



Sweden 2007

Freedom of choice and dignity for the elderly

Short Report



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



The Peer Review was held in Stockholm (Sweden) on 13-14 September 2007 and hosted by the Swedish Ministry of Health and Social Affairs. In addition to the host country, five peer countries took part: Austria, the Czech Republic, Ireland, the Netherlands and Portugal. Also participating were stakeholder representatives from the European Older People's Platform (AGE) and the International Association of Mutual Benefit Societies (AIM), together with representatives of the European Commission's DG Employment, Social Affairs and Equal Opportunities.

1. The policy under review

In Sweden as in most parts of Europe, the population is ageing. Over 17 percent of the Swedish population, or almost 1.6 million people, are 65 years old or older. Between now and 2050, the number of people aged over 80 is likely to almost double. Research and development are needed if high-quality, cost-effective care for the elderly is to be enhanced or even maintained. Recently, the quality of care has been a major topic of public discussion, as has the need for respect and understanding of individual needs. The main elements of the Swedish system:

- **The National policy for the elderly**, as laid down by parliament, is that older people are to:
 - be able to lead **active lives** and have **influence** on society and their own everyday lives;
 - be able to grow old in **security** and retain their **independence**;
 - be treated with **respect**;
 - have access to **good health and social care services**.
- There is a strong emphasis on **enabling 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 do so, and special housing is seen as an option to be used only when all alternatives have been exhausted (mainly in the case of dementia). Grants for the adaptation of housing make it easier for elderly people with disabilities to stay on in their own homes.
- Social care and health care for the elderly are regarded as **primarily public sector tasks**, to be performed by **trained and qualified staff**.
- Overall **responsibility for care of the elderly** rests with the State. However, Sweden's 290 municipalities are responsible for the social services. Health care is run by the 21 county councils. A high level of local autonomy means that structures for the provision and financing of services can vary. The municipalities are responsible for the health care in special housing and in daycare (not for work done by doctors). Half of Sweden's municipalities are also responsible for home health care in regular housing (not for work done by doctors).
- Various **client choice models** have been introduced by a small but increasing number of municipalities (27 out of 290 by December 2006). They entail opening up all or part of the care to competition. Providers all receive the same payment, except in the case of supplementary services for which the providers themselves set the price. Under the Social Services Act, private providers are subject to the same quality requirements as public ones.

- **Incentive grants** are paid by the central government to the municipalities and county councils in order to improve the quality of care – with the emphasis on access to doctors, medication reviews, preventive work, dementia care, rehabilitation, diet and nutrition, and the social content of care.

2. Key lessons and aspects of transferability

What can be learnt from the Swedish experience, what parts of it might be transferable to other countries, and what lessons can the Swedish hosts draw from the Peer Review? Among the key points that emerged:

- A precondition for **real choice** by consumers is **full information** about what is available. But complete information about care for the elderly is also very complex. “One-stop shops” could draw the information together and help users and their families to arrive at a choice.
- **Staying on at home** is many elderly 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. The participants praised the way in which Sweden strikes the balance between care at home and residential care.
- **Dignity** is a very important issue in care for the elderly but it is also a difficult concept to grasp. There was a general agreement on the need to examine this issue in more detail in the future.
- While it is important to have some practical form of **needs assessment**, this must be related to the care that is provided afterwards. It was noted that **universal access to services** is a major Swedish achievement. If people are assessed and are found to be eligible for services, then the services must be required to accept them.
- **Quality** must be measured if it is to be achieved. There have to be quality indicators, and it was suggested that these might be set at the European level. It was suggested to rely on dignity and human rights in defining good quality of care.
- A sufficient supply of **well-qualified staff** is essential. However, working in long-term care often has a negative, low-status image which must be upgraded. Good pay is an important part of this, but so is good training.
- The right **balance between central direction and local autonomy** in care provision needs to be struck. It was felt that countries could usefully examine this question together.
- The Swedish use of **private providers** was of great interest to many of the participants, as in most other countries, there is under-provision.
- **Informal care** provides a substantial part of the coverage in many European countries. 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. Some countries have a strong history of formal care, and some of informal care. Mutual learning could take place at some point between those two models. However, it may be that the balance will need to be different in different cultures.

- **Personal budgets** could be an interesting complementary instrument between formal and informal care. Personal budgets allow individuals to use an (virtual) account to buy care, employ care assistants or pay for personal services suited to person's needs.
- The usefulness of **linking health services with social services** was recommended to Sweden for consideration. Furthermore, the provision of health services and social services should not be split between county and municipal level.
- The **financial sustainability** of care services, and the implications for the future of the welfare state, has been well studied in Sweden, and participants have been able to draw valuable information from those analyses.
- The use **of technology in care services** is being studied in a number of the peer countries, and indeed in EU-supported projects, and this information could be shared.