process, and he wondered whether we should be moving towards a European minimum standard for long-term care.
- Access
  - The transfer of social care responsibility to the municipality (including for special housing)
  - The right to long-term care through a needs assessment without means testing, carried out by a case manager in the municipality
  - The right to appeal if the person is not satisfied with the decision
  - Protection against high costs
  - Preventive measures: medication reviews; preventive action against falling accidents; preventive dental care; better access to doctors, so as to avoid unneeded hospital admissions; technology for the elderly
  - Housing supplement/grants for pensioners.
- Quality
  - A European Charter of rights for people in need of long-term care and assistance could be useful. In this respect, he particularly cited the existing German charter.
  - Sweden’s efforts to better coordinate health services and social services
  - Freedom of choice for individuals in social care, with competition based on quality and not price
  - Follow-up by the municipality on the services carried out
  - The national Steps for Skills initiative to support municipalities’ long-term quality and skills development in health and social care for older people
  - Support for informal family carers through various types of action
  - Efforts to provide patients with information on quality, costs, and efficiency through “open comparison of care services”.

- **Sustainability**
  - Sweden spends 3.8 % of its total GDP on long-term care. This is a remarkably high level.
  - Efforts to combine increased efficiency with more preventive and health-promoting measures
  - Promotion of research on the elderly in the different fields.

He also raised some questions for the Peer Review:

- **Access**
  - *Freedom of choice for individuals:* How to get good information on care services and hospitals? How to evaluate the performance and efficiency of the private providers vis-à-vis the public/municipal provider?
  - *Decentralisation:* How to decrease the inequalities and differences in social services and benefits provided by the municipalities? Sweden's use of an equalisation fund could be one solution.
  - *Staff:* How to provide and pay sufficient trained and qualified staff (problems of sustainability, quality, job attractiveness)? This is a big problem in many countries. It would be useful to have more information on how the Swedes tackle it.
  
- **Quality**
  - *Informal carers:* How to support them and find the right balance between them and the formal carers?
  - *Indicators:* How to ensure quality indicators? European ones would be useful, although they would need to be developed with caution, as the situation varies from one country to another.
  - *Technology:* How to integrate (standardised) intelligent technology for long-term care, particularly at home, and how to finance it?
  - *Sustainability:* How to provide sustainable and sufficient funding for long-term care?

He announced that AIM would be organising an international conference on long-term care, in Brussels in February 2008. He hoped that some of the peer reviewers could be speakers at that conference.

### AGE – European Older People's Platform

Isabel Borges explained that AGE is a platform of older people's organisations in the 27 Member States of the EU. It aims to promote the rights of older people in the European Union and to build a bridge between the institutions and older people's organisations at the national level. It has about 145 member organisations. Some years ago, they represented around 25 million people. In the meantime, that figure will have risen considerably.

AGE and its members had found the discussion paper interesting. AGE's first comment was about dependency, which the discussion paper described as a long-standing condition. But of course, dependency can also happen very suddenly – for instance, if somebody has a fall or has surgery. AGE wants the development of structures and services to accommodate the needs of older people

who become suddenly very dependent on family or friends. At a time when Europe is seeking to promote longer working lives, as well as labour mobility and gender equality, care structures for dependent people have to be in place.

Access to care is quite different in the rural areas than in the cities. This also needs to be taken into account. She agreed with the previous speaker's emphasis on access, quality and sustainability. These issues need to be tackled together. Global health is a human right. AGE welcomes the charters introduced by the German and French governments. Efforts should be made to develop something similar at the European level, if Member States can commit to such a charter. AGE is very much in favour of the development of European quality standards for long-term care. There is a huge debate going on at the moment at the European level. AGE has been cooperating with AFNOR, the French standardisation organisation, which is developing a study on the feasibility of quality standards in long-term care. AFNOR is doing this in cooperation with the European Committee for Standardisation (CEN). This work on quality standards is, of course, linked to the work on the issue of elder abuse, which is now also being taken up at the European level. The European Commission will probably issue a communication on this in 2008.

If Member States propose new measures to limit public expenditure on long-term care, will they also assess the impact that such measures will have on the quality of care? This is linked to the issue of support for family carers, which she had raised in the Swedish context at the previous day's session. She thought that Swedish older people's preference for living at home reflected a general feeling among older people throughout Europe. Interestingly, though, AGE member organisations that had commented on the discussion paper, including its Swedish members, had stated that older people do not want to live alone in a house. They want some social support, and they want to move to a sheltered area where they can have access to care and a number of services. This is especially the case for single or widowed older people. So she felt that some caution has to be exercised when stating that older people want to live at home for as long as possible. There is certainly a cultural element in this. In Sweden, where residential care is of a high quality, older people may want to go into it. In some southern European countries, where residential care of a low standard has developed over the years, there may be more reluctance. Recently, she had visited a long-term care home in Budapest, together with members of a Hungarian older people's organisation. Afterwards, she asked them if they would like to live there. They all said that they certainly not want to do so. This was because it was overcrowded and the conditions were not very good.

There needs to be more coordination of budgets in order to ensure a continuum of care – for example, when somebody comes out of hospital. AGE has been very much involved in the debate on developing technologies that will enable older people to stay at home and to remain independent within the community. eHealth (electronic health) systems, which will be coordinated at the local level, will need to be interoperable if they are to be used in long-term care. Their cost-effectiveness and their real usefulness to older people will also have to be evaluated.

Quality indicators are important, and AGE would like to take part in their development in future. They should also include indicators of social quality.

On the quality of staff, the Peer Review had heard that Swedish care staff are highly qualified. But AGE's Swedish member organisation had reported that they are not. So there is probably an issue that needs to be tackled here. One of the weaknesses is that the assessment tools are in the municipalities. There is no assessment tool at the national level. Comparative data on the quality of delivery would be useful.

AGE would, she said, be happy to work further with the peer reviewers on the issue of health and long-term care, and to participate in the conference organised by AIM.

### Transferability

*The participants split into two groups to discuss what could be learned from the Swedish experience and how far it might be transferable to other countries. The groups then reported back to the plenary.*

### Feedback from working groups

His group had discussed 12 topics, Henk Nies reported. He summarised them as follows:

- **Choice and information.** A requirement for real choice is that consumers should have good information about what is available. This is easier said than done. The information needs to be reliable and comparable, but complete information is also very complex. Wide, complicated choices do not necessarily make things easier for the consumer. And some people will face additional difficulties in making a choice because they have particular communication problems – for example, illiterate or demented people or migrants. A suggestion from Ireland was that all this information should be drawn together within one structure, which could also give assistance in arriving at a choice.
- **Choice and informal care.** In many European countries, informal care provides 70-80% of the coverage. But often there is simply no alternative. This is a challenge for the future, because family structures are weakening and people often live far away from their elderly relatives. Informal care must be supported in such a way that it corresponds to people's choices and is a realistic option. Gender is a factor in informal care. A more equal role in providing informal care should be facilitated for both sexes. Employment policies should also take the issue of informal care into consideration.
- **Choice of living at home.** But what is "home"? This is not just a question of staying where one has always lived, but also of being able to participate in the community and society. Staying at home is many people's preference, but for others "home" may have negative connotations – due to bad social or housing conditions for example. In these cases, they may prefer residential accommodation, because it provides more safety and security. Older people's housing requirements need to be taken into consideration, and innovative housing is needed.
- **Dignity** is, he said, a very important issue but it is also a difficult concept to grasp. Although the Swedish hosts had proposed its inclusion in the theme for the review, it had not been much discussed – perhaps because of its difficult nature. Group participants had pointed out that impoverished people often have particular difficulty in being treated with dignity. There may be class differences in some countries, and some groups are at particular risk of being treated in an undignified way – such as people with dementia and, sometimes, people who are dying. Dignity at the end of life is important, but the issue there is where does intervention start and end.

- **Access** is another important issue. In many countries, there are forms of needs assessment - sometimes based on very local instruments, sometimes nationally defined. While it is important to have some practical form of needs assessment, it is also important that it is related to the care that is being provided afterwards. If people are assessed and are found to be eligible for services, then the services must be required to accept those people. Examples were cited from Portugal where services can refuse people, even though they are entitled to those services. Systems should not provide any scope for such cherry-picking. It was noted that universal access to services is a major Swedish achievement.
- **Quality** needs to be measured if it is to be achieved. There have to be quality indicators. Participants had again asked if such indicators should not be set at the European level. Quality also has to do with well-trained staff and standardised, well-defined services.
- **Labour force.** A sufficient supply of well-qualified staff is essential, because the majority of long-term care is people's work. However, working in long-term care often has a negative, low-status image. It is important to upgrade the profile of this work. Good pay is an important part of this, but so is good training, so that the job becomes a highly respected one. There must be the right incentives to work in long-term care, as well as the right national qualification and education systems. So education in gerontology and geriatrics must not be neglected. It will help to attract people into the labour force for long-term care.
- **Immigrants as a solution.** In many countries, illegal immigrants now make up a significant proportion of the workforce in long-term care. This has some disadvantages: communication skills and education may not be at a sufficient level. There is also the question of the brain drain caused in the countries from which the immigrants come. The tendency to rely on immigrants as a solution is an EU-wide phenomenon, and it should be a matter of concern.
- **The split between medical care and social care.** In many countries, long-term care is dominated by the medical profession, whereas a combination of social care, medical care, housing and welfare is needed. This is a huge challenge, and every country is struggling with it. Often, there is conflict between professionals, and it takes years to overcome these problems. A good data system is needed to support inter-agency working.
- **Decentralisation.** Many countries have a split between the national and local levels. Is this really helpful? In the Swedish case, for example, is the county council level necessary, or does it create extra difficulties? The view taken in the group was that some degree of decentralisation is needed, but the pros and cons should be weighed. The disadvantage of decentralisation is inequality of access, which should be avoided. So there should be some levelling systems and some definition of quality in order to prevent inequalities at local level. It may also be wondered if it is efficient when each local authority re-invents the wheel. Some things could be developed at national level. The question is how to balance the responsibilities and tasks between the layers.
- **Sustainability.** Will there be sufficient supply of care in future? In some countries, private companies are playing a role in the sustainability of care, but this might lead to inequality of access, with the best care going to those who can afford it. No real answer to this dilemma was found during the discussion.

- **Bureaucracy.** This has to be kept within reasonable limits, but especially when managing scarce resources, some degree of accounting and control is necessary.

The other group had discussed very much the same issues, Jane Carolan reported, but it had structured them a little differently. It had divided the discussion into two elements: what the non-Swedish participants could learn from the Swedish model; and the suggestions that they could make to the Swedish hosts on the basis of their own experience. Points raised were:

- **Quality indicators.** The Swedish work on improving quality indicators for services had been of particular interest to participants from other countries, as a way of improving data and statistics and of assessing quality, but also in terms of the transparency offered for users of the services.
- **The challenges of providing information to users of the services.** All participating countries have made attempts to do that, and were therefore very interested to learn from what is happening in Sweden. Projects in Sweden and Austria aim to talk to people about their needs and let them know what is available. A variety of interesting models of “one-stop shops” for information were volunteered for sharing.
- **The Swedish use of private providers** was another point of interest to many of the peer reviewers, who would like to know how the Swedes had managed to get 40 different providers queuing up to provide services in one small area. Many other countries are struggling to achieve that level of choice for the consumer. Portugal has considerable experience in the related area of subcontracting to other agencies.
- **The sustainability of the labour force** was another issue raised. This discussion had been similar to that in the other group, as regards both maintaining the labour force and ensuring that it has a high level of training. In Austria, for example, a lot of work has been done on the job profile of home helps, so as to make it a more attractive, professional job.
- **The link between home care and institutional care** in Sweden had been examined with great interest, as most countries have a policy of encouraging more care in the home. In particular, the reviewers had learned from the way Sweden strikes the balance between the two and assists users in making their choice.
- **The financial sustainability of care services,** and the implications for the future of the welfare state, has been well studied in Sweden, and peer reviewers from other countries had been able to draw valuable information from those analyses.
- **Experience of elderly dementia care** in Sweden, Austria and the Netherlands could usefully be pooled and provided to other countries.
- **As in the other group,** the right balance between central direction and local autonomy had been discussed. How much importance should be assigned to the flexibility needed in order to meet individual needs? The Swedish model was of particular interest, and it was felt that countries could usefully examine this question together.
- **Formal versus informal care** was another discussion point. Some countries have a strong history of formal care, and some of informal care. Mutual learning could take place at some

point in the middle, between those two models. However, it may be that the balance will need to be different in different cultures.

- The usefulness of the Peer Review process itself was another important lesson. Many participants felt that they had drawn valuable information from this examination of the Swedish experience, but that there was still much more to learn.
- The usefulness of linking health services with social services, as in Ireland, was one lesson that Sweden might wish to draw from the review.
- The use of technology in care services is being studied in a number of the review countries, and indeed in EU-supported projects, and this information could usefully be shared.
- The personal allowances provided to elderly people in the Netherlands, allowing them to buy in the services of their choice, is an idea that could be examined by Sweden and other countries. Currently, about 10% of elderly people in the Netherlands are taking this option. A qualitative research on this approach in seven EU countries has been carried out.
- The use of volunteers, as in Portugal, might also be of interest to Sweden.
- Small-scale living opportunities, as promoted in the Netherlands, are another special housing option that might be of value elsewhere.

Björn Halleröd commented that there has been a substantial decrease in professional care provided by municipalities in Sweden.

#### Relevance and key learning elements for peer countries and stakeholder representatives

Clemens Tesch-Römer launched the discussion with some deliberately provocative questions:

- Should we regret that there are cultural differences in Europe, or should we instead take advantage of that fact? There is sometimes an assumption that the North is a paradise and the South is backward, and everything has to move from the North to the South with a time-lag of about 15 years. Would it not be better to regard the diversity in Europe as providing a variety of solutions, so that we can learn from each other?
- What are the relative merits of centralisation and local autonomy? There are arguments for both solutions. The local level knows where the problems lie. But central solutions are sometimes more efficient, particularly as they avoid the need to reinvent the wheel. A balance has to be struck between the two.
- How can the roles of the family and the State be reconciled? Giving the family more responsibilities often means placing those responsibilities on women. If long-term care responsibilities are to be assigned to the family in future, then men will also have to take them on.

- How can we maintain solidarity? In several Member States, we are witnessing the establishment of a two-class health and social care system. Choice for the better off would mean inequality. How can the right balance be struck?
- Should there be a reliance on migrants to provide a 24-hour care service at home? In his view, the answer is clearly “no”. Yet this is the case in a number of European countries.
- Should we have standardised needs assessments or leeway for specificities? He would argue in favour of needs testing that it is standardised at the regional or local level, but the risk is then that the individualities of the person tested will be lost.
- Where there is consumer choice, what about those who have difficulties in deciding? Who decides on their behalf? Although it is good to emphasise consumer choice, it does imply that people are autonomous, that they are capable of thinking about alternatives, obtaining the necessary information and understanding the consequences of a decision. Does consumer choice favour the middle class, which is used to taking decisions, and so foster inequality?
- As personal budgets imply individual solutions, how can equality of service be guaranteed?
- How can public-private partnerships be used to the best effect? Looking at the example of Nacka, how can a sufficient number of private enterprises be attracted into care at the local level, so that supply exceeds demand and there is real choice?
- Does abolishing bureaucracies mean losing rationality? Bureaucracy implies that documented reasons have to be given for decisions. If the paperwork is just thrown out, nobody can check afterwards why and what has been done and how.
- A recurring theme had been the relationship between the health and social care sectors. Are these parallel worlds or is there mutual support? How can the relationship be improved? Should general practitioners have better training in geriatrics?
- How can elder abuse be detected and prevented? One theory is that if there is too much of a burden on a family, this can lead to elder abuse. The alternative view is that a lifelong ambivalent relationship with a parent or partner might turn into abuse under the stress of long-term care. His institute is doing a qualitative study on this, but it is proving very difficult. How can one get access to these families? (*Isabel Borges interjected that abused older people themselves often oppose investigation of the abuse*). There is also abuse in long-term care facilities. He believed that doctors have to be brought into these facilities and must be responsible for alerting the management and other institutions when needed.
- Long-term care also means caring for people who are dying. How can we die in dignity? This needs to be discussed. The right solution has not yet been found for accompanying this last period of life.
- How can we ensure sustainable funding of long-term care?

He felt that much had been learned from the review. There is no “either/or” in the relationship between the family and the State. The shared responsibility should be emphasised, and each should do what they can do best. Special housing and quality assurance should, of course, be the responsibility of the State. Preventing loneliness, ensuring joint activities and giving emotional support is the task of the family. Dementia has to be acknowledged. We should all be aware that it could be our own future. Several countries have already developed guidelines on dementia care, and experience on this should be shared. Benchmarking is a good means of improving quality within services, but an outside view is also needed. He would favour a small number (perhaps five) of simple quality indicators at the European level, so that comparisons can be made within and between countries. Defining and measuring quality is important, but there must also be transparency – the information must be publicly available. Sustainability should be viewed not only in terms of funding but also in terms of the labour force. Combined efforts must be made to attract motivated, intelligent people into the long-term care sector. If technology can be used in such a way as to free up staff time for a better quality of care, then this is also a way of improving the sustainability of the system.

Henk Nies felt that standardised needs assessment and respect for individual specificities can go together. For instance, ICF (International Classification of Functions) is standardised, but it takes individual specificities into consideration. The same goes for personal budgets. People should have a choice between a personal budget and services in kind. The personal budget can also be used to address the issue of isolation. The experience in the Netherlands is that it can be a good alternative.

Roland Bladh suggested that in some countries, personal budgets might be a better idea than in others. This could depend on the stage of development of financial controls. He had found the presentation on Nacka interesting, although it was not a typical Swedish example. It had provided many points that peer reviewers could take home with them. On the question of how to ensure a sufficient number of suppliers to provide real competition and choice, he suggested that Sven Lusensky, who has extensive experience of the privatisation of various care activities in Sweden, might be invited to comment.

Sven Lusensky (National Board of Health and Welfare, Sweden) said that Nacka is very special. There are perhaps three or four such municipalities in the whole of Sweden. There are several reasons why Nacka has succeeded in attracting so many private enterprises. One is that the firms do not have to compete in a public procurement exercise. Nacka says that if a company has the necessary qualifications, it can go out and try to get customers. The position in Stockholm, for example, is very different. There, every enterprise has to take part in a public procurement procedure. Competing in this can be a very burdensome exercise for small enterprises. That is the big difference between Nacka and most Swedish municipalities. In most of them, the competition is between six to eight big companies, one of which wins and the winner takes all. Consumer choice is another important factor. If a company has to look for its clients itself, rather than having them assigned to it through public procurement, then it makes more of an effort. When he looked at Nacka in 2005, about 60 private enterprises were involved. In 2007, there are about 40. Soon, there may be about 30. But once a company has a client, it will tend to retain him or her. Elderly people do not switch suppliers, unless the supplier is really very bad. The question had been raised as to whether customer choice is something for the middle class. The situation in Nacka is, he felt, rather like that. It is a middle class community, and elderly people's families tend to live in the same area. So if elderly people cannot choose for themselves, they talk to their son or daughter, who is close by and well-equipped to make choices. The Peer Review had heard that there is no problem in recruiting qualified care staff. But that is the view of the municipal administration, which no longer recruits such staff. If one spoke to the managers of small-scale care companies, one might hear a different story. In sum, however, he

believed that Nacka has two big advantages: no public procurement process, and a commitment to consumer choice.

**Gijs Adriaansens** commented that, in the Netherlands, the law stipulates that the municipality should ensure that there is more than one provider, so that people have a choice. The law also states that the client should have the option of receiving a personal budget. He added that he had not yet heard, during the review, any good answers to the problem of ensuring the sustainability of care services in future. **Petr Wija** (Ministry of Labour and Social Affairs, Czech Republic) emphasised the importance of individual needs assessment. Standardisation should not mean that people's individual needs are ignored. On the issue of centralisation versus local autonomy, he thought that the criterion should be equality of access to services, notably as regards rural areas. It is also important to support families. As well as focussing on elderly people, there needs to be a focus on carers, in terms of information, financial support and social protection. In the Czech Republic, a care allowance has been introduced, with the amount depending on the level of dependence. But the problem is that no services are available to be bought with this money, so the municipality has to provide the services anyway. The law establishing this system was influenced mainly by a strong lobby of people with disabilities, whose priority was to receive money that would enable them to choose various services. This law does not really fit the situation of elderly people.

**Fernanda Rodrigues** suggested that a clear recommendation should come out of this meeting for a European approach to setting quality standards in care for the elderly, notably through a charter. **Lucy Aarnink** (Ministry of Health, Welfare and Sport, Netherlands) agreed that more comment was needed on the European perspective and the future treatment of this topic within the Open Method of Coordination.

**Hanna Lantz** (Ministry of Health and Social Affairs, Sweden) pointed out, in terms of process, that social inclusion issues are on the agenda of the PROGRESS Committee. Before that, there is the Social Protection Committee, where the subjects of this year's Peer Reviews were decided, on the basis of suggestions from the Member States. One of the questions raised was how to help elderly people to remain in their own homes. That was when Sweden came up with the idea of hosting this review, because it felt that it had things to say and to show in this field. So she suggested that those with ideas for future Peer Reviews should promote them via the two committees.

Regarding charters of rights, **Clemens Tesch-Römer** wondered what the other peer reviewers felt about their use in practice. Were they likely to be mere statements of principle? And, if they really did go beyond lip service, there are several ways of using a charter. One would be simply to distribute it as information, for example to care recipients. A second way would be to use it in quality management systems within services. A third way would be to limit public procurement contracts to bidders who guarantee that they will apply the rights set out in the charter. And concerning financial sustainability, should not economists become involved? His impression was that the members of the present review, himself included, did not have the detailed economic expertise needed. **Niclas Jacobson** felt that many international documents are symbolic but are nonetheless very useful. At the European level, even the process of drafting a document would be helpful, as it would get the subject of human rights in the care of the elderly onto the agenda. **Isabel Borges** added that particularly the topic of abuse should be kept in mind. She understood that a Eurobarometer on this issue would be published, together with other European studies. There needed to be a focus on this subject at the European and national levels. **Henk Nies** said that any charter should be evidence-based. Research could be conducted to examine which values are of sufficient practical use to be included in a charter. In developing quality of life indicators for people with disabilities, the Dutch experience had been that it was very helpful to have a theoretical framework which had a scientific

basis. It had then been relatively easy to agree on the issues that should be incorporated into a quality instrument. So a charter could be a guiding framework that can be operationalised into quality indicators, and also into the criteria for needs assessment. Gijs Adriaansens emphasised that choices for the future will not just be about levels of care, but also about models of care. Will we opt for client participation, or will the decisions be taken for the clients, which probably implies more institutional care? It may well be that the same model will not be appropriate for every country, at least over the next ten years. So another discussion point might be what level of care is sustainable in each country. Roland Bladh said that the projections prepared by DG ECFIN (the European Commission's Directorate-General for Economic and Financial Affairs) are based on a model with three factors: the amount of home care, the amount of institutional care and the amount of other care activities. So it already covers some of the ground suggested. Fernanda Rodrigues insisted that social standards must be included in any discussion of long-term care. She realised that this is a southern emphasis which might not prove popular in a mainly northern Peer Review. But if we wish to maintain the European social model, we must agree on certain levels of care.

### Closing remarks

Roland Bladh doubted if the present review had given a full, true picture of the situation in Sweden regarding long-term care and care for the elderly. However, this was not necessarily a problem, as the presentations on the morning of Day 1 and the visit to Nacka had provided ideas for other countries to take back with them as inputs for their own activities. This is one of the purposes of Peer Reviews. He was also sure that the discussion had provided inputs for the Swedish participants. There had been considerable discussion about freedom of choice, or consumer choice, but little about dignity. Perhaps that could, as suggested by various participants, be a topic to take up again later. The working groups had sparked some very useful exchanges of views and had come up with more critical analyses than the previous sessions. They had been beneficial for him and, he hoped, for all the participants. He thanked all the participants, the organisers and the host country for the efforts put into preparing the review. Referring back to the current process of development in the care services of the Czech Republic, he drew attention to European twinning arrangements under which local communities cooperate across national frontiers. There might, for example, be scope for cooperation between a Czech, a Swedish and a Dutch community on a specific project relating to the transition phase. However, it might also be the case that this idea is already being implemented. The Commission would examine what could be brought from this Peer Review into the Open Method of Coordination (OMC) process. And he welcomed the suggestion to have the national information provided by Member States within the OMC process displayed on the Web in a structurally more accessible way than it is at the moment. The information could then be used more easily in discussions. In 2008, there will be national reports within the OMC process and plans and ideas for the following three years will be set out. In parallel, European activities are ongoing on the issue of abuse and maltreatment. These will probably result in a Commission communication in early 2008, and there are also plans for a conference on this topic in the first quarter of 2008.

Lucy Aarnink added that a lot of work is being done within the indicators sub-group of the Social Protection Committee, which after quite a long debate has formulated some crucial indicators. These are not yet in the public domain. Roland Bladh said the discussions within the Social Protection Committee had shown that indicators are a very complicated subject, including in the fields of health care and long-term care. In health care, a vast number of indicators are already available, so the process will be to select a few of them and agree to use them in common. For long-term care, the situation is slightly different, because there are relatively few generally acknowledged indicators. Here, the task will be not only to select and agree on indicators but actually to develop them. This

process will take time. The indicators sub-group would next meet in October 2007, and hopefully it would take a step forward.

Kent Löfgren said it had been very important to the Swedish hosts that the peer reviewers had taken the time to learn about their experience and had shown such interest. In discussing how to present their system to experts from other countries, the Swedes had also clarified some points for themselves. So he thanked everybody for coming and hoped that Sweden had been able to give them something in return. In Sweden, problem-solving in long-term care has been a discussion topic for at least 500 years. It has been reshaped many times and will no doubt have to be reshaped many times again. But it is clearly very important to the whole nation. After all, we all grow older, and we all want dignity and security in our old age. But social care, health care and care for the elderly are moving targets. Although we are better at them than ever before, the demands are increasing and the satisfaction with care is decreasing. We may have to contend with a growing gap between expectations and our quality efforts. Regarding sustainability, means will have to be found of distributing assistance to those with major needs but also to those with small needs. Nobody must be left out. The system is not a stepless one when somebody's needs are growing. There are thresholds. The current discussion in Sweden is about whether the thresholds are too high at the time when people's needs are just beginning to become greater. If that is the case, then people are being left out, and the burden on their relatives is increasing. For the Swedish government, dignity and consumer choice are both very high on the agenda, and it will try to promote both of them. There is an ideological element in this – the present Swedish government, like the municipality of Nacka, believes that everyone should make their own choices. There are no major problems of sustainability, financing or staffing in Swedish care, but great caution must be exercised when creating further new rights to care. That would be very risky, and the government is in discussion with the counties and municipalities on this. If central decisions place further responsibilities on local authorities, then central government will have to show where the finance is to come from. If people want the best, then it always has to be paid for – either individually or from taxes. So Sweden will follow future European discussions on sustainability very closely and hopes to benefit further from the peer reviewers' insights. He thanked them all for their visit.