Swedish Association of Local Authorities and Regions

Developments in Elderly Policy in Sweden

Fact sheet

The elderly population

Age	Number	Percent of total population
65+	1,608,000	17.4%
80+	491,000	5.3%

	Average life expectancy at birth		Average remaining life expectancy at age 65	
Year	*Men*	*Women*	*Men*	*Women*
1950	70.9	74.0	13.8	15.0
2007	78.9	83.0	17.8	20.7
2020	80.9	84.4	19.0	21.7
2050	82.1	85.2	19.8	22.3

Special housing for elderly, residents

Long-term care/ housing according to legislation	95,200
Short-term care/ housing according to legislation	9,700
OAP housing for people aged 55+	33,000

Home modifications for the elderly and disabled

People with granted aid	72,700
Costs	EUR 958 million

Day activities

People aged 65+, number	10,600

Special transport services

People granted transport services	341,300
Number of trips	11,100,000
Costs	EUR 2.7 million

Personal safety alarms

People aged 65+, number	145,000

Nursing in home care

Age group 65+	146,900
Age group 80+	110,200

Home care in regular housing

Age group	Number	Percentage of age group
65+	153,700	9.6%
80+	110,700	23.0%

Special housing for the elderly

Age group	Number	Percentage of age group
65+	95,230	6.2%
80+	76,100	16%

Publicly financed care by contractors

Home care	11% of total people receiving care
Special housing	14% of total people receiving care

Staff

Employed	253,300 (incl. sick leave and leave of absence)
Working	223,900
Hourly paid employees	56,900
Upper secondary school	90%
Nursing training	76%

Municipal costs

Total cost	EUR 452 billion
Care of the elderly	EUR 87 million (19.2%)
Elderly care financed by client fees	4%

County councils' costs

Total costs	EUR 219 billion
Share of healthcare	91%
Healthcare for people aged 75–84	23.2% of total bed-days
Healthcare for people aged 85+	14.3% of total bed-days
Healthcare financed by patient fees	3%

Developments in Elderly Policy in Sweden

Telephone: 08-452 70 00
Web sites: www.skl.se/aldre, www.aldreriksdagen.se www.aldreportalen.se

Order copies of the report on phone 020-31 32 30 (within Sweden only) or from our website www.skl.se/publikationer where it can also be downloaded in PDF format.

ISBN 978-91-7164-448-0
ISSN 2000-0545

Cover photo: A feeling of the South Seas in Luleå – Stina Larsson and Folke Nyman relaxing in the sunroom at the Fyren centre for the elderly. Photography: Stig Lakso
Photo on pg 39: Urban Brådhe

Translation: Jennifer Evans/Changeling Translations
Layout/production: Kombinera
Print: Åtta45, Stockholm 2009

Preface

The Swedish Association of Local Authorities and Regions (SALAR) continuously monitors developments affecting the elderly, and since 2001 has been reporting on developments in medical care and social services to the elderly in its *Care of the Elderly in Sweden Today* report. For several years now the public interest has turned ever more not only towards care of the elderly but also towards public policy regarding the elderly. For example, this year's version includes a chapter on the future funding of welfare, an issue that SALAR's special Committee on Welfare Funding deals with.

For this reason, we have changed the focus of our report and for the second year in a row we present it under the heading: *Developments in Elderly Policy in Sweden* – now also in this English-language version.

The report is a summary of official statistics from Statistics Sweden, the National Housing Board and the Swedish Institute for Transport and Communications Analysis, as well as data from the National Board of Health and Welfare, the Ministry of Health and Social Affairs, the Swedish Association of Local Authorities and Regions, the Swedish National Institute of Public Health, the Swedish Institute of Assistive Technology, the EU and others.

The report is for everyone who is interested in and affected by issues regarding the elderly – in Sweden and now also for an international public. We hope that it will contribute to a richer perspective on the situation of the elderly and provide a basis for discussion on the challenges of today and tomorrow in this huge part of the welfare sector.

Developments in Elderly Policy in Sweden was compiled by Kristina Jennbert, co-ordinator of elderly-related issues, with contributions from employees in the Health and Social Care Division, the Education and Labour Market Division and the Economy and Governance Division.

Stockholm, May 2009

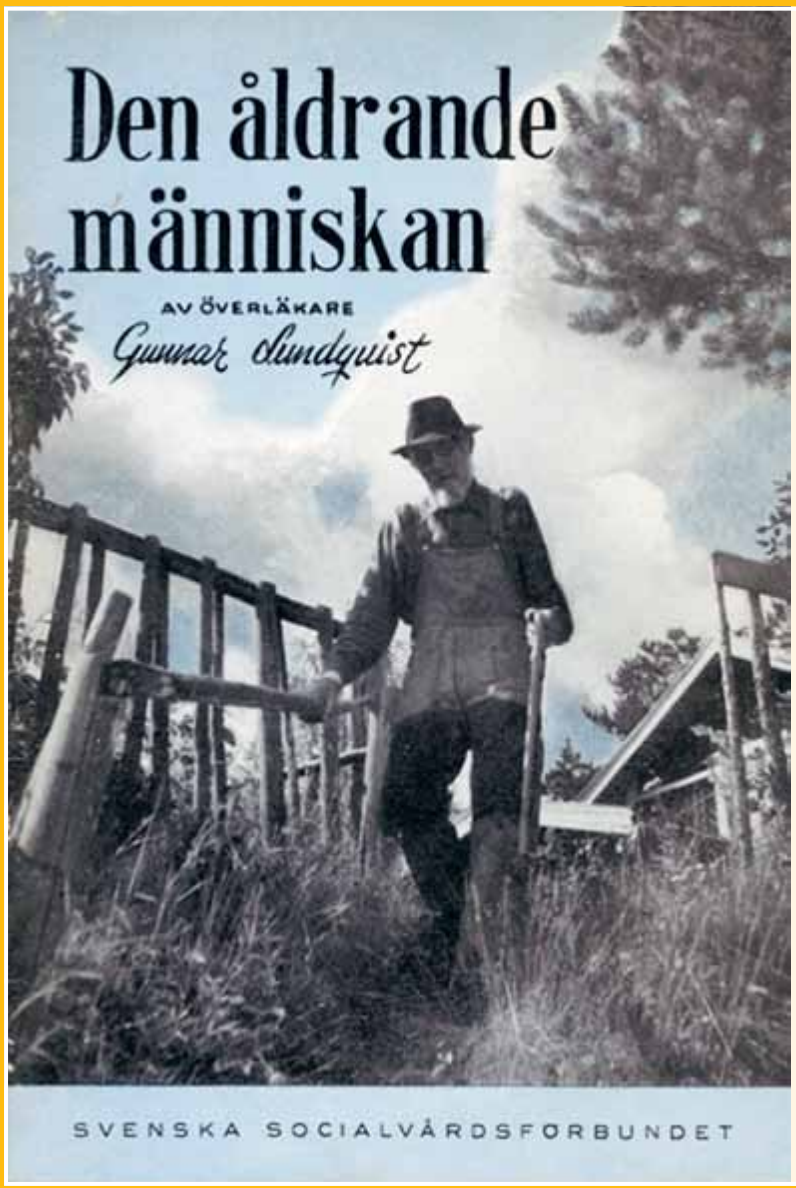
Göran Stiernstedt

Director
Health and Social Care Division
Swedish Association of Local Authorities and Regions (SALAR)

Contents

Demographics and living circumstances

1



"Speak slowly and clearly, facing the elderly person.

You do not necessarily need to raise your voice when you speak to an elderly person. Remember that elderly people cannot move quickly. Be considerate of them in traffic.

Allow plenty of time when visiting an elderly person. Listen to what the person has to say. Do not talk so much yourself. Do not contradict an elderly person unless it is absolutely necessary.

Do not think that rest alone makes an ideal life for an elderly person."

SOURCE: Excerpt from a 1951 pamphlet from the Swedish Royal Board of Social Affairs (now the National Board of Health and Welfare)

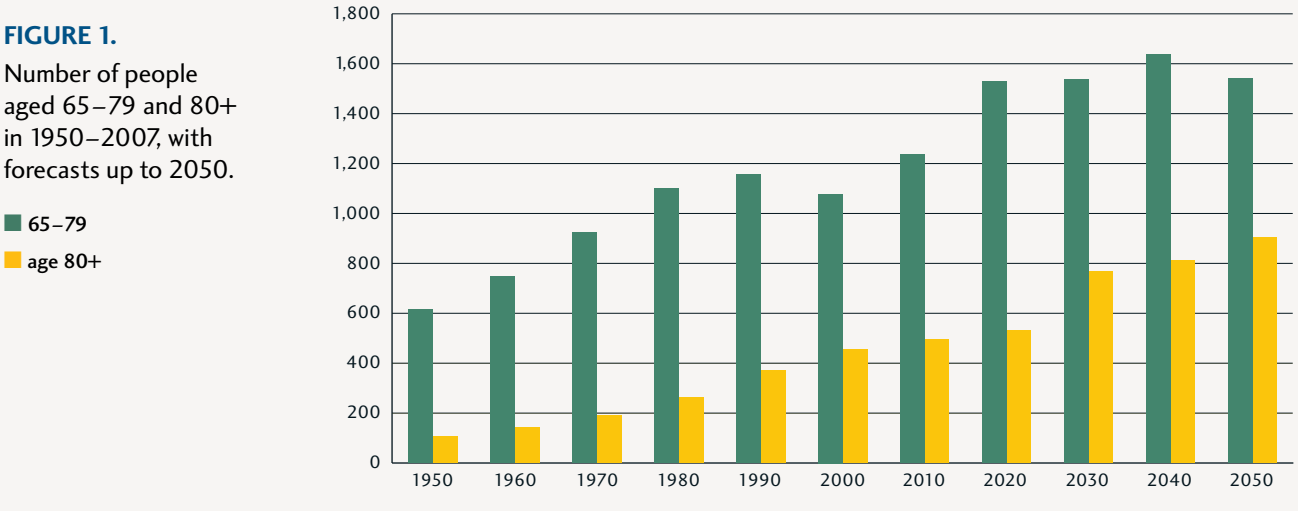
Demographics and living circumstances

An ageing population in Sweden and the world

According to Statistics Sweden's revised population forecast in 2008, the Swedish population is expected to increase each year throughout the forecast period until 2050, when it will reach 10.4 million. The number of people aged 80 and older at that time will have doubled compared with the millennium shift, from 453,000 in 2000 to 903,000 in 2050. In 2008 the population aged 80 and older is 64% women, a figure that is expected to drop to 56% at the end of the forecast period.

In the coming ten-year period the number of people aged 80 and older will remain more or less unchanged. Currently the demographic trend is "taking a breather", while a more significant increase will occur as we approach the 2020s.

FIGURE 1.
Number of people aged 65–79 and 80+ in 1950–2007, with forecasts up to 2050.



This graph shows a significant increase in the number of people aged 80 and older from the 1950s until the millennium shift. Modern care of the elderly developed during this period; the healthcare structure underwent several changes in connection with the ÄDEL reform of 1992, while at the same time the local authorities' and county councils' financial status deteriorated.

Demographic conditions differ between local authorities. Figure 2 shows which local authorities already have a high proportion of people over 80. Dark green indicates higher than 7%. The local authorities in the sparsely populated rural regions in the north of the country are primarily the ones with a large 80+ population. The big-city areas are much lower, under 5%, but are expected to "age" significantly in the coming years.

Elderly people with immigrant background

Total immigration to Sweden in 2007 was a record nearly 100,000. The figure is expected to be high again in 2008, as a total of 92,000 people arrived in the country during the year. The proportion of the entire Swedish population who were born in other countries was 12.9% in 2007, with a slightly lower figure for the population aged 65 and older (11.4%).

Figure 3 shows the proportion of foreign-born individuals per local authority in relation to the total aged 65 and older in 2007. Large proportions of elderly people with foreign roots are mainly found in big cities and in a handful of local authorities near the borders with our neighbours, Norway and Finland.

In SALAR's 2008 conference on the elderly, or "Elderly Parliament", lecturer Sandra Torres gave a speech entitled "Should we feel sorry for elderly immigrants – many myths and few facts". The issue came to the fore in the 1980s, when some of the local authorities in metropolitan areas did the first problem surveys on what it can be like to grow old in a foreign country – most of them based on hypothetical scenarios with no empirical basis. The question is what we really know today about the immigrant portion of our elderly population and what we insist on taking for granted. Sandra Torres states that our assumption that elderly people with immigrant roots are all the same prevents us from seeing the great variety within the group. This has led to a nearly hysterical obsession with issues such as adapting Swedish care of the elderly to cultural needs.

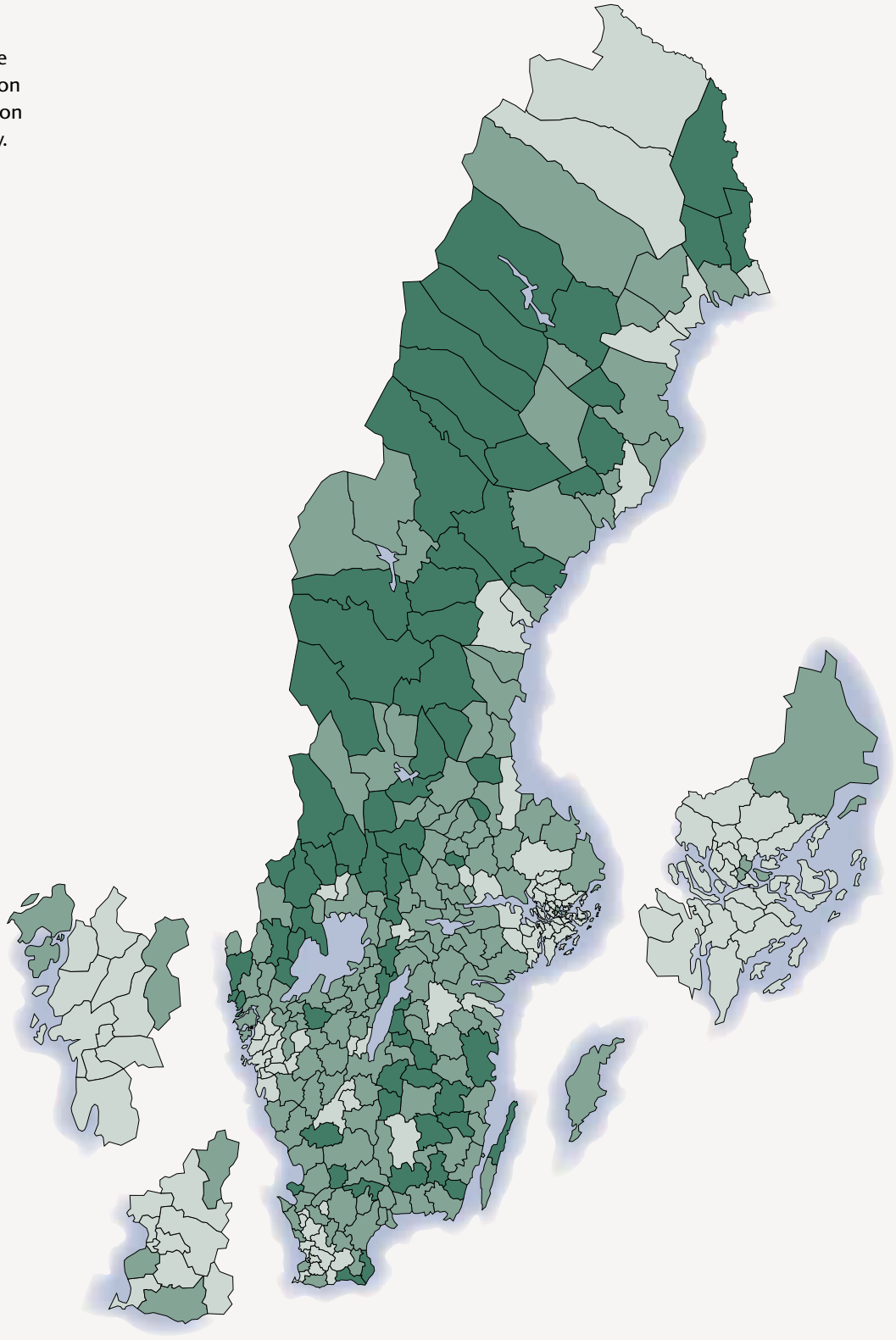
The question is what we really know today about the immigrant portion of our elderly population and what we insist on taking for granted.

Swedish residents today represent some 145 countries. Over half of them were born in the Nordic region and 10% in a non-European country. The knowledge we have is largely based on immigrants who arrived late in life from countries outside of Europe, which is the absolute smallest group in the category of elderly immigrants. One consequence of the on-going ethnification is that many older immigrants do not recognise the portrayals of their situation as particularly unusual or problematic. This makes for a difficult situation for staff in the care of the elderly, who must constantly deal with stereotypes that keep them from dealing with these patients as unique individuals. The special needs of elderly immigrants appear to be a social construction that creates the image of an approaching welfare problem; however, there is no empirical basis for this perception.

FIGURE 2.

Percentage of people over age 80 in relation to the total population in the local authority.

- 2.1–5.2% (77)
- 5.3–6.8% (141)
- 6.9–10.3% (72)



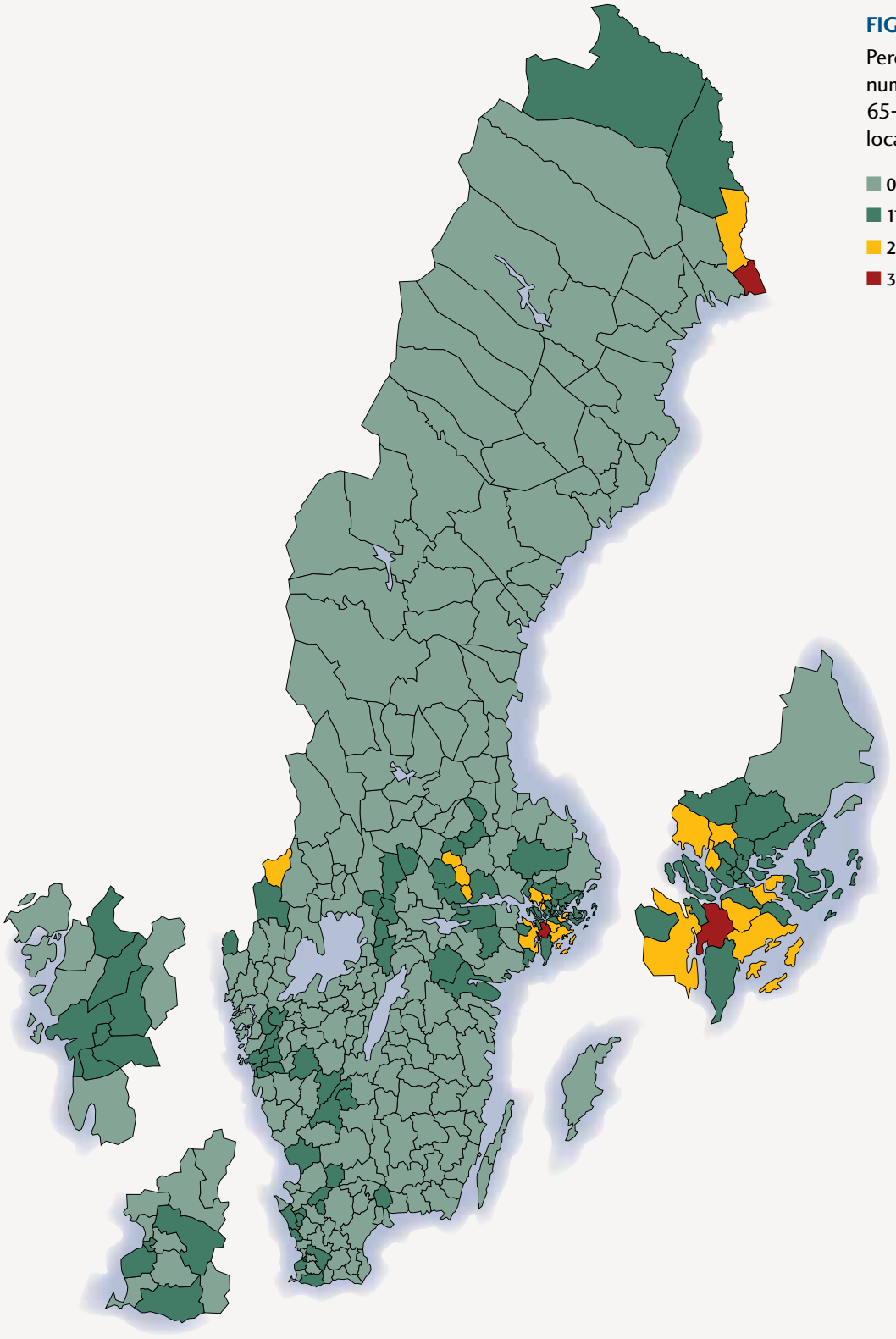


FIGURE 3.
Percentage of the total number of people aged 65+ born abroad, per local authority in 2007.

The world is getting older

Dropping birth rates and increasing life spans are creating an ageing population in Europe. In 2008 there were about 80 million people aged 65 or older in Europe, which amounts to 17% of the total population. The percentage aged 80 and older was 4.4%. The most dramatic change will occur in the 80+ age range, which will increase by 50% in the next 15 years.

Eastern Europe has extremely low birth rates, which will change the population structure in the long run. Slovakia and Poland are two countries where the birth rate is 1.2 children per woman, as compared with the EU average of 1.5, the Swedish rate of 1.7 and the Irish rate of 2.0. Fertility rates have dropped in all countries in the world in recent years, and there is no more talk of a population explosion, but of a future "ageing wave". Fertility rates in China have dropped from 6.2 to 1.7 in the past 50 years, and in India the figure has dropped from 6 to 3.1.

The percentage of people aged 65 and older world-wide is expected to swell from 7% in 2000 to 16% in 2050, according to the UN. People aged 80 and older will increase by 308 million in the coming 50 years, a quadrupling of this group. The largest increase will take place in Asia (*Från folkökning till folkminskning, Befolkningsutvecklingen i världen 1950 till 2050 (From population growth to population decline, Population development in the world from 1950 to 2050)*, Statistics Sweden's demographic reports 2005:4).

Health and living conditions

Average life expectancy

The average life expectancy has increased dramatically, primarily in the first half of the 20th century. In 2007 the average life expectancy in Sweden was 78.9 years for men and 83 years for women, an increase of over 24 years for men and 26 years for women since 1900. Mortality for men is decreasing more than for women, which is

TABLE 1.
Average life expectancy and average remaining life expectancy, broken down by sex, with forecasts up to 2030.

SOURCE: Statistics Sweden 2007, Medellivslängd och återstående medellivslängd (Average life expectancy and average remaining life expectancy)

	Average life expectancy at birth		Average remaining life expectancy at age 65	
Year	*Men*	*Women*	*Men*	*Women*
1800	35.4	38.4	9.3	9.8
1850	40.5	44.4	10.0	10.8
1900	54.5	57.0	12.8	13.7
1950	70.9	74.0	13.8	15.0
2007	78.9	83.0	17.8	20.7
2010	79.4	83.3	18.0	21.0
2020	80.9	84.4	19.0	21.7
2030	82.1	85.2	19.8	22.3

reflected in a greater increase in remaining life expectancy for men than for women at age 65. The forecast shows continued growth of the average life expectancy.
The primary reason for the increasing life expectancy is a significant drop in morbidity and mortality in cardiovascular diseases. Some explanations for this may be healthier lifestyles with better diets, less smoking and so on, as well as better healthcare, medicines and improvements in working environments. The National Board of Health and Welfare's Public Health Report in 1997 estimated that Swedish healthcare has extended the average life expectancy by 5 years, of which 1.5 years were due to preventive measures.

At the same time, new studies show that obesity and overweight have increased significantly in recent years. Obesity is about equally common among women and men in the population as a whole. In the period from 1980/81 to 2004/05 the number of obese people in the population increased from 5% to 10%. The proportion of overweight people is significantly higher than the proportion of obese people, and is significantly more common among men than women, based on body mass index (BMI). In 2004/05, about half of Swedish men were overweight or had some degree of obesity. The corresponding percentage among women was just over a third. In the 65–84 age group, the percentage of obese people, with a BMI in excess of 30, had increased from 9%–16%.

In the period from 1980/81 to 2004/05 the number of obese people in the population increased from 5% to 10%.

Average life expectancy and average remaining life expectancy after age 65 varies with civil status, socio-economic position, region, housing situation and more. People with a higher education have overall lower mortality than those with upper-secondary or lower education. The relative difference in mortality between levels of education is generally greatest among younger people; the differences even out with increasing age.

A current doctoral thesis discusses the importance of level of education as a possible factor for assessing future need for healthcare (*Demographics and Future Needs for Public Long-Term Care and Services among the Elderly in Sweden: The Need for Planning*, Ilija Batljan, Department of Social Work, Stockholm 2007).

Regional differences in average life span in Sweden and in the world

In Sweden there are big regional differences in remaining average life expectancy. A 65-year-old in the county of Uppsala, Kronoberg or Halland will live a bit more than a year longer than a 65-year-old in Norrbotten or Västernorrland. The differences are even greater when you compare local authorities, and the greatest difference is in men.

A report from the Swedish National Institute of Public Health analyses various measures of ill health and other factors that may affect health (*Hälsan och dess bestämningsfaktorer i olika typer av kommuner (Health and its determinants in different types of local authorities)*, FHI 2003:49). The analysis shows differences between groups of local authorities just as between men and women. A person's local author-

Suicide among men is most common in the sparsely populated and rural communities, while it is most common among women in the big cities.

ity region explains one-third of the difference in ill-health figures and one-fifth of the difference in average life expectancy for both men and women. Among causes of death, ischaemic heart disease has a rural factor – it is most common in the sparsely populated and rural areas and least common in the suburban, urban and metropolitan areas. In contrast, alcohol-related mortality is common both in big cities and in the countryside. Suicide among men is most common in the sparsely populated and rural communities, while it is most common among women in the big cities.

Differences in life expectancy are also visible between regions with more and less resources. The authors of *Hälsan på spåret* (*On the Track of Health*, Swedish National Institute of Public Health, 2006:06) traced differences in average life expectancy based on underground and commuter train lines in the Stockholm area. On the Östermalm–Skarpnäck route, consisting of nine underground stations, the average life expectancy differs by 2.7 years for women and 3.5 years for men.

The Stockholm County Council's last Public Health Report in 2007 shows a difference in average life expectancy between a woman in the Danderyd district and a man in the Sundbyberg district of just over 9 years, and that this difference has increased since the previous report in 2003.

The difference in the average life expectancy of a woman in Danderyd and a man in Sundbyberg is a bit over 9 years

The differences between countries of the world is also great. Japanese women live longest world-wide, averaging 85 years, while a woman in Swaziland lives to 33 on average. The average life expectancy in China has expanded by 30 years in the past half-century, while in Malawi the life expectancy for women has only increased by three years, mostly due to HIV/AIDS. Looking at the world at large, global average life expectancy has increased from 45 to 65 years, and the UN estimates that it will grow by an average of 10 years in the next 50 years.

Elderly people's health, functional capacity and need for assistance

In a European perspective, people aged 85 and older in Sweden reported a higher self-assessment of their health than the same age group in other EU countries.

The health status of the elderly is closely related to natural ageing, but is also connected to lifestyle – diet, exercise, overweight, smoking, alcohol use and so on. In the 1980–2003 period, age-related differences in health have decreased, and health trends among the elderly have definitely been better than in younger people. A 2006 report from Statistics Sweden shows that elderly people's subjective perception their health status has improved significantly *(Äldres levnadsförhållanden; Arbete, ekonomi, hälsa och sociala nätverk 1980–2003 (Living conditions of the elderly: Work, finance, health and social networks 1980–2003))*.

In a European perspective, people aged 85 and older in Sweden reported a higher self-assessment of their health than the same age group in other EU countries. Figure 4 shows the percentage who assess their own health as good or very good in a survey of elderly people in Europe. Topping the list are Sweden (51%), the United Kingdom (47%) and Iceland (46%). In southern Europe, Italy, Greece and Malta, the percentage of people aged 85 or older who assess their own health as good or very good is significantly lower.

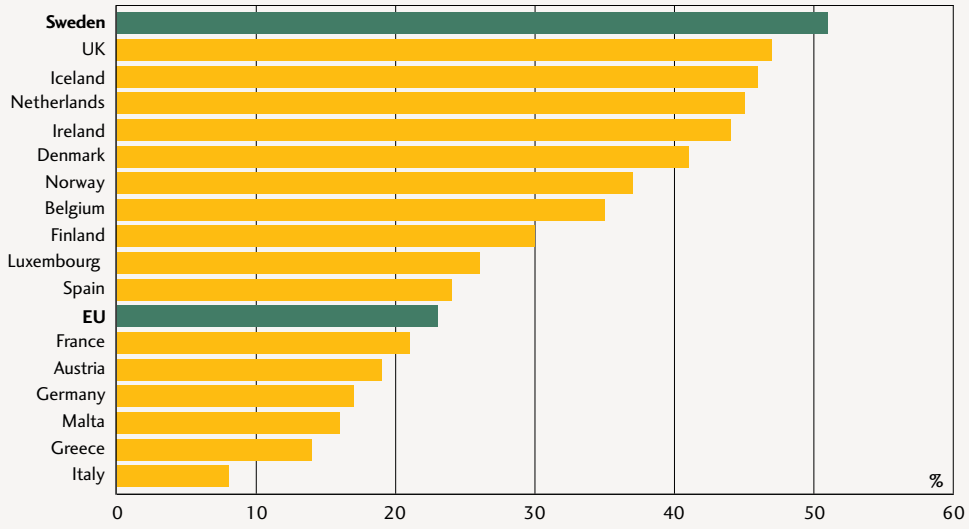


FIGURE 4.
Self-reported health. Percentage of residents aged 85 and older who consider themselves to have good or very good health in Europe in 2006.

SORCE: Eurostat

The future health trend for the elderly is the subject of extensive studies with controversial, conflicting results pointing to both better and poorer health. The choice of health indicators, varying development trends over time, uncertainties in available choices, drop-outs and how representative the study group is are some factors that can explain the contradictory results. However, nearly all studies show a positive trend in elderly people's ability to manage daily activities. Some explanations for this are access to better technological equipment in the home, home modifications, rollators and so on, which compensate for physical disabilities.

However, the percentage of elderly people reporting various kinds of health problems and diagnosed diseases has increased over time. Most of this increase involves only minor problems, but the proportion of more severe problems has also increased, as has the proportion of people reporting several problems at the same time. Reduced mortality even among elderly patients who have survived a stroke, heart failure or other such adverse event means that more people are living with functional disabilities and residual symptoms *(Mats Thorslund, Läkartidningen nr 43, 2005)*.

The Stockholm County Council's 2007 Public Health Report shows that the health situation of the county's elderly population is relatively good, but that there are differences between age groups. In the 65–79 age range, ⅔ described their health as good or very good, as compared with only 40% of the 80–84 age range. Between 1998 and 2002 self-reported health decreased, but then appears to have stabilised since 2002. In the 65–74 age group, 90% of men state that they can manage their primary activities, compared with 81% in the 75–84 age range.

In the 65–84 age range 48.8% of women and 55.3% of men are overweight or obese. In the same age range, 17% of women and 9% of men describe themselves as extremely worried, downhearted or diagnosed with clinical depression.

Need for assistance

The report we mentioned previously, *Äldres levnadsförhållanden* (*Living Conditions of the Elderly*, Statistics Sweden 2006) shows that most elderly Swedes – and the figure is increasing – had no need for assistance at all, both in 1988/89 and in 2002 (65% and 73% respectively). In both studies, one-tenth needed significant assistance if we include those who also need help with personal care.

The percentage of elderly people stating that they need assistance has decreased in both sexes and in all age groups. In 1988/89, nearly one-fifth of men aged 80 and older stated that they had no need of assistance. The figure was just over half four years later.

TABLE 2.
Elderly men and women's own stated need for assistance, as a percentage.

		Age 65–79			80 and older		
	Year	*No need*	*Minor need*	*Major need*	*No need*	*Minor need*	*Major need*
Men	88/89	76	18	6	19	50	31
	02/03	89	7	4	54	26	20
Women	88/89	75	20	5	25	41	34
	02/03	82	14	4	39	35	26

Family and social networks

In total one in four people between the ages of 20 and 85 is alone – an increase of four percentage points since the early 1980s. The percentage living alone is greater among elderly men, but the increase is greatest among younger and middle-aged men. Among old-age pensioners, more live with their own families today than a few decades ago – a result of the fact that people live longer, healthier lives. As most women marry older men, and men have a higher mortality in general, women run a greater risk of being left alone. The majority of women live alone late in their lives, while the majority of men live with someone until they die.

In a magazine called *Äldre i centrum (Focus on the Elderly)*, issue 3:2004, Professor Gerdt Sundström writes about what he calls the "Golden Anniversary Avalanche". Never before have so many Swedes been married so long to the same person as they are today. Each year 20,000 women become widows and 10,000 men become widowers. As a rule they have many years of marriage behind them and half of all marriages last to their golden anniversary, ending only in the death of one of the partners. Around 1980, lifetime marriages lasted an average of 40 years; today that figure is 49 years.

The risk of divorce has increased since the 1970s. Of couples who married in 1955, 16% were divorced twenty years later. Of those who married in 1980, 34% were divorced twenty years later. It is also increasingly common to live together without being married or to "Live Apart Together", LAT. The greater life expectancy and

larger number of partners during one's life means that more people have relatives of multiple generations.

The most important social contacts for many elderly are their partner and children. Over half of all elderly people have both a partner and children. More of the single elderly have children today than in the late 1980s. An unchanged proportion – 39% – have siblings. Fourteen percent are without partner or children, corresponding to about 220,000 people aged 65 or older.

In 1954, about 27% of people aged 67 and older in Sweden lived with their children. Today about 4% share a household with their children, while among elderly immigrants the figure is about 7%. In many countries elderly people are forced to move in with their children or other relatives when they can no longer taker care of themselves and there is no community care for the elderly, or such care is too expensive. In Spain 30% of the 80+ population live with their children. In Italy the figure is 20%.

Half of those interviewed in the National Board of Health and Welfare's report *Äldres levnadsförhållanden 1988–2002 (Living Conditions of the Elderly, 1988–2002)* have children living within a 10 km radius, and two-thirds see their children at least once a week. In the 65–79 age range, 81% of women and 65% of men have a close friend they can talk to about anything. Even in the 80+ age range, 62% of women and 54% of men have such a close friend. In general, the elderly have a more close-knit social network today than before, and many of them help someone else outside their own home.

According to the Public Health Survey of 2007 (Stockholm County Council), most elderly people have regular contact with friends and family. Seventy-five percent get together with one or more of their closest friends once a week, 12% do so daily, and 5–7% meet friends less than once a month. Nearly 95% of women speak with family and friends on the phone at least a few times a week. The corresponding figure for men is 85%.

The greater life expectancy and larger number of partners during one's life means that more people have relatives of multiple generations.

Loneliness among the elderly

Infrequent or nonexistent contact with children, partner or friends is not the same as loneliness. People can feel lonely even among other people and family members. Statistics Sweden's survey on living conditions provided the following picture of various age groups' perceptions of loneliness.

TABLE 3.

Feeling of loneliness	Age 55–64	Age 65–74	Age 75–84	85–
Never feel lonely	55	56	49	38
Occasionally, but it's not a problem	36	36	40	41
Occasionally and would like to have more social contact	7	6	7	10
Often feel lonely	2	1	3	7
Almost always feel lonely	1	1	1	5

One necessary condition for avoiding loneliness is the existence of people one wants to and actually can spend time with.

Similar results are found in a research report from the Danish Knowledge Centre on Ageing (*Portrætter af gamle ensomme – gør boligen en forskel?* (*Portraits of Lonely Elderly People – does housing make a difference?* 2006)). Three percent in the 52–62 age range state that they often or occasionally feel lonely; the corresponding figure in the 77–82 age range is five percent. A conclusion of the study is that there is a close relationship between loneliness, physical and mental disability and social alienation.

All of those interviewed experienced loneliness rooted in the lack of a spouse or the lack of a physical, social and emotional relationship. One necessary condition for avoiding loneliness is the existence of people one wants to and actually can spend time with. Different kinds of housing for the elderly often have meeting places, but this is no guarantee that there are others there that the individual wants to spend time with.

Living conditions of the elderly

Nearly 94% of the population aged 65 and older live in regular housing – private houses or blocks of flats. The remaining 6% live in special housing, which is granted on a needs basis under the Social Services Act.

An increasing proportion of the elderly population lives in detached or semi-detached houses, and the amount of space available for elderly residents has increased significantly *(Äldres levnadsförhållanden (Living conditions of the elderly)*, Statistics Sweden 2006). Flaws in housing standard and accessibility in the home are no longer criteria for moving to special housing, a major change from the situation just a decade ago. With increasing age, such factors as high thresholds, stairs between floors in the house, lack of a lift, heavy gardening and the need to clear snow can greatly inhibit an elderly person's ability to live independently.

TABLE 4.

Age	Detached and semi-detached house	Block of flats
65–74	63% (+14%)	36% (-13%)
75–84	45% (+5%)	48% (+2%)
85+	29% (+6%)	43% (+2%)

In 2002 the National Housing Board estimated that a total of 320,000 households live in flats on the third floor or higher in a building with no lift.

A large proportion of people approaching retirement age live in detached or semi-detached houses built in the "housing boom" of the 1970s. Of a total of 518,000 households living in houses, 230,000 are in the 50–64 age range and 83,000 are pensioners. Of those living in blocks of flats, many live in buildings from the 1940s, 50s and 60s that often have no lift.

For the past few years the Swedish municipalities have been restructuring special housing for the elderly, including service flats. Many service flats no longer meet the current requirements for special housing, and increasingly the operations are being transferred to municipal housing companies or other administrators.

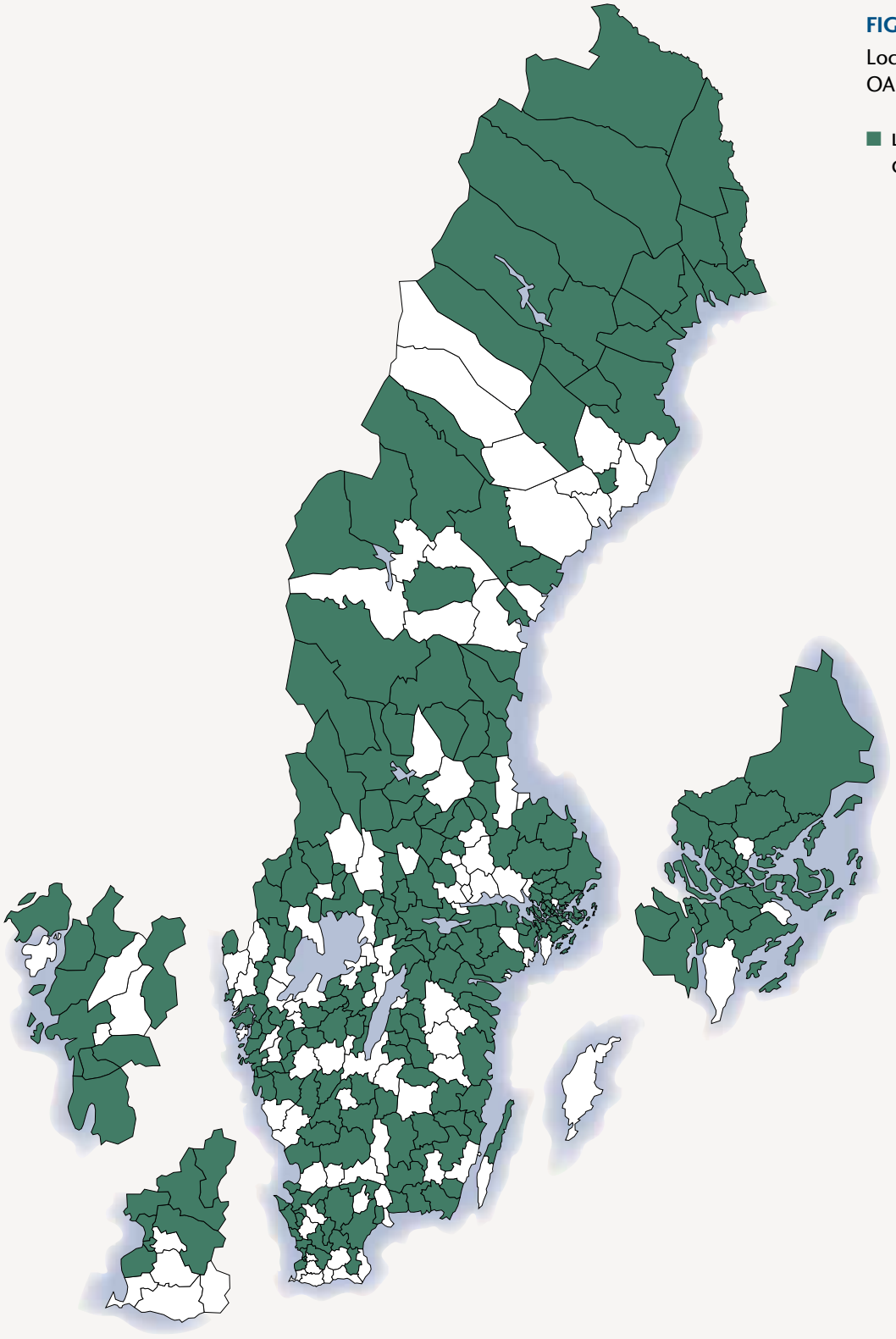
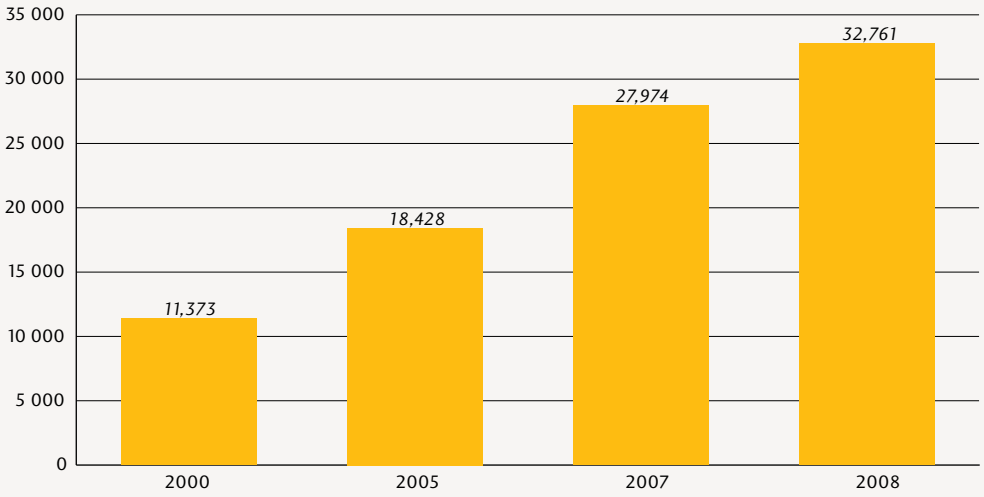


FIGURE 5.
Local authorities with OAP flats in 2008

Local authorities with OAP flats (185)

FIGURE 6.
Increase in the number of OAP flats 2000–2008.



This development is reflected in the growing number of OAP flats, homes intended for people over a certain age and meeting the requirements of good accessibility and requests for social activities. These homes are brokered by the housing companies, and where needed home help services are offered, just as in other regular housing. In the early 21st century there were some 12,000 OAP flats, and five years later there are nearly 20,000 *(Seniorbostäder, en kartläggning (OAP flats, a survey)*, Statistics Sweden 2005). In 2008 a new survey was conducted with the Delegation of Elderly Living, which shows that the number of OAP flats has increased to nearly 33,000 and are found in 67% of Swedish municipalities. Another 5,000 flats are planned.

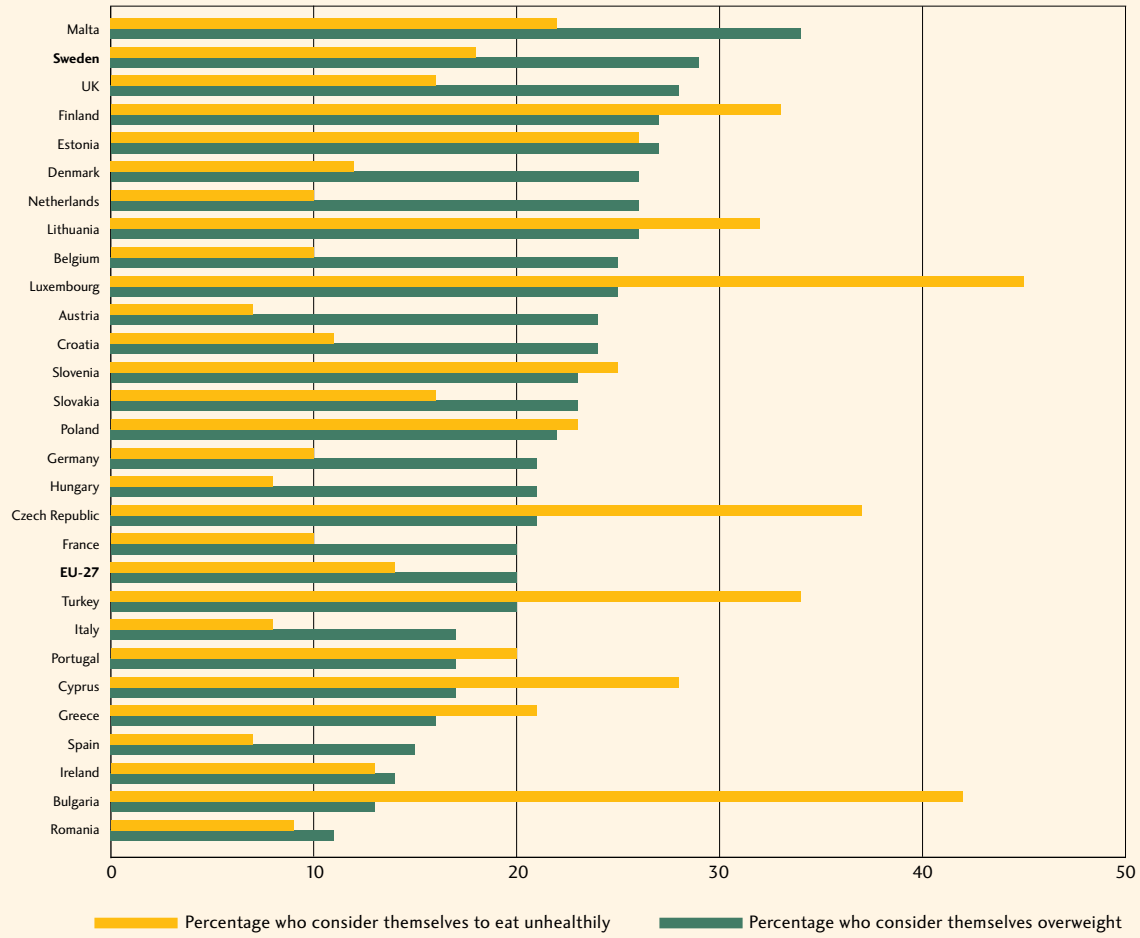
The responses also indicate that over 10,000 OAP flats are former service flats, which were previously covered by the statistics for special housing forms for which a formal decision from the local authorities' social services was required.

Today 52% of elderly people live in flats owned by local-authority owned companies, an increase from 24% in 2000. For the remainder, ownership is split up among tenant-owner associations, foundations and private property owners.

Early on and preventive

– from informal care to personal safety alarms

2



In the spring of 2007 some 29,000 residents in the EU-27 were interviewed about their living habits, lifestyles and so on. On average 20% considered themselves overweight and 14% stated that they did not eat particularly healthy food. This figure shows that Malta and Sweden tip the scales most in Europe – however, there is no clear tie between excess weight and unhealthy food.

SOURCE: Eurobarometer Health and long-term care in the European Union, 2007.

Early on and preventive – from informal care to personal safety alarms

Family carers and community support

Extent of informal care

Statistics Sweden's report *Äldres levnadsförhållanden (Living Conditions of the Elderly)* describes changes in informal care by family carers since the 1980s. Many elderly receive assistance from family members and home help services, which means that there is significant overlap. This overlap was greater among those who live alone than among those who live with a partner, and one-third received assistance from both home help and family carers.

Between 1988/1989 and 2002/2003, the percentage who had only home help services had decreased among men aged 80+ and living alone, and the percentage of those with both home help services and family carers had increased. For women in that age range living alone, the percentage of those with "combined assistance" had increased, as had the percentage who had only informal care.

The Statistics Sweden report further categorises care providers, who make up an estimated 24% of the population aged 55 and older. Of them 20% assist someone outside of their own household and 4% help someone within their own household. Based on the extent of the help given and whether the recipient is a person in the care provider's own household, Statistics Sweden divided care providers into family carers, care providers and helpers.

Family carers make up 3% of the population aged 55 and older (84,000 people). They help one person *in their own household* daily or several times a week, and in four of five cases the recipient is a spouse. This group provides the most extensive assistance – nine of ten do so daily. Being a family carer is most common in the ages of 75–85 and is equally common among women and men.

Care providers make up 6% of the population aged 55 and older, and assist a person *outside their own household* daily (three of ten) or several times a week. Six of ten help a family member and the others help a friend, neighbour, workmate or other person to whom they are not related. Being a care provider is most common in the 55–74 age group and among women.

Helpers are the largest group, amounting to 15% of the population aged 55 and older. They provide assistance once a week or less often, and in six cases of ten the recipient is a family member.

The National Board of Health and Welfare report *Omsorg människor emellan, en översikt av omsorgsgivande i den svenska befolkningen* (*Care Between People, an overview of informal care in the Swedish population*, 2006) confirms the perception of extensive care provided by family and friends of all ages, but in particular among people aged 45–64. There are signs that informal care is increasing in general, but the true scope depends in part on how such care is defined. Informal care appears to be more gender-equal in Sweden than on the continent – Swedish men provide care almost as often as women, although perhaps with less intensity. Both men and women often provide informal care while also holding a job. One in five working people also provide informal care, and these people appear to be in better health than those not providing informal care. However, a smaller group caring for a partner or other near relative does experience some degree of health problems. Informal and formal care – the latter primarily in the form of home help services – often overlap in Sweden, particularly when the recipient is an elderly person living alone. According to the National Board of Health and Welfare report, more than a million Swedes provide informal care to loved ones. Part of the increase that has been observed is probably due to increasing need, but part of it likely reflects a general growth in social networks: more near and dear people means more informal care to provide.

Informal care appears to be more gender-equal in Sweden than on the continent – Swedish men provide care almost as often as women, although perhaps with less intensity.

Developments in informal care

Government support for informal care was implemented almost ten years ago. In 1999–2001, SEK 300 million were allocated to stimulate the development of support to family members, called the Anhörig 300 intervention. The National Improvement Plan for Healthcare (2001–2004) also highlighted family members, and in 2005 the government decided to contribute SEK 25 million per year over three years (2005–2007). The budget bill for 2006 earmarked another SEK 100 million per year for the 2006–2007 period, resulting in a total of SEK 125 million per year. Of this funding, family and pensioners' organisations received SEK 5 million and another SEK 5 million were set aside for a national centre for excellence regarding problems faced by family members.

The 2008 incentive payment totals SEK 100 million, of which nearly SEK 90 million is earmarked for the local authorities. The budget bill for 2009 still has the nearly SEK 100 million, plus an additional SEK 15 million, for a total of SEK 114,850,000. Of this money, SEK 10 million goes to family and pensioner organisations and to two national centres for excellence, one for family members dealing with the elderly and one for dementia issues. Organisations seeking funding apply to and receive grants from the county councils. For 2010 the incentive payment is expected to be increased by SEK 15 million.

In 2007, 90% of local authorities applied for incentive funds. The reasons that not all local authorities applied for funding include lack of resources, priority given to

other means of development and the fact that the local authority is busy developing support to family members using previous incentive funds.

The goal of this funding is to develop an infrastructure for support to family members, rather than to fund temporary projects. The local authorities' involvement in the issue has increased very significantly in several areas since 2004, as has the work with county councils, volunteers and non-profit organisations.

In 2007, 95% of local authorities stated that they are pursuing development; this is the highest proportion since 2002, when the National Board of Health and Welfare first began monitoring the local authorities' efforts to support family members. Table 5 shows the development of various forms of support since 2004.

TABLE 5.

Type of support	Percentage of local authorities offering support/ pursuing improvement efforts			
	2004	*2005*	*2006*	*2007*
Pursuing improvement efforts	73	78	90	95
Family support consultant	50		55	
Respite via short-term care	99	100	99	100
Respite via day activities	92	92	93	94
Respite in the home	91	94	94	97
Individual talks	74	81	84	90
Family support group	72	76	82	87
Family support centres	32	40	50	59
Education	32	33	38	69
Recreation, well-being activities	12	18	35	48
Volunteer centre	–	–	26	30
Other type of support	31	34	41	52

In 2006 a survey was conducted on how many local authorities had a family support consultant and the result was 55%. This year's survey was answered by co-ordinators with some 70 different professional titles, some with the words "family support" in the name and others without. Because of the great diversity, the results were inconclusive.

All local authorities provide respite in the form of short-term care, and nearly all also provide day care/day activities and short-term care assistance in the home. One quarter of the local authorities do not require a formal decision on support for an informal care giver to receive respite assistance in the home, and 70% of local authorities provide such assistance at no charge. The number of hours offered averages at 12.5 per month, and 73% of local authorities offer respite services on week-ends as well as week days. The greatest increase in measures in recent years is in training of family carers, activities for wellbeing and family support centres/meeting places for family members.

According to the National Board of Health and Welfare's 2007 report on support to family members, *Kommunernas anhörigstöd (Community Support to Family Mem-*

bers), there were 276 family support centres or meeting places, 156 of which had been started since 2006. Nearly 80% are a part of standard local authority operations.

In the autumn of 2007 the National Board of Health and Welfare launched a new website called "Focus on family carers". By autumn 2008 the site had ten articles written by researchers and people working to develop support to family members.

Support to family carers (Ds 2008:18)

In April 2008 the Swedish Ministry of Health and Social Affairs presented a memorandum with a proposed change to chapter 5, section 10 of the Social Services Act (2001:453). The aim was to clarify that the Ministry *shall*, rather than *should*, offer support or respite to people caring for a family member who has a long-term illness or is elderly, or supporting a person with a functional disability. The memorandum has been circulated for comment and a bill is being prepared in the Swedish Government Offices.

National Centre for Excellence – Family carers

March 2008 saw the opening of the Nationellt Kompetenscentrum Anhöriga (National Centre for Excellence – Family carers), which answers to the Ministry of Health and Social Affairs and aims to collect, structure and spread information about family carers. The centre's new internet portal, **www.anhoriga.se**, was launched on 6 October 2008.

Family carer allowance

A family carer allowance is a form of remuneration in the national insurance system for individuals who choose to leave gainful employment in order to care for a severely ill family member. An employee can also receive this allowance if the patient is being treated at a medical facility. Not only family members but also others with close relationships to the ill person, such as friends or neighbours, can be entitled to the allowance. A family carer allowance provides for 60 days of care. In 2007 some 10,000 people were remunerated for just over 93,000 days (half days and quarter days re-calculated to full days). Since 1999 the number of days' allowance paid out has increased by 21%.

TABLE 6.

Year	Insured	Days
1999	7,625	77,335
2007	9,843	93,271

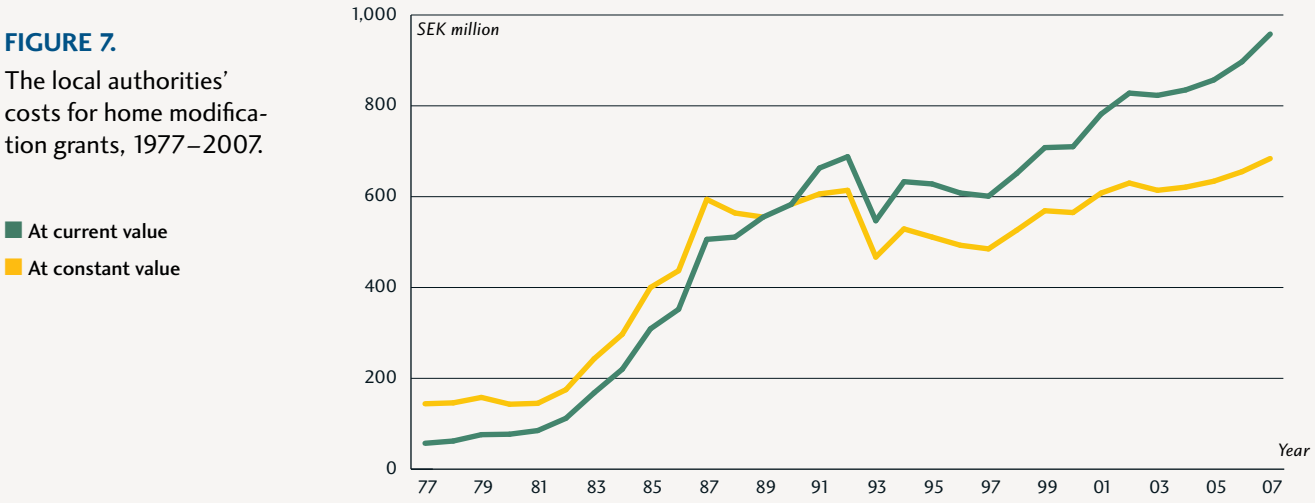
Home modification grants

According to the Swedish Act on Home Modification Grants, etc. (1992:1574) the local authorities provide grants for certain measures needed for the disabled to use their homes efficiently. Applications are made to the local authority and there is no price ceiling for home modification grants.

The number of approved grants increased from 67,200 in 2006 to 72,700 in 2007. The total cost to the local authorities rose from SEK 897 million in 2006 to SEK 958 million in 2007.

About 61% are under SEK 5,000, and about 84% are under SEK 20,000. The average cost per case amounted to about SEK 13,200 in 2007. Modifications to houses are more expensive than those in blocks of flats. The average value of modification costs in houses in 2007 was SEK 19,200, while for blocks of flats it was SEK 9,400 (National Housing Board 2008).

FIGURE 7.
The local authorities' costs for home modification grants, 1977–2007.



Day activities

Day activities in the official statistics refer to individually granted support in the form of hobby activities, social activities, treatment, rehabilitation and so on to people with a dementia disorder or physical or mental disability. As of 1 October 2007 about 9,700 people aged 65 and older in regular housing and just over 900 people in special housing had been granted day activities, a total of 10,600 people of whom 64% were women. This is a reduction of over 2,100 people compared with 2006.

Volunteer work

A very large percentage of the population does volunteer work in various aid organisations, cultural activities and clubs. The sports movement in particular sees a great deal of volunteerism. This is confirmed by studies from 1992, 1998 and 2005 (*Medborgarnas insatser och engagemang i civilsamhället (Citizens' efforts and commitments in civilian society)*, Sköndal Institute 2005). This population study, which covers a long period in time, shows that men continue to volunteer somewhat more than women and that a larger proportion of women are involved than previously. The age pattern remains unchanged throughout these years: adult, middle-aged people are most commonly involved in volunteer work. In the 75–84 age range 32% of men and 24% of women participate in volunteer work. The study shows that Swedes are exceptionally active in an international perspective, and claims of dwindling dedication are not supported by these studies. In terms of values, volunteer work continues to be viewed positively by the population.

The study shows that Swedes are exceptionally active in an international perspective, and claims of dwindling dedication are not supported by these studies.

A relatively large part of the population provides informal support and assistance *outside* the home or to a person in need of care *within* the provider's household. The total amount of volunteerism appears to have remained quite stable throughout the 1990s – about 30% provide informal assistance outside the home – and the amount of time spent is equally stable.

Of the 50% of the population aged 16–84 who state that they provide informal assistance outside the home, 28% do so for people who do *not* require special care. Caring for a family member within the household involves a relatively small percentage of the population, but each of the people providing such help provides many hours a month – an average of 63 hours. See also pages 28–30.

	Assistance outside their own home *(tot)*	**Assistance outside their own home** *(no need for care)*	**Assistance outside their own home** *(special need for care)*	**Assistance within own home** *(special need for care)*
Percent	50	28	22	5
Hrs/month	12	9	14	63

TABLE 7. Percentage of the population aged 16–84 who had performed informal assistance measures in 2005; average number of hours.

The largest percentage of assistance was provided to someone in the immediate family or other relatives (53%), which means that the remaining 47% regularly supported friends, neighbours and colleagues.

The special-interest organisation Forum för frivilligt socialt arbete [Forum for Voluntary Social Work] has published a book about values-based welfare, *Samhället är större än staten* (*Society is Bigger than the State*, 2006), with contributions from various organisations, political figures and research. "As I see it, we will become more and more dependent on volunteers to enhance welfare," says Bengt Westerberg, president of the Swedish Red Cross.

Special transport services

In 1975 a special government grant for special transport services was introduced, which led to the rapid expansion of these services in all local authorities. In 1982 the Social Services Act made it obligatory for local authorities to provide special transport services for the disabled. As of 1997 transport services became a part of traffic policy and no longer falls under care and support. According to the National Special Transport Services Act (1997:736) the local authorities are responsible for ensuring good-quality special transport services. Special transport services can be granted to people who have a permanent functional disability and have significant difficulty in getting around on their own or travelling with public transport. The most common transport is a taxi, but special vehicles are sometimes included.

On 31 December 2007, a total of 341,288 people were entitled to special transport services, a drop of nearly 13,000 people as compared with the previous year. The number of people granted special transport services dropped from 1997–2007, from 47 to 37 per 1,000 people. One reason for this may be that public transport has become more accessible and adapted to people with disabilities. On the county level, the percentage of residents granted special transport services varies from 27 per 1,000 residents in the County of Kalmar to 46 per 1,000 in Västernorrland. About 80% of those granted special transport services are over 65, and nearly 38% of people aged 80 and older are granted special transport services. Of those who were entitled to special transport services in 2007, about 67% were women.

A total of about 11,108,000 one-way trips were made with special transport services in 2007, and just over 80,600 with the national special transport services. The number of single trips with special transport services has dropped by over 26% in the past decade. On average, each person granted special transport services makes 33 trips per year, a reduction of 5 trips per person per year compared with 1996.

Users who must travel outside the range of the local transport services can be approved for national special transport services. The local authorities grant approval and provide funding for expenditures in excess of the regular travel costs. This allows for travel by air, rail or other means, or by taxi or special vehicles, at a cost to the traveller corresponding to a standard second-class train ticket.

The net cost to the local authorities for special transport services and national special transport services in 2007 amounted to SEK 2.7 billion including the County Council of Stockholm, which manages special transport services for the whole county. The net cost increased by SEK 125 million between 2006 and 2007.

Assistive devices, IT and technology for the elderly

Assistive devices

The responsible authorities for healthcare – the local authorities and county councils – are required to provide assistive devices for people with disabilities. These activities are regulated by the Act on Health Services. The local authorities are re-

sponsible for providing assistive devices to people with physical disabilities living in special housing in all communities, and in regular housing in the 160 communities where the local authority has taken over home medical services. The responsible authorities for healthcare determine what constitutes an assistive device, so the range varies. Many local authorities and county councils do not provide simple assistive devices – mainly household aids – which must be bought from the county councils' assistive device centres or commercially.

There are no reliable statistics regarding the costs of assistive devices, but the collective costs to the county councils and local authorities is estimated to be at least SEK 6–7 billion annually. Estimates show that most assistive devices, about 70%, are prescribed to elderly people. Above all, they are aids for motor disabilities, hearing and visual impairments. The Swedish Institute of Assistive Technology (SIAT) is pursuing a statistical development project in 2008–2010 by order of SALAR.

In autumn 2008 a compilation of assistive device statistics being conducted outside of SIAT will be completed.

Technology for the elderly

In the spring of 2007 the Government requested the Swedish Institute of Assistive Technology to manage a development programme, "Technology for the elderly", focusing on technology for family carers, increased information about and availability of good products for the elderly, and technical devices for the home that can make it easier for elderly people to stay in their familiar homes. SIAT has SEK 22 million annually for the years 2007–2009 to carry out the project. A total of 31 projects were granted funding in 2008, and the second (and next-to-last) application period ends in October 2008. The final project report will be published in 2010.

The first two application periods in the project resulted in over 160 applications. The 71 development projects that were granted development funding are now under way and being reported in continuously. The third and last opportunity to apply for development support was 15 October 2008. The single largest project in the programme began in January 2008 in the province of Halland: an experimental project aiming to provide information on and access to good products for the elderly. Interested parties can read about the project on **www.lthalland.se/teknikförældre**.

Technology and dementia in the Nordic region

For the first time all the Nordic countries have conducted a joint project to share knowledge and experience on the prescription of assistive devices that support cognitive functions to people with dementia. Called Technology and Dementia in the Nordic Region, the project aimed to take advantage of existing knowledge and experience in the field of new technology, assistive technology for cognitive support and dementia in the Nordic countries. The project was conducted through interviews with people who have dementia disorders or cognitive failure, their families and friends, and prescribers of technical devices that support people with cognitive impairment. The project has clearly shown that knowledge is lacking in the area. Many

of the interviewees wished that they had received technical devices earlier and that they had learned that devices were available in an earlier phase of their condition. The project's report, *Teknik och demens i Norden (Technology and Dementia in the Nordic Region)* was presented in the spring of 2008.

Freedom of choice in technical devices

In August 2007 the Government asked SIAT to conduct a trial regarding freedom of choice in technical devices. To be carried out in 2008 and 2009, the trial aims to increase freedom of choice in technical devices. The project is not focused specifically on the elderly, but on individuals who have been judged in need of technical devices – primarily people with a functional disability who have a long-term need for technical devices for rehabilitation and habilitation. The final report for the project will be published in 2010.

The project is under way in the counties of Kronoberg, Stockholm and Sörmland. It is being carried out as an investigation with a practical design in which the participating county councils test out the freedom of choice in the technical device field in the framework of existing legislation. The practical trial began in May 2008.

The European Commission is focusing on the development of new digital technologies for the elderly in Europe

The European Commission is investing EUR 600 million to develop new digital solutions for the elderly in Europe. The goal is for Europe to be a centre for the development of digital technologies that will help the elderly to be independent and live longer at home. The ultimate goal is to improve the quality of life of elderly people at home, at work and in society. To do this, the Commission wants to help companies develop highly innovative digital products and services. One step in this project is to start a new pan-European research programme.

One example of good innovative digital solutions for the elderly, in which SIAT is participating, is the i2home project. SIAT's role in the project is to help establish requirements and develop the interface for the system, as well as to test the interface with user groups to ensure the desired functionality.

The i2home project aims to develop a system consisting of hard and software to control and communicate with products in a home through various units. The idea is that units and equipment in the home must be made more accessible to people with mild cognitive impairments through a new, common standard for user interfaces.

Health-promoting and preventive measures

Many local authorities pursue health-promoting and preventive care measures for the elderly. Key focuses are the widespread health issues facing many elderly, such as diet, exercise and physical activity, health talks, house calls, injury prevention in-

cluding handyman services, medication reviews and more. Interest in public health measures directed at the elderly is growing as increasing numbers of studies show the positive effects of such efforts.

The Swedish Institute for Health Sciences, called the Vårdal Institute, has a thematic web room entitled "Health in the elderly – how can we promote it?", which provides information on health-promoting and preventive care measures for the elderly, including physical activity, diet, culture, living environment and so on. **www.vardalinstitutet.net**

Preventive care house calls

In the Government's efforts to enhance quality in elderly issues, since 2006 funding can be sought for preventive house calls focusing on fall prevention. According to a follow-up report from the National Board of Health and Welfare *(2006, 2007 och 2008 års stimulansmedel riktade till vård och omsorg om äldre personer (The 2006, 2007 and 2008 incentive payments for health and social care of elderly people)*, National Board of Health and Welfare 2008), 184 local authorities and 15 county councils are conducting projects in this field. The report shows that in many cases the communities work with local health centres. Several principals have asked the Swedish Rescue Services Agency to train staff in risk and fall prevention.

Many local authorities and county councils offer house calls to people aged 80 or 85 and older, but some also include younger groups. In the house calls, the visitor talks about subjects such as technical devices, the risks of medication and the importance of diet and exercise, and tries to identify flaws and risk factors in the home that can increase the risk of falling. These house calls will be followed up, in many cases with the support of R&D units, universities and other institutions of higher education.

Injury prevention – fall injuries

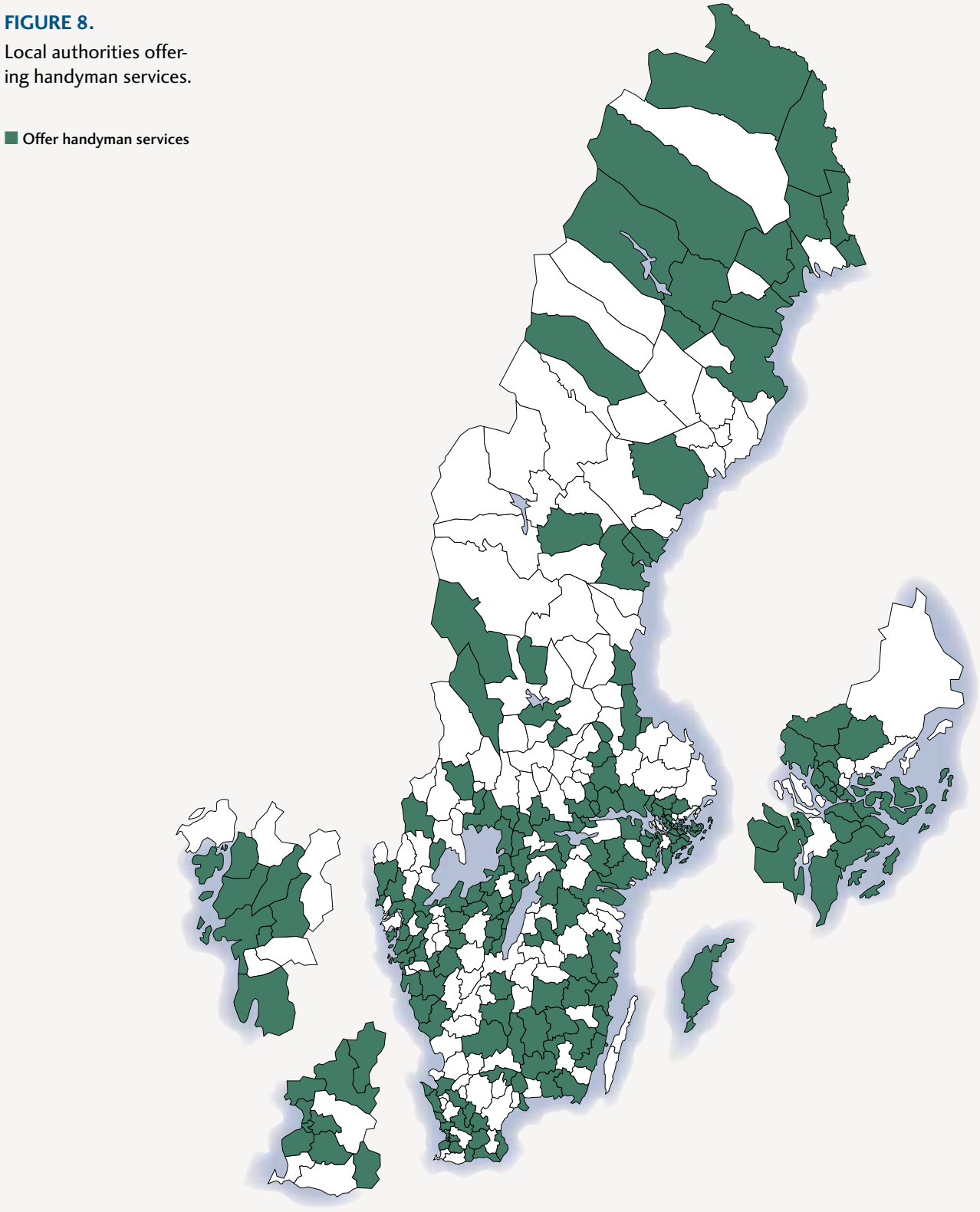
Falls cause more injures among the elderly than any other type of accident, making up 45% of the total number of elderly accident victims treated at hospital. Falls by the elderly represent 6% of all bed-days at hospitals. The Swedish Rescue Services Agency estimated that fall injuries among the elderly cost society over SEK 5 billion annually. A common fall-related injury is a hip fracture, for which the cost of care is estimated to be SEK 250,000 per person.

The Swedish Rescue Services Agency estimated that fall injuries among the elderly cost society over SEK 5 billion annually.

In a report entitled Öppna *jämförelser 2008*, *Vård och omsorg om äldre* (O*pen Comparisons 2008*, *Health and social care of the Elderly*, SALAR 2008) an average of 57 per 1,000 residents aged 80 and older were hospitalised for care due to fall injuries in 2005–2007. Women are consistently more represented in treatment for fall injuries. On average 65 women per 1,000 residents are treated for fall injuries, while the corresponding figure for men is 43. The spread is wide among local authorities, varying between 34% and 85%.

There are several examples of good profitability through injury prevention measures. Since 1995, the Lidköping local authority has carried out systematic preventive

FIGURE 8.
Local authorities offering handyman services.



measures to reduce the number of hip fractures among the elderly. Applying these results to the whole of Sweden shows that over 4,200 hip fractures could have been prevented, a cost reduction of about one billion kronor.

New survey on injury prevention measures

In the autumn of 2007 SALAR and the Swedish Rescue Services Agency conducted a survey on the local authorities' and county councils' work with injury prevention among the elderly – a follow-up to a previous survey in 2004. Their report entitled *Skadeförebyggande arbete för äldre* (*Injury Prevention Measures for the Elderly*, SALAR and SRSA, NCO 2008:2) shows that half of Swedish local authorities today have funds set aside for work with the safety of elderly people, in comparison with just over 5% of local authorities in 2004. Nearly all local authorities use deviation reporting, and nearly 80% state that they use accident and near-accident reporting to find risks that elderly people may be subject to. Over 60% of local authorities include sections on injury prevention measures in courses offered to staff in the health and social care fields. According to this survey, over 40% of local authorities regularly make preventive healthcare house calls to the elderly.

According to the survey, nearly 70% of local authorities offer handyman services. Many offer the service free and some charge per hour or per visit. Figure 8 shows the number of local authorities offering handyman services in 2007.

In autumn 2007 the Swedish Rescue Services Agency and the Institute for Evidence-Based Social Work Practice (IMS, a part of the National Board of Health and Welfare) published a book entitled *Systematiskt arbete för äldres säkerhet – om fall, trafikolyckor och bränder (Systematic Work for Safety for the Elderly – About Falls, Traffic Accidents and Fires)*, a compilation of the existing expertise and experience from practical safety work.

Food for the elderly

The diet and meal situation of the elderly was spotlighted a few years ago and became one of the areas the Government chose to highlight with special incentive payments for improvements. They produced a bill, *Nationell utvecklingsplan för vård och omsorg om äldre (National Improvement Plan for Health and Social Care of the Elderly)*, Government bill 2005/06:115. The National Board of Health and Welfare is under a government mandate to provide national support for quality improvement in meal and nutrition issues in care of the elderly. This mandate has resulted, among other things, in a popular website with several articles which can now be read and downloaded from a special portal for the elderly, **www.aldreportalen.se**.

Starting in 2006, 71% of local authorities and 75% of county councils applied for and received funding in the field of diet and nutrition. Several local authorities and county councils have recruited dieticians for varying lengths of time in order to analyse the diet situation of the elderly, train care staff in skills such as basic nutrition,

Setting an inviting table

Decorating for the occasion and season

Serving from deep dishes at the table

Nice tablecloth and napkins on weekends and holidays

Serving a sufficient portion

Food is whole and enticing before being cut up or mashed

Tell what is being served

Serve side dishes in bowls at the table

Jazz up with fresh herbs and vegetables

Switch off the telly. Perhaps play soothing music at low volume

Create a calm, appetising atmosphere

Celebrate birthdays and name days!

Check the calendar every day to find a reason to celebrate!

the importance of diet for health and wellbeing, diet for the elderly, adapted diets and mealtime environment.

The grants have further been used to involve all care staff using tools such as the IHI breakthrough method and implementing changes in small, continuous steps. The Falun local authority states that "thanks to the incentive funds, we have had the resources to develop routines and guidelines for our work to ensure diet quality for our elderly". The local authority in Gävle has determined, with the support of the incentive funds, that it will continue to need a dietician in care of the elderly in the future. Lycksele feels that it has significantly increased quality in diet and nutrition by hiring a dietician. The diet project in Gagnef has already "led to better control and prevention of malnutrition in special housing". The local authority of Orust has established routines "in order to discover risk factors related to poor nutritional status early on".

Trosa's local authority has conducted a project called "Rekindle the joy of eating in care of the elderly". The project showed a lack of routines and guidelines for table setting and serving, so all units were instructed to create a meal policy for pleasant meals offering togetherness and relaxation (see sidebar).

In 2007 and 2008 the Government set aside SEK 1.35 billion annually for continued development of projects regarding diet. A follow-up report presented by the National Board of Health and Welfare in 2008 shows that about 60 local authorities and five county councils will use the funds to hire new dieticians or extend the short-term contracts of existing dieticians. Several of the diet projects deal with the importance of diet for effective medication and for better balance, new routines at special housing, etc. to reduce the length of the nightly fast through measuring the time between the last evening meal and breakfast.

Nearly all local authorities offer meals on wheels to the elderly and disabled *(Matdistribution, trygghetslarm, service m.m. (Meals on wheels, security alarms, service etc.)*, SALAR 2006). In total 57,300 people received meals on wheels, an increase of about 5,000 recipients since 2004. No information is available on the total number of people receiving meals on wheels in 2007. Many local authorities offer the meals as a service, and therefore do not list them in official statistics.

Rehabilitation

The importance of extensive, well-co-ordinated rehabilitation activities for elderly people is increasing as lengths of stay in somatic and geriatric care decrease and more and more people are able to return home after a stroke, hip fracture, etc. The local authorities are responsible for rehabilitation in special housing, and in some communities the local authorities have assumed responsibility for home medical services. The county councils are responsible for rehabilitation of the elderly in other local authorities.

In the Nationell utvecklingsplan för vård och omsorg om äldre (National Improvement Plan for Health and Social Care of the Elderly), Government bill 2005/06:115,

rehabilitation is one of the four areas provided with special improvement funds. In autumn 2006 funds amounting to SEK 600 million were paid out, and nearly 80% of local authorities and county councils applied for rehabilitation funds. Nearly 40% of the money was used for this. The new government's focus on improvement in the elderly field includes rehabilitation as one of seven areas for which SEK 1.35 billion has been set aside for 2007 and 2008 and is also suggested in the budget bill for 2009.

Most applications focus clearly on elderly people's opportunities to live independently. The Ronneby local authority writes in its application that the goal is to give care recipients the most independent life possible and reduce their dependency on others, which enhances self-esteem and quality of life. As an element of this, many local authorities and county councils have invested much of this money in fall prevention.

Both local authorities and county councils use the funds to augment their rehabilitation staff with occupational therapists, physiotherapists and rehabilitation assistants. In several cases they have established rehabilitation teams with specialist knowledge about severely ill elderly patients. They also provide training for a rehabilitative attitude. Several local authorities and county councils applied for rehabilitation grants in order to make the final stages of life good for elderly people. The local authority and hospital in Enköping applied for funds for short-term care beds in order to provide good terminal care.

Several county councils have received grants to support the development of an unbroken continuum of care between the county councils and local authorities. For example, the county council of Norrbotten and the Kiruna local authority received a grant to develop a continuum of care for stroke patients.

In summary, efforts have focused on three areas:

- Improving rehabilitation operations with the support of occupational and physiotherapists. Local authorities and county councils have hired rehabilitation staff and created rehabilitation teams.

- Developing new work methods focusing on a rehabilitative attitude in nursing.

- Interaction between principals regarding skills and routines in connection with discharge and systematic healthcare planning.

A clear trend is that rehabilitation of elderly patients takes place in the home. In 2005 there were 70 home rehabilitation teams in Sweden, with a core of occupational therapists, physiotherapists, nurse's aides, assistant nurses or rehabilitation assistants. Another 70 local authorities and county councils intended to start rehabilitation teams using the new improvement funds.

Services with simplified needs assessment

A new law (2006:492) that went into effect on 1 July 2006 states that "local authorities shall have the authority to provide, without prior individual needs assessment, services to people aged 67 and older, intended to prevent injury, accident or ill health and which do not constitute personal nursing care". Local authorities are entitled to charge reasonable fees based on grounds they determine themselves, as long as the fees do not exceed the local authority's cost price.

This means that local authorities have a right – not a duty – to provide such services as long as they do not include personal nursing services. According to the bill a "service" may be a task that a younger, healthy person with no disabilities can do independently, such as changing light bulbs and lifting heavy objects. In cases where the tasks performed can be assumed to prevent injury, accident or ill health, or to significantly contribute to the individual's physical or mental wellbeing, the local authorities are allowed to offer them as services. Walks are an example of such services. Tasks for which even younger people normally need assistance are also covered by the term service.

The local authorities' right to offer services should include people up to age 67, but the local authority decides on the age groups to which each service applies. Various kinds of services can be offered to different age groups; for example fall prevention in the form of changing light bulbs for everyone over age 67 and cleaning services for everyone over 75.

In Härryda, according to information on the local authority's website, people aged 75 and older can easily order assistance with several activities from a service menu, including: pet care, simple cooking or baking, shopping, clothing care, waste sorting, escorting, walking and social activities, changing sheets, housekeeping and laundry. They can purchase up to eight hours of services per month and up to four hours a day, and they can freely choose the service or services they want. Services are charged according to a set rate (SEK 141 per hour in autumn 2008).

Tax-subsidised household services

As of 1 July 2007 taxpayers are entitled to deduct 50% of the price of household services up to SEK 50,000 per year. To qualify for the deduction the task must have been carried out in or close to the home. The person or company carrying out the work must have a business tax certificate. It is also possible to deduct for services carried out in a parent's home, as long as the services are eligible for deductions.

The household services deduction applies to services such as housekeeping, clothing care, cooking, lawn mowing, hedge trimming, snow shovelling and other forms of care and supervision that a person may need and which are carried out in or close to the home, or in connection with walks, visits to banks, health centres and other similar simple errands. Tasks falling under healthcare are not covered by the deduction.

Social activities

In the government's efforts to improve quality in the care of the elderly, local authorities can apply for funds to provide greater social interaction. Many are planning to open day activities and meeting places, offer cultural activities and give nurse's aides a clearer role as contact people for social activities.

Some local authorities have hired a geriatric educational specialist to determine needs and propose measures to break loneliness and boredom.

Several intend to offer a range of activities in collaboration with volunteer organisations and offer training to volunteers. There are also projects to create social meals, improve the outdoor environment by planting gardens to stimulate social activity, improve indoor environments in special housing to create meeting places and also to allow for physically strengthening activities.

Personal safety alarms

The elderly and disabled can obtain personal safety alarms after a needs assessment and decision by the authorities, or as a general across-the-board measure. New information in the National Board of Health and Welfare's statistics showed that 145,000 people had been granted personal safety alarms as of 1 October 2007. In the spring of 2006 some 158,000 people in the 274 local authorities that responded to the survey had personal safety alarms (Statistics Sweden 2006). No information is available on the total number of people with personal safety alarms in 2007. Many local authorities offer the alarms as a service, and therefore do not list them in official statistics.

3 Health and social care

In the autumn of 2008, the national daily *Dagens Nyheter* reported that 45,000 elderly people with a dementia disorder are medicated with antipsychotic medicines. According to research, this can lead to a 3–4 times greater risk of death or injury, often through a hip fracture, broken leg or stroke.

Gulli Johansson, pictured with grandchildren Isac and Noah, became known nationally through SVT's investigative journalism programme Mission:Investigate as one of those who has been medicated for epilepsy for 11 years and suffered severe side effects.

SOURCE: Free daily paper *Metro*, 24 September 2008. Photographer: Urban Brådhe.

Health and social care

Home help services

As of 1 October 2007, a total of 153,723 people aged 65 and older were granted the right to home help services. In comparison with 2000, the number of elderly people with home help services has increased by 23% or just over 28,000 people.

TABLE 8.
Number and percentage with home help in regular housing 2000–2007.

	2000		2004		2007	
Age	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
65–74	17,476	2.4	16,800	2.2	19,600	2.4
75–79	21,778	6.4	20,200	6.4	23,100	7.4
80–84	33,265	13.4	36,300	13.7	39,800	15.9
85 and up	52,805	27.1	59,000	27.3	70,900	29.5
65 and up	125,324	8.2	132,300	8.5	153,700	9.6
80 and up	86,070	19.0	95,300	19.8	110,700	23.0

The percentage of the population aged 65 and older with home help services in 2007 was 9.6%. A downward trend in the 1990s has turned and we see a significant increase in the number and proportion of home help recipients in each age group. The percentage aged 80 and over who have been granted home help services increased from 19% in 2000 to 23% in 2007.

Figure 9 shows differences among the communities regarding the percentage of the 80+ population receiving home help services as of 1 October 2007. Half of the local authorities are on the median level of 23%, with a variation from 8% to 37%.

In 2007, 35% of people aged 65 and older had been granted 1–9 hours of home help per month, 20% had been granted 10–25 hours and 3% had been granted more than 120 hours. Figure 9 shows the proportion of people aged 65 and older according to the number of home help hours they receive per week. Some 4,600 people in this age range receive more than 30 hours of help per week.

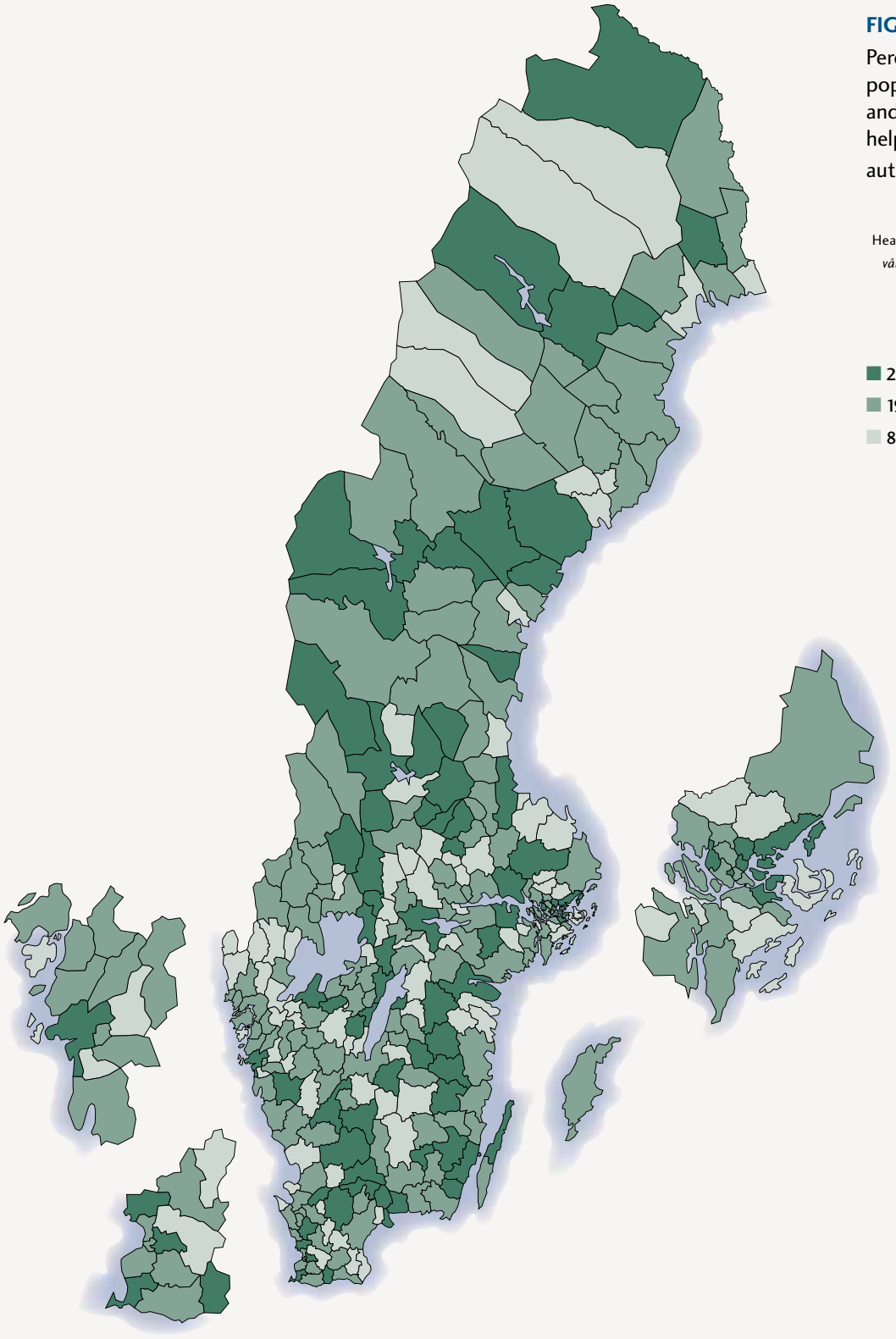
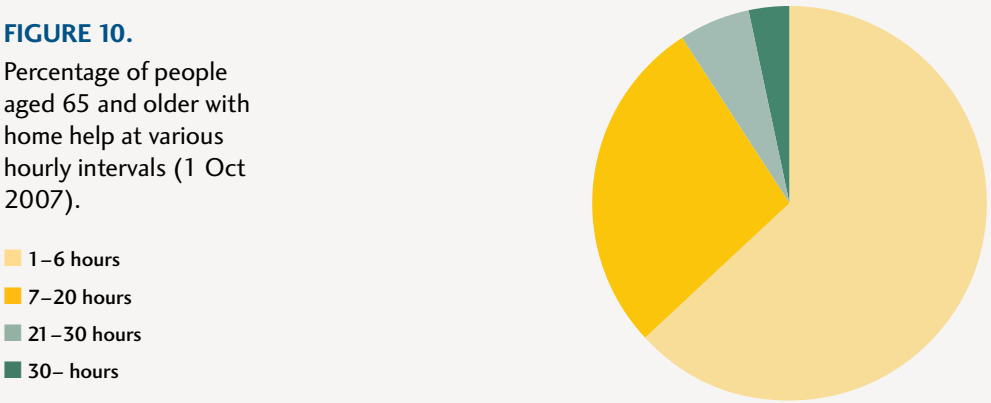


FIGURE 9.

Percentage of the population aged 80 and older with home help in 2007, per local authority.

SOURCE: National Board of Health and Welfare 2008, *Äldre – vård och omsorg år 2007*, official Swedish statistics.

FIGURE 10.
Percentage of people aged 65 and older with home help at various hourly intervals (1 Oct 2007).



Elderly receiving aid under the LSS Act

The Act concerning Support and Service for Persons with Certain Functional Impairments (LSS) is intended for people with major, long-lasting functional impairments. The law defines which people with disabilities are entitled to interventions:

- People with learning disabilities, people with autism or autism-like conditions (group 1).
- People with significant, permanent intellectual impairments or brain damage caused by physical trauma or disease in adulthood (group 2).
- People with lasting physical or mental impairments that are obviously not the result of normal ageing and that are severe enough to cause significant difficulties in activities of daily living, leading to extensive need for support or service (group 3).

In 2007, about 4,100 people aged 65 and older had been granted aid under the LSS act (not including advice and support), or 0.25% of the population in this age group. The number of elderly people granted aid under LSS has increased by about 2% since last year. In nearly all age groups, more men than women receive some form of aid. Nearly 6,700 interventions were for people aged 65 or older. The most common intervention in this age group was a home with special services for adults. Following that are the interventions contact person, escort service and daily activities.

The LSS committee presented its final report, *Möjlighet att leva som andra. Ny lag om stöd och service till vissa personer med funktionsnedsättning (Able to live like everyone else. New Act concerning Support and Service for Persons with Certain Functional Impairments)*, SOU 2008:77, in August 2008. The committee proposes that age 65 should be a general threshold for new approval of interventions under LSS. The only exception is daily activities, for which the minimum age is suggested to be 67 as with the labour market in general.

LSS intervention	1999	2004	2007
Personal assistant	49	236	317
Escort service	741	918	966
Contact person	1,016	1,296	1,494
Respite service	54	59	53
Short-term stay	63	64	53
Housing, adults	1,853	2,238	2,398
Day activities	944	914	922

TABLE 9.
Number of people aged 65 and older for whom LSS interventions were granted in 1999, 2004 and 2007 (the same person may be granted more than one intervention).

SOURCE: National Board of Health and Welfare 2008, Personer med funktionsnedsättning/funktionshinder – insatser enligt LSS respektive år.

Home medical services

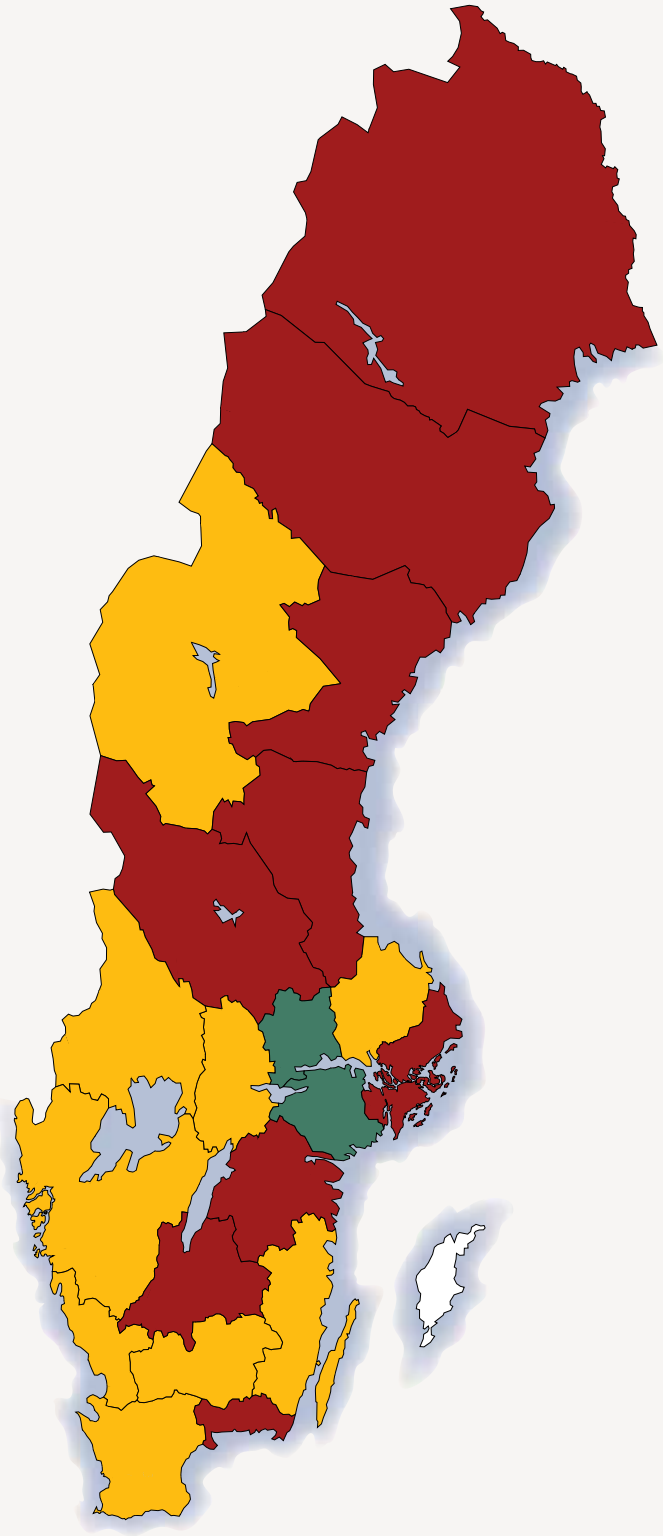
The Ädel reform in 1992 gave the local authorities responsibility for healthcare in special housing and day centres, but not for doctor interventions, which fall under the county councils. According to Section 18 of the Act on Health Services, local authorities shall offer good healthcare to people living in special housing and utilising day activities. The county councils are responsible for providing home medical services in regular housing, but can transfer this responsibility to the local authorities if this is agreed on. In 2007, 56% of the country's 290 local authorities had full or partial responsibility for home medical services in regular housing, an increase from the previous year, when this responsibility was transferred from the county council of Kalmar to its local authorities. According to the official statistics, 146,900 people aged 65 and older received home medical services in the framework of the local authorities' healthcare responsibilities (refers to the measured month, September 2007). Of these, 75% were age 80 and older and 67% were women.

The Nationell utvecklingsplan för vård och omsorg om äldre (National Improvement Plan for Health and Social Care), Government bill 2005/06:115, proposed that the local authorities would have primary responsibility for home medical care. In the autumn of 2006 the new Government decided not to implement a national regulation of home medical services. In the spring of 2007 the National Board of Health and Welfare received a government mandate to map out the scope of home medical services, including target groups, limits of responsibility where other medical care principals take over, availability, comparison between county councils that are and that are not responsible for home medical services and so on. The final report, *Hemsjukvård i förändring. En kartläggning av hemsjukvården i Sverige och förslag till indikatorer (Home Medical Care in Transition. A survey of home medical care in Sweden and suggested indicators.* National Board of Health and Welfare 2008), presented in November 2008, roughly estimates that about 250,000 people received home medical care in 2007.

The number of house calls by doctors and other professional categories to people granted home medical services increased in 2002–2006 according to the report, mainly in local authorities that have taken over responsibility for home medical services in regular housing. These local authorities also offer the patients greater

FIGURE 11.
Allocation of responsibilities for home medical services in 2008.

- County council/region in which local authorities are responsible for home medical services
- County council/region is responsible for home medical services
- Discussions on responsibility are under way



access to examinations and treatments. The survey clearly shows that the content of care is tending towards increasingly more advanced medical interventions in the individual's home, as a result of the Ädel reform.

Short-time accommodation, short-term care, short-term spaces

The designations short-term accommodation, short-term care and short-term space are used synonymously about operations offering a limited-time stay, an intermediate stage between special housing, support and assistance in regular housing and in-patient hospital care granted under the Social Services Act. Short-term accommodation can be housed in or near special housing and in recent years it has increasingly expanded into independent operations. Short-term accommodation is a multifaceted operation used for rehabilitation, convalescence and recovery after a hospital stay, waiting for a space in special housing, examination/diagnostics, home-hospital care/respite for family members, a "breather" allowing time to consider whether the patient should continue to live at home or move to special housing, and also for terminal care. Short-term accommodation/care comprises a part of the special types of accommodation, and the local authorities are responsible for medical interventions in such facilities.

The number of people aged 65 and older living in regular housing who were granted short-term accommodation/care as of 1 October 2007 was almost 9,700. Of these 64% were age 80 and older.

Year	2000	2003	2005	2007
Number of people	8,400	8,890	8,660	9,700

TABLE 10.
Number of people aged 65 and older granted short-term care on 1 October in the stated years.

SOURCE: National Board of Health and Welfare *Äldre – vård och omsorg*, the stated years

According to the National Board of Health and Welfare report *Öppna jämförelser 2008, Vård och omsorg om äldre (Open Comparisons 2008, Health and Social Care of the Elderly* 2008), short-term accommodation had a nationwide mean of 1.25 full-time (equivalent) employees per patient, compared with 0.98 for permanent/mixed accommodation. An average of 92% of nursing staff had nursing training, compared with 81% in assisted living facilities.

In the autumn of 2006 the Stockholm County Council and the regional supervisory unit of the National Board of Health and Welfare inspected 12 short-term accommodation facilities ranging in size from 10 to 54 spaces. The results were presented in a report entitled *Hälso- och sjukvård i korttidsboenden för äldre (Healthcare in Short-Term Accommodation for the Elderly)*, National Board of Health and Welfare 2007. Seven of these facilities were operated by the local authorities and the others were run by contractors or privately. Half of the patients were waiting for a space in special housing, and nearly a third were in the short-term care facility for respite or home-hospital care. Nearly all short-term accommodation facilities are pursuing

some kind of quality improvement measures and several had quality advisory boards that develop routines, review deviation reports and more. The inspection also identified risk areas, including medicine management, based on the special character of a short-term care facility with its high patient turnover.

In the spring of 2007 the Högsbo district of Göteborg inspected a short-term care facility called Flatås Gård, which has 24 beds. Some areas for improvement that were identified include the collaboration between various professions and the clarification of the goals for each individual's stay at the facility. A high turnover averaging 16 new care recipients per month and 17 concluding their stay (spring 2007) also requires efficient transfer of information, safe drug management, interaction between different care providers and good access to doctors.

Review of patients ready for discharge in 2007

On 1 July 2003 the act (1990:1404) concerning the local authorities' liability to pay for certain healthcare was changed and the term "medical treatment completed" was changed to "ready for discharge". The National Board of Health and Welfare's regulations on collaboration regarding admission and discharge of patients in inpatient care, from January 2006 (SOSFS 2005:27), requires more co-ordination between the local authorities and the county councils. In cases where a patient is assessed to need continued care after discharge from inpatient care, a co-ordinated care plan must be established in order for the payment liability to apply.

The National Board of Health and Welfare in collaboration with SALAR conducted a one-day review of ready-for-discharge patients in somatic care in the autumn of 2007. At the same time they reviewed care planning in connection with discharge from hospital care (*Inventering av utskrivningsklara patienter och vårdplanering i samband med utskrivning (Review of Ready-for-Discharge Patients and Care Planning in Connection with Discharge)*, National Board of Health and Welfare 2007). The study showed that 7.6% of beds were occupied by patients who no longer required inpatient care. More than half of these patients were awaiting transfer to a short-term space in the local authority. Payment liability had gone into effect for 388 of the 1,319 people reported as ready for discharge. A care plan had been established for 924 of the 1,319 patients, a requirement for payment liability to go into effect.

Special housing

According to the Social Services Act, the local authorities must establish special types of housing for service and nursing of elderly people who need particular support. In special housing, most residents have their own rental contracts today. The local authority determines what housing is covered by the term special housing.

These residences are allocated by the local authority according to the assessment of the need for aid. The local authorities are responsible for healthcare interventions

up to the level of registered nurses, and the county council is responsible for doctor interventions. People living in special housing have staff available 24 hours a day.

Elderly people in special housing

On 1 October 2007, 95,200 people aged 65 and older lived permanently in special housing. That corresponds to 6.2 percent of all people aged 65 and older. Compared with 2000, the number of "spaces" in special housing has decreased by 26,000. Table 11 shows the change between 2000 and 2007, showing a shrinking percentage of people living in the facilities defined and registered in the public statistics as special housing according to the Social Services Act. During the same period, the number of OAP flats increased from 12,000 to just over 33,000, of which about 10,000 are former service flats, a type of accommodation that was previously included in the statistics for special housing (*Enkätundersökning om seniorbostäder (Survey of OAP Flats)*, SALAR 2008).

	2000		2004		2007	
Age	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*
65–74	10,870	1.5	8,700	1.2	7,900	1.0
75–79	16,718	4.9	12,800	4.1	10,850	3.6
80–84	28,280	11.4	24,900	9.4	21,000	8.5
85 and up	65,437	27.7	58,400	27.0	55,200	24.4
65 and up	121,305	7.9	104,800	6.7	95,232	6.2
80 and up	93,717	20.7	83,300	17.3	76,100	16.0

TABLE 11.
Number and percentage in each age group living permanently in special housing.

SOURCE: Statistics Sweden, National Board of Health and Welfare *Äldre – vård och omsorg*, the stated years

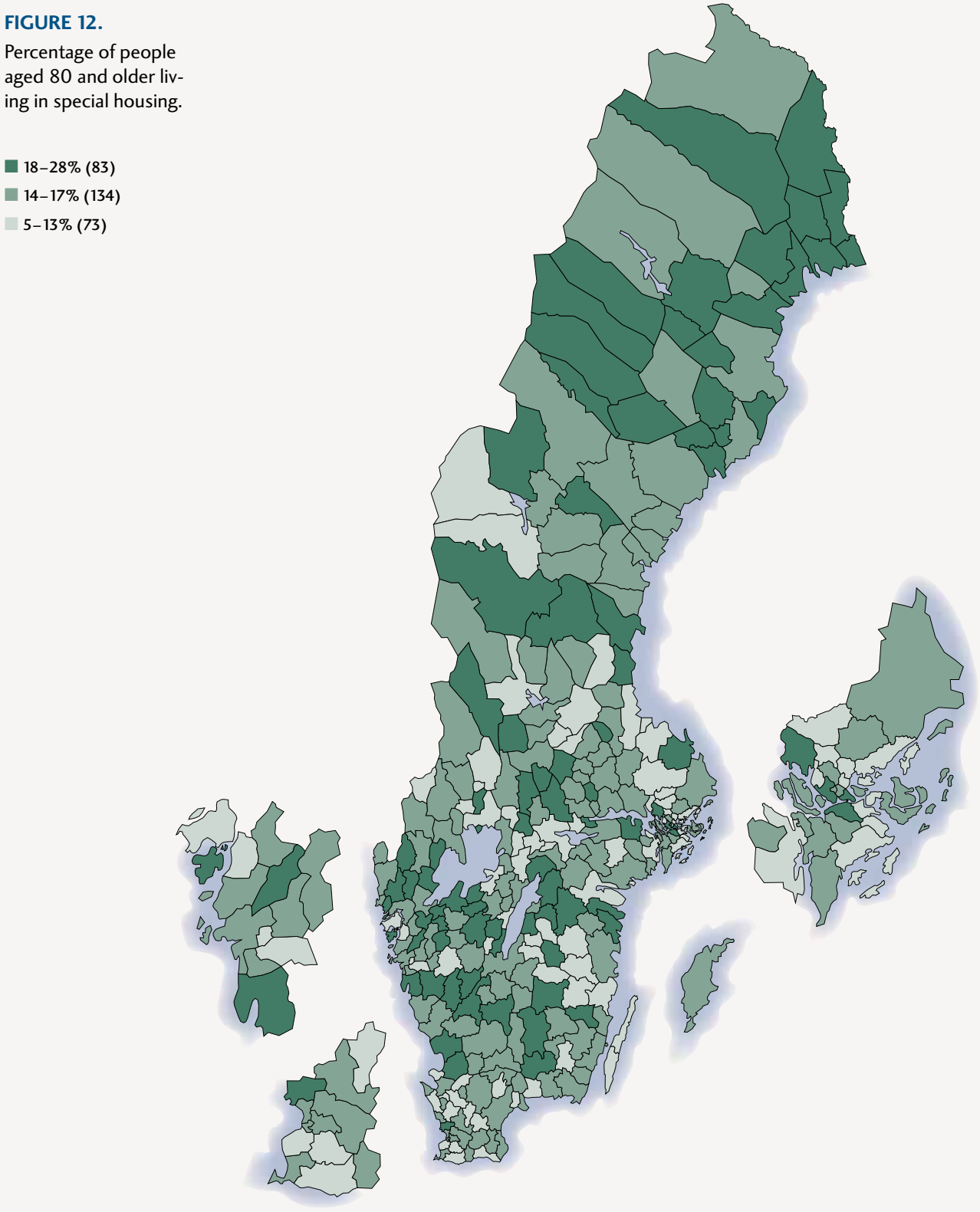
The data indicate the number of residents in special housing on 1 October in the stated years, but many more elderly people pass through special housing in the course of a year. Turnover has increased, currently amounting to almost 30% per year according to a report from the Swedish National Study on Ageing and Care (*Vårdbehov och insatser för äldre 2001–2005, (Need for Care and Interventions for the Elderly in 2001–2005)* Stockholm Gerontology Centre Report 2006:8). This means that a much larger group benefit from the extensive patient management provided by special housing.

Figure 12 shows the percentage of people aged 80 and older living in special housing. Half of the local authorities are on the median level of 16%, with a variation from 5% to 28%.

In this context it is important to note that the graph is not an indicator of the entire range of interventions for the elderly. A low proportion of 80 year-olds in special housing may be matched by a high proportion receiving home help services.

FIGURE 12.

Percentage of people aged 80 and older living in special housing.



Housing standard

In 2007, 78% of special housing had full residential standard, with *at least* 1–1.5 rooms including cooking facility, toilet and shower or bath. Four percent of residents (about 3,800 people) lived in a single room without cooking facilities, toilet, bath or shower. One percent, or about 950 people, shared their home with a person other than a spouse or partner. The percentage of residents in this category has dropped from 3 to 1 percent as compared with 2003.

Meeting of needs and expansion of special housing

According to the National Board of Housing, Building and Planning's latest housing market survey, *Bostadsmarknaden 2008–2009 (The Housing Market in 2008–2009)*, the local authorities make the following assessment regarding the meeting of needs for the current and coming year.

Local authority's assessment	2005	2006	2007	2008
Needs covered	70	61	47	46
Covered after expansion in 2007–2008	23	27	35	39
Not covered even after planned expansion	6	10	14	14

TABLE 12.
Local authorities' assessment of needs coverage in 2005–2008. Percentage.

A majority of the local authorities (246) judge that their needs are met or will be met after an on-going or planned expansion by the end of 2008.

Cohabitation guarantee

On 1 June 2006, a change was made in the Social Services Ordinance (2001:937) that spouses, cohabitants and registered partners who *both* need special housing shall be offered spaces in the same facility if they wish.

Local authority costs for special housing

Most of the local authorities' costs for care of the elderly – over 61% in 2007 – go to healthcare and social services in special housing. The cost per resident per year averages SEK 511,500, more than twice the cost per user with home help services in their own homes (which averages SEK 219,600). The investment cost of new construction is over SEK 1.5 million per flat, including the common areas, staff areas and so on.

The Government decided on 1 June 2007 to introduce a special investment fund of SEK 500 million per year for construction and renovation of special housing for the elderly over a 5-year period. Grants from this fund may not exceed SEK 130,000 per flat (50 sq.m. x SEK 2,600). As of the start of May 2008 the county councils have approved applications for new construction of 1,700 new flats and for remodelling 430 flats at a total of SEK 246 million (SEK 490 million in autumn 2008).

The cost per resident per year averages SEK 511,500, more than twice as much as the cost per user with home help services in their own homes (which averages SEK 219,600).

Costs per individual in special housing

Costs to individual residents comprise the rent on the apartment, fees for food and a fee for medical care and social services provided under the Social Services Act and the Act on Health Services. Housing costs vary depending on several factors, such as the size of the flat, but most residents receive a housing allowance for pensioners (BTP). For a person living alone, the BTP can amount to up to 93% of the monthly housing costs that do not exceed SEK 5,000. If the cost of the home exceeds SEK 5,000 per month, the pensioner pays 100% of the amount in excess of that amount. The individual's income and any personal wealth are taken into account when the regional social insurance office decides on BTP. The cost of meals also varies and can amount to SEK 2,500 a month.

In 2008 the maximum fee for medical interventions and social services is SEK 1,640 per month according to the Social Services Act (chapter 8, sections 3–9). About 40% of residents in special housing are exempted from fees. The resident's contribution to special housing costs amounts to 4%; the remaining 96% are paid through local government taxes.

The Delegation of Elderly Living

The Delegation of Elderly Living was established in May 2006 after the new government took over, with Barbro Westerholm as the chairperson. According to its directives the delegation is to monitor and analyse needs and trends regarding housing issues for the elderly. It is to propose measures to stimulate the creation of more suitable housing adapted to the needs of the elderly in order to improve opportunities for social contacts and activities.

The delegation presented a progress report entitled *Bo för att leva – seniorbostäder och trygghetsbostäder (Accommodation for Life, OAP Flats and Sheltered Housing)*, SOU 2007:103, in December 2007. The progress report was circulated for comment in spring 2008, and SALAR's response was that there is a need for more homes with high accessibility, varying kinds of service and built-in opportunities for social activities. SALAR feels that such housing should be offered within the framework of regular housing. The delegation aims to present its final report in December 2008.

On moving to special housing

Nearly 90% of those moving to sheltered housing have needs that crop up unpredictably.

Since the start of the 21st century, Fokus Kalmar Län has conducted studies of moves to special housing. The results in their report, *Beviljad ansökan. Om flyttningar till särskilt boende (Application Granted. On moving to special housing)*, Fokus rapport 2006:1, show that nearly 90% of those moving to special housing have needs that crop up unpredictably. This group includes many people who have lost their sense of time and space, and have sometimes lost touch with people around them and the ability to call for help. They have also lost the ability to be alone for more than short periods, and therefore need staff within hearing range. Elderly people with impaired orientation are by far the biggest proportion of those who have been granted special

housing; a large number of them are at risk of putting themselves in danger, and one in five has a behavioural disorder.

The moving studies also describe a group of people with disabilities requiring nursing care, which flare up at short, critical intervals. This includes individuals who can call for help, but who do not really trust themselves and their own physical ability. They cannot take care of their bodies, their homes and their possessions, and their weaknesses are primarily physical.

Health and social services for people with dementia disorders

The risk of developing a dementia disorder doubles with each increment of 5 years starting at age 60. In the 65–70 age group, the risk is 1.5%, while in the oldest group, aged 95 and older, the risk is 45%.

The progression of dementia disorders is divided into stages: Mild dementia (30%), in which the patient can manage a home but needs help with some things; moderate dementia (47%), in which the patient needs assistance with daily activities; and severe dementia (23%), in which the patient needs assistance with most activities of daily life.

About 45% of the total number of patients with dementia (142,200 in 2005) live in special housing for the elderly, while 55% live in regular housing. Of the latter, the majority have a mild or moderate form of dementia (see table 13).

Degree of dementia	Number
Mild	50,000
Moderate	21,000
Severe	7,000

TABLE 13.
Number of people with varying degrees of dementia disorders living in regular housing.

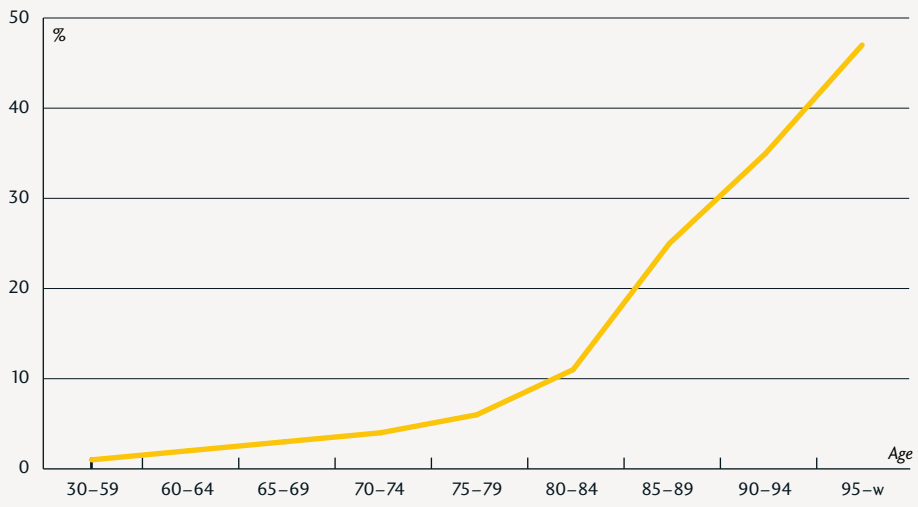


FIGURE 13.
Percentage of people with dementia disorders in various age groups.

The majority of people living in special housing have a dementia disorder – an estimated 70–80%.

The Kungsholm Project is a study that shows how a dementia disorder can significantly shorten a person's life. Individuals with and without dementia disorders were studied for five years. About 70% of those with dementia died while only 35% of those without dementia died. Each year some 25,000 people develop a dementia disorder and 20,000 die.

Stimulus funds for dementia care

Starting in 2007 local authorities and county councils can apply for funds to improve their interventions in dementia care. The National Board of Health and Welfare did a follow-up in summer 2008 and found that about 60 local authorities and 5 county councils plan to start or enhance existing dementia care teams. There are also efforts to train and further develop skills in the field, which was also a large segment of the government's initiative towards skills development in care of the elderly, Steps for Skills, in 2005–2007. Some local authorities provide special support and training to family members, while others have plans for establishing daytime care facilities for dementia patients. In dementia as in other fields, several R&D units are involved in the follow-up. A handful of local authorities are planning user or family member surveys to follow up the initiatives.

Better dementia care

The Federation of Swedish County Councils and Swedish Ministry of Health and Social Affairs conducted a nationwide project from 2002 to 2005, with a follow-up in 2006–2007, to improve dementia care in Sweden. The breakthrough project was called "Better Dementia Care" and brought together 41 teams from 38 local authorities and 13 county councils. The individual projects can be viewed and downloaded from the portal for the elderly, **www.aldreportalen.se**.

Rules for protection and safety in dementia care

An investigation on safety measures in health and social care for people with impaired decision-making ability presented a report in December 2006 that proposed rules for safety and legal protection in dementia care (SOU 2006:110). The investigator proposes two new laws to regulate necessary coercive measures in the care and treatment of people with impaired decision-making ability due to dementia disorders under the Swedish Ministry of Health and Social Affairs' area of responsibility: One law on coercive and confining measures in certain cases in social services, and one on coercive measures in certain cases in medical treatment. The report has been circulated for comment and the proposals are being prepared in the Swedish Government Offices.

National guidelines for dementia care

In 2003 the National Board of Health and Welfare was instructed to develop guidelines for health and social care of people with a dementia disorder. The national guidelines are based on a complete assessment of the best available expertise on the effects, cost effectiveness, ethics and the intention of legislation of various measures. The guidelines are intended to support the principals' allocation of resources and form a basis for local care programmes. Extensive literature searches are being conducted in 27 selected fields to create an evidence-based body of data. The guidelines are expected to be circulated for comment in spring 2009, and ten seminars are planned for the autumn of 2009.

The Swedish Dementia Centre

In the autumn of 2006 the government decided to mandate the National Board of Health and Welfare to develop a national centre for excellence in the health and social care of the elderly, including issues regarding family members and dementia. The Swedish Dementia Centre opened its doors in January 2008 along with a National Centre for Excellence – Family carers. Both centres are financed by the Government with SEK 10 million each in 2007 and 2008.

The Swedish Dementia Centre (SDC) is run by the Stockholm Gerontology Research Centre and Silviahemmet foundations and is located in the Ageing Research Centre in Stockholm. The centre launched an extensive web portal, **www.demenscentrum.se**, in the autumn of 2008. The site contains basic facts about the various dementia disorders and more targeted information for family members and care staff. It contains articles and links to examples describing methods and approaches. Under the *You work as …* vignette, various professions, such as occupational therapists, nurses and assistant nurses can find links to networks and other professional information.

Two databases are being built up, one for Swedish doctoral theses on dementia and one for professional literature and other publications, films and audio books in the field. Both databases are available via the SDC's website, along with all forms of courses on dementia, from upper-secondary to university level.

Healthcare for the elderly

Medical advances and duration of care in inpatient facilities

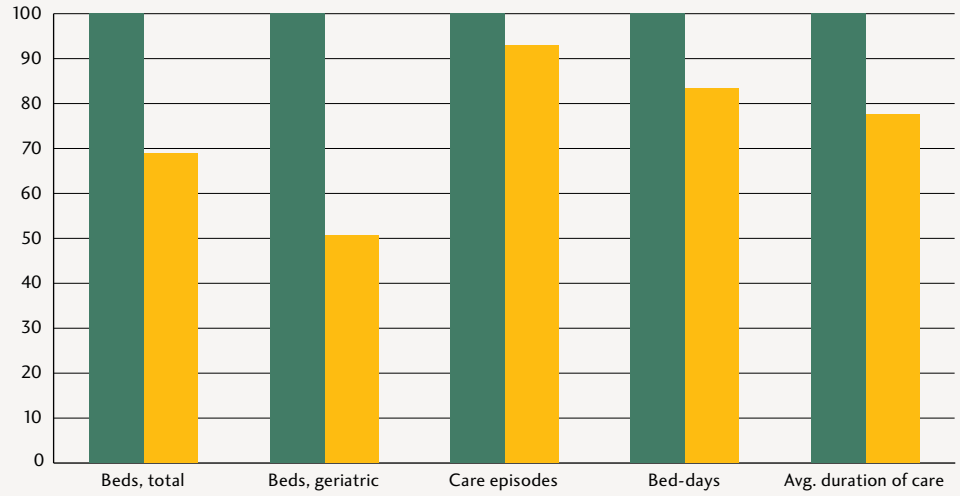
Advancements in medicine allow increasingly better treatment of ailments and injuries even up into advanced ages. Cataract operations are an excellent example. Twenty years ago this operation was performed as an inpatient procedure; today it is an outpatient procedure done at an eye clinic and takes 8–15 minutes. In 1980 Swedish hospitals performed about 7,000 cataract operations; by 2006 this figure had increased to nearly 73,000. In addition, 632.5 cataract operations were performed per 10,000 people aged 70 and over in 2006.

The total number of beds in hospitals has decreased in the past ten years by 31%, and the number of geriatric beds has been cut in half. Figure 14 describes various components of the changes in healthcare structure of the past decade.

The average duration of care is shrinking, while more and more healthcare is carried out as outpatient procedures at hospitals, in primary care, through home medical care and in community health and social care. The number of care episodes in inpatient care has decreased by 6% for all age groups, and duration of care has dropped from an average of 7 days in 1996 to 6 days in 2006.

FIGURE 14.
Development trend in the number of beds, care episodes, bed-days and average duration of care in 1996–2006. Index 1996 = 100.

SOURCE: SALAR 2007

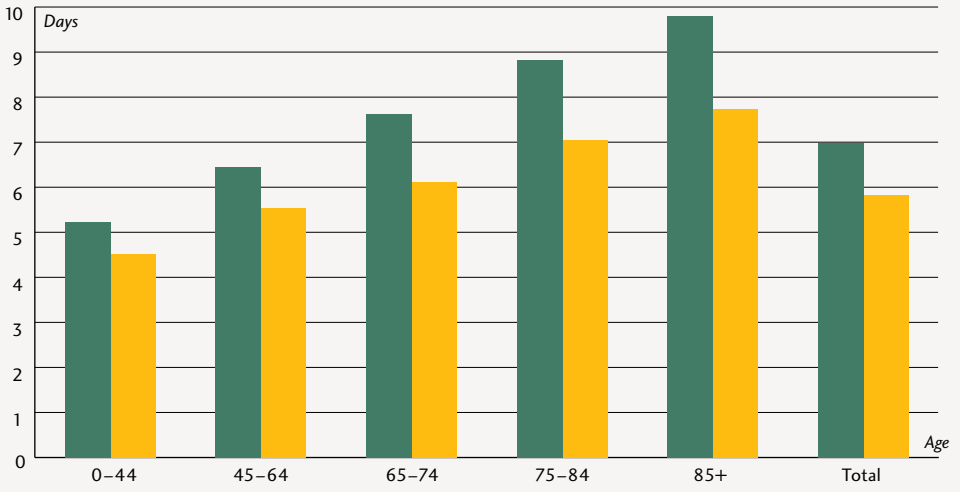


Reduced average duration of care for all ages

The reduced number of beds has led to a greater patient turnover in healthcare, and the average duration of care has dropped in all age groups over the past decade by

FIGURE 15.
Average duration of care in the healthcare system for various age groups in 1996–2006.

SOURCE: SALAR 2007.



an average of one day. The average duration of care in the oldest age group – 85 and older – decreased by about two days between 1996 and 2006.

Medical care utilisation by the elderly in inpatient care

Of all care episodes in 2006, 11% involved people aged 85 and older and 19% involved the 75–84 age group. People aged 85 and older comprised 2.6% of the population and accounted for 14.3% of bed-days. The 75–84 age group comprised 6.2% of the population and used 23.2% of bed-days.

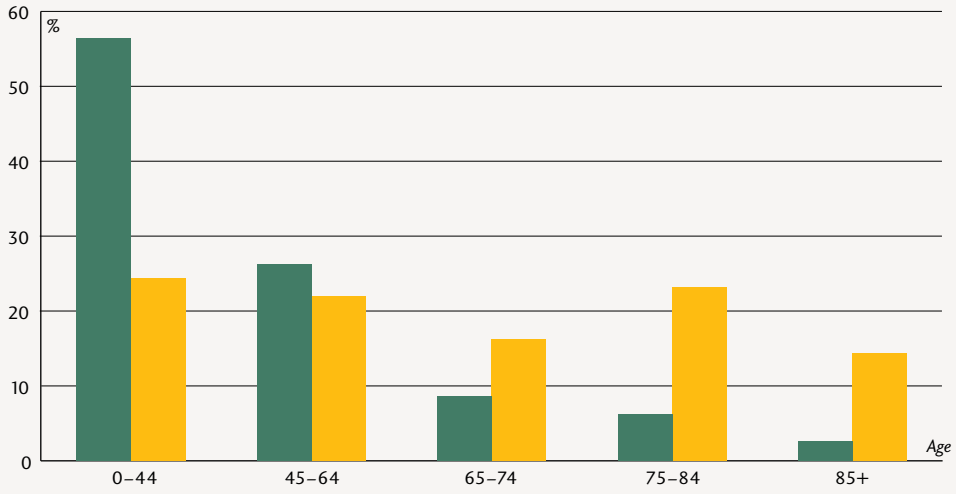


FIGURE 16.
Percentage of the population in various age groups and bed-days in 2006.

SOURCE: SALAR 2007.

Percentage of the population

Percentage of bed-days

Hip replacement surgery

The number of hip replacements has increased significantly among the very eldest. In 1987 about 500 people aged 85 and older received a new hip. In 2006 that figure had increased to 2,900. During this period the number of people aged 85 and older increased by 80% while the number of hip replacements increased by 462%.

Cardiovascular disease

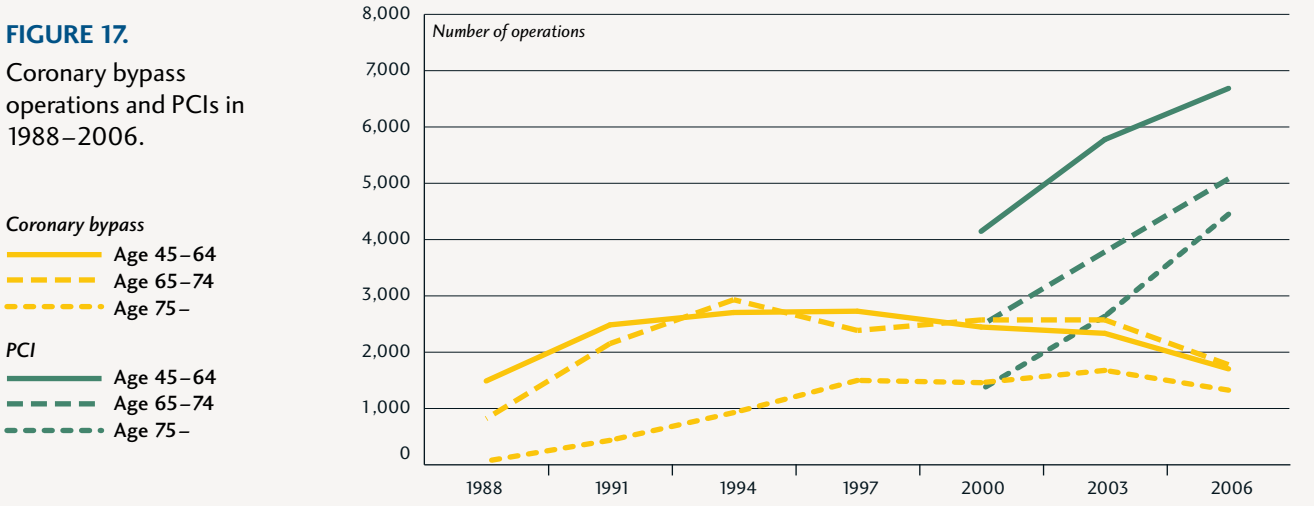
Nearly half of all Swedes die of some form of cardiovascular disease, and more than half suffer from such conditions. The most important cause of cardiovascular disease is arteriosclerosis, and the most common cause of that is age. In 2006 patients aged 74–84 represented over 34% of bed-days caused by cardiovascular disease. In comparison, the 65–74 age group represented 23% of bed-days. Patients over age 74 represented more than half of the bed-days.

Balloon angioplasty (PCI) is used to expand severely stenotic coronary arteries, while coronary bypass surgery is a much bigger intervention. Bypass surgery is usually done when there are multiple stenoses in the coronary arteries or if a PCI is not

technically suitable. The costly bypass operations are decreasing while PCIs, which can be performed locally and take only one to two hours, are increasing.

Figure 17 shows how bypass surgery has developed (note that data for PCIs are only available from 2000). In the 75+ age group, very few such procedures were performed 20 years ago while 5,800 were done in 2006.

FIGURE 17.
Coronary bypass operations and PCIs in 1988–2006.



Stroke

Stroke is one of the great national diseases and the risk increases with age. A 2006 report from the Swedish Stroke Register, Riks-Stroke, showed that 80% of people suffering a stroke were over age 65, and the average age was 76, an increase of one year compared with 1998. Women were on average 5 years older than the men when the stroke occurred. The total number of care episodes is estimated to be over 25,000 per year. With nearly one million bed-days per year, stroke is the single largest somatic condition in terms of bed-days in inpatient care. The total cost to society is estimated to be at least SEK 14 billion annually.

With nearly one million bed-days per year, stroke is the single largest somatic condition in terms of bed-days in inpatient care.

Stroke is the most common cause of neurological disabilities in adults and the third most common cause of death, after heart attack and cancer. Advancements in blood pressure treatment and improved care in the acute phase have cut stroke mortality and led to a lower incidence of life-threatening effects or severe functional disabilities.

Nearly 82% of the patients received care at special stroke units at some point during the duration of care, and the proportion who were sent directly to such a unit was 68%. Men were treated significantly more often at stroke units than women, a difference of 2.8%. Patients being treated at a regular ward are somewhat older than those at a stroke unit.

The proportion of patients stating that they need assistance in activities of daily life (ADL) three months after the stroke has dropped from 28% in 1995 to just over 20% in 2006. The proportion of stroke patients who lived at home and received no

home help services three months after the stroke has increased in recent years. In 1999 a total of 58.5% lived at home with no help services, and in 2006 the figure was nearly 68%. Nearly 10% lived in special housing.

Mental health of the elderly

The National Board of Health and Welfare report *Vård och omsorg om äldre – Lägesrapport 2007 (Health and Social Care of the Elderly – Status Report 2007)* shows that ageing leads to an increased risk of poor mental health. Among other things, the risk of suffering from depression after age 65 is four times greater. Some 10–15% of women and men over age 65 suffer from some form of depression; 5% of them have a more severe form. Other mental illnesses among the elderly are psychoses, estimated to exist in 2% of the elderly population; bipolar disorder in 1–3%; and generalised anxiety disorder (diffuse, long-term tendency towards anxiety) in 3–5%.

Between 300 and 400 people over age 65 commit suicide each year, which is about one-fourth of all suicides in the country. Men over age 65 have the highest suicide frequency per 100,000 residents.

The Stockholm County Council 2007 Public Health report states that the greatest proportion of the population with a self-assessed mental illness are young women; the same proportion is reported throughout Sweden.

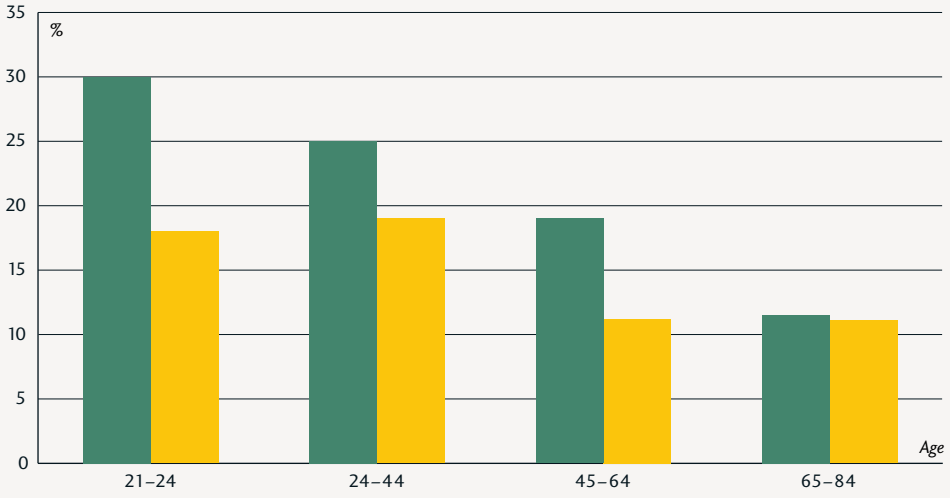


FIGURE 18.
Percentage with self-assessed poor mental health according to GHQ12 2006.

SOURCE: *Folkhälsorapport 2007*, Stockholm County Council.

Doctor participation in the local authorites' healthcare

The county authorities are responsible for doctor interventions in community healthcare. According to the Act on Health Services (HSL section 26 d), as of 1 January 2007 the county council shall sign agreements with its local authorities regarding the scope and methods of doctor intervention in community healthcare. If the

county council does not meet its responsibilities as defined in the agreement, the local authority is entitled to hire doctors and be reimbursed by the county council. According to the National Board of Health and Welfare survey of home medical services, 93% of local authorities have agreements for doctor participation in special housing and 49% have agreements for doctor participation in regular housing.

As of autumn 2006 special stimulus funds will be available to improve access to doctors in regular and special housing. A follow-up of the stimulus funds in 2008 showed that every county council had applied for funds to bolster doctor participation in special and regular housing. Many interventions were started with the grants paid in the autumn of 2006.

Most county councils have agreements with the local authorities regulating doctor staffing at special housing, and the new resources have consistently been used to make the doctors more available. They have done so by building up on-call services or hiring more doctors for medical centres. Above all, the stimulus funds have been used to develop mobile teams of doctors who can make more house calls to elderly patients. The Uppsala county council has also expanded its geriatric psychiatry team. Another initiative is general increases in the doctors' hours in special housing facilities, higher pay for doctors where needed in special housing, and additional training for doctors in geriatrics.

Use of medicines by the elderly

For many elderly people, drug treatments offer a chance to have a good life despite various ailments. The use of medicines by the elderly today is extensive and has increased in recent years, largely because new medicines have allowed more effective treatment for many of the diseases that are common in elderly people. The most common medicines are those for cardiovascular and nervous system diseases – mainly psychoactive drugs and analgesics – which reflects the pattern of illness among the elderly.

There is strong scientific support for the beneficial effects of such medication, in reduced morbidity and/or reduced mortality for many of the medicines used by elderly people up to age 75. However, it is very rare for studies to include the very eldest. Incorrect use of medicines leads to great risks for ill health and poor quality of life. The risk is particularly great with extensive use of multiple medicines in combination with high co-morbidity. Studies have shown that 10–20% of acute hospitalisations are caused by drug-related problems, such as dizziness, bleeding, muscle weakness, balance problems, fall injuries and confusion.

Scope of medicine use among the elderly

People over age 75 make up about 9% of the population and are prescribed just over 27% of all medicines. Over 25% of elderly people use sleeping drugs and sedatives. An estimated 10% of people over age 65 do not use prescription drugs. People over age

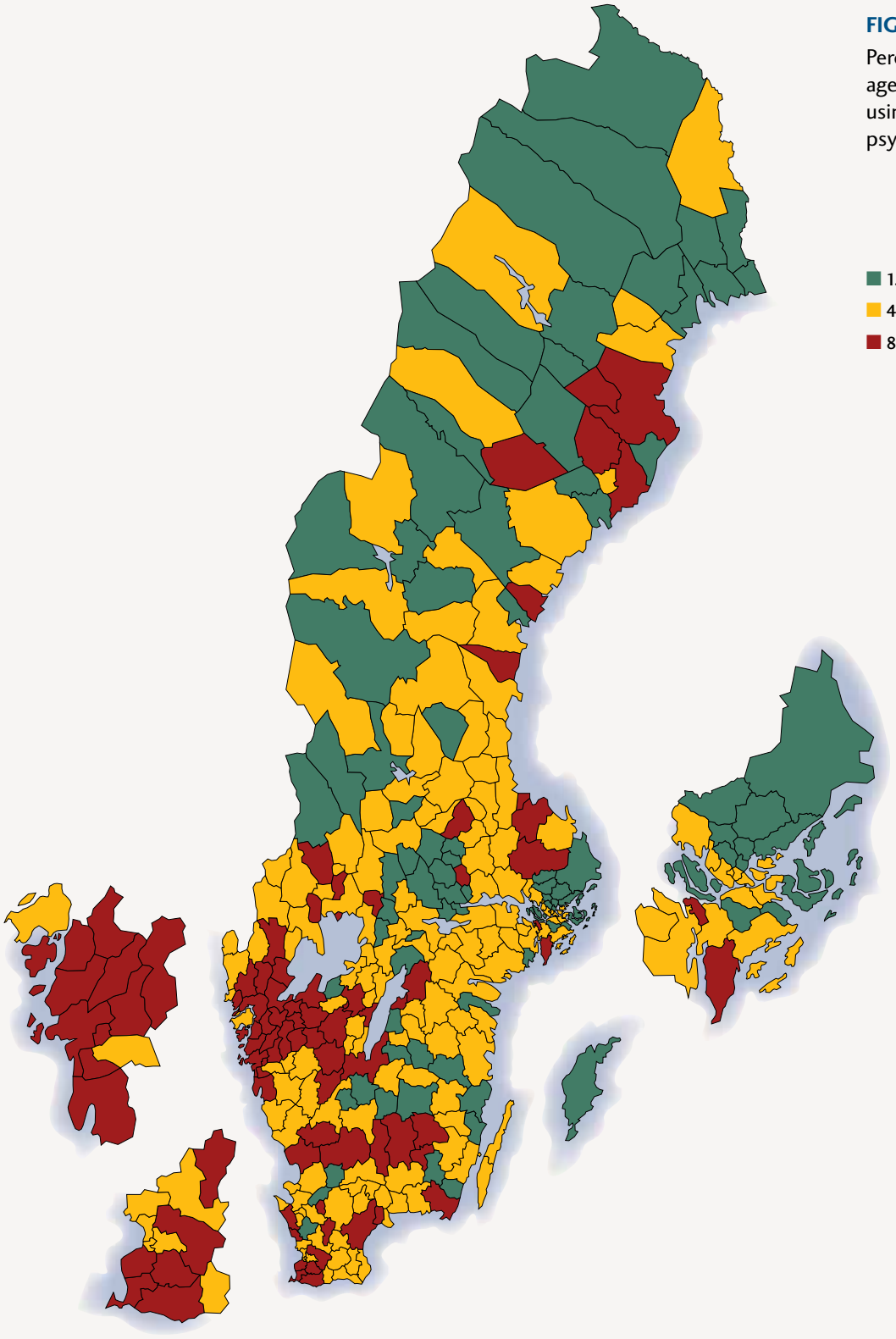


FIGURE 19.

Percentage of people aged 80 and older using three or more psychoactive drugs.

SOURCE: National Board of Health and Welfare Läkemedelsregistret 2007.

- 1.4–4.5% (77)
- 4.6–8.4% (141)
- 8.5–10.4% (72)

People over age 80 use an average of five medicines, an increase of two since 1993.

80 use an average of *five* medicines, an increase of *two* since 1993. Sixteen percent of people aged 80 and older – nearly 80,000 people – are being treated with 10 or more medicines. Some examples are concurrent use of diuretics, anticoagulants, laxatives, soporifics, nitroglycerin, ACE inhibitors, beta-blockers, eye drops, vitamins, analgesics, drugs for gastritis/gastric ulcers, potassium, antidepressants and often three or four psychoactive drugs at once. The total cost of medicines in 2007 amounted to SEK 26.2 billion, of which over 40% went to people aged 65 and older.

Open comparisons

Two 2008 open comparisons were published, one on medical quality and effectiveness between county councils and one on health and social care of the elderly, which show large variations in prescribing trends for psychoactive drugs, drugs with potential type D interactions and 10 or more pharmaceuticals on the county council and local authority level.

The proportion of elderly people aged 80 and older taking 10 or more prescribed medicines averaged 16% nationwide in 2007, with a variation among counties from 10% on Gotland to 20% in Uppsala county. On the local authority level, Emmaboda had the lowest proportion, 6.4%, while Svedala was highest, 23%. On average, about 6% of people aged 80 and older take three or more psychoactive drugs with a variation from 1.4% in Ljusnarsberg to up to 10.4% in Öckerö. The proportion of women taking these drugs is significantly higher than men, 7% and 4% respectively.

Figure 19 shows the local authorities ranked according to the frequency of people aged 80+ taking three or more psychoactive drugs. A high frequency of such prescriptions (shown in red) occurs primarily in southern and south-western Sweden.

SALAR's project for better use of medicines, 2006–2007

In 2006 the Swedish Association of Local Authorities and Regions conducted a project aiming to support the local authorities' and county councils' efforts to improve medicine use (*Förbättra läkemedelsanvändning och livskvalitet hos Äldre (Improving Medicine Use and Quality of Life for the Elderly)*, SALAR 2006).

The project included a questionnaire survey to determine the scope of medication reviews in special housing. Over half of the responding local authorities state that they conduct medication reviews according to the definition in the questionnaire. Many say that they monitor the use of medicines in another way and that there is great commitment in the local authorities to improve monitoring of medicines for the elderly.

The **SÄLMA breakthrough project** was conducted in 2007 as a part of SALAR's medicine project. Seventeen local authorities and eight county councils/regions participated, with some 20 interdisciplinary teams following the breakthrough method. Its final report, *SÄLMA 2007: Säker läkemedelsanvändning för en bättre livskvalitet hos äldre (Safe Use of Medicines for an Improved Quality of Life for the Elderly)*, summarises the teams' efforts. Doing things right from the start in terms of prescribing

medicines, and above all involving the elderly patient in his or her own medicine use, is a key message. The project developed a question form that patients can take to their doctor's appointments so they can remember questions they need to ask, such as: "Why am I receiving this medicine?", "When and how do I take it?", "How long should I use it?", "Are there other ways of treating my condition without drugs?" The ambition is to distribute the "Do you know why you take this medicine?" form to all elderly people.

Several of the teams have demonstrated the benefit of making this information more easily accessible to the elderly, for example when prescribing. The participating teams have improved safety in elderly people's use of medicines and worked systematically to close the gap between knowledge and practice in the field. During the project period, various changes were tested and those shown to lead to improvements became practice. All teams have achieved safer routines and measurable improvements in elderly people's use of medicines and all are continuing on in the same spirit.

The National Board of Health and Welfare published a report in 2003 entitled *Indikatorer för utvärdering av kvaliteten i äldres läkemedelsanvändning (Indicators for Evaluating Quality in Elderly People's Use of Medicines)*. A popularised version of the report was published for the SÄLMA project, called *Kvalitetsindikatorer som stöd för en säkrare läkemedelsterapi hos äldre* (*Quality Indicators Support Safer Drug Therapy for the Elderly*, SALAR 2007).

Stimulus funds for medication reviews, 2006–2008

The Swedish Government decided in 2006 to earmark stimulus funds for improving quality in elderly policies. One of seven areas for improvement involves support for work with medication reviews. Half of all local authorities and 90% of county councils applied for grants. All of the projects involve medication reviews in collaborative projects between local authorities and county councils, and the majority indicate that no such reviews, or only a handful, were conducted before the stimulus funds were provided in 2006.

Most people conduct medication reviews using interdisciplinary teams with a special focus on special housing. The teams often consist of a doctor, a pharmacist (sometimes remotely located), a nurse and sometimes an assistant nurse or a nurse's aide. Local authorities and county councils are also focusing on enhancing the knowledge of medical and caring staff about medicines and side effects.

National Pharmacy Register

A new law went into effect in 2005 (the Prescription Medicines Registration Act, SFS 2005:258) requiring that all prescribed medicines be registered in a national database on the individual level. Patients can obtain a copy of their medicine list either from the national pharmacy website or give their approval for their doctor or pharmacist to access the information. The purpose of this list is to enhance patient safety and security in their use of medicines.

In collaboration with the national pharmacy monopoly, Apoteket AB, SALAR conducted a pilot study to evaluate the benefit of the National Pharmacy Register for prescribers. Their report *Läkemedelsförteckningen – utvärderingsrapport* (*National Pharmacy Register – Evaluation Report*, SALAR 2007) shows that the list is an excellent tool, but that the usefulness of the information was limited. The study indicated that factors such as easier log-in and changes in legislation could make the listing more useful. The desired change in legislation, now in the pipeline, will allow more categories of health care professionals than just prescribers to be able to gain access to the medicine list.

National Initiative for Improved Patient Safety

In 2007 SALAR and the local authorities and regions took an initiative to reduce nosocomial injuries in Swedish healthcare. One of the goals was to halve the number of healthcare-related injuries from the 2006 level of 10% to 5% by the end of 2009. Other areas in which special measures are being taken include preventing medication errors, fall injuries and pressure sores.

Each individual patient's medicine list is checked to ensure that it is complete, correct and reasonable. Changes in prescriptions must be documented and motivated. When the patient is ready for discharge from hospital, the medicine list must be reviewed with the patient and possibly family members as well. Afterwards, this information is passed along to the unit that will continue managing the patient's care.

More effective medicine use in the long term – collaboration between the government and the county councils

A work group was appointed in 2008 to find the best way to make long-term medicine use more effective, after an agreement by which the government remunerates the county councils for its costs for medicine. The agreement includes 16 points under three headings: Improved management and monitoring, improved knowledge of pharmaceuticals and improved use of pharmaceuticals. The work group will produce an action plan, which will be presented in February 2009.

Debate on elderly people's use of medicines in autumn 2008

In the autumn of 2008, the national daily *Dagens Nyheter* published a series of articles on the medication of elderly people with dementia disorders. Researchers pointed out the increased risk of death or stroke with extensive prescribing of antipsychotic drugs to elderly people. Despite earlier warnings, the use of these drugs has increased, and some of the ones used are not approved for treating dementia disorders. As a result of the criticism, the Medical Products Agency tightened its recommendation for drug treatment of people with dementia disorders.

Development of community care

In 2007 SALAR published a report under its Community Care Project of 2005–2006, *Närvårdssamverkan i praktiken, Från ord till handling (Community Care Collaboration in Practice, from words to action)*. A year previously it had published the report *Att utveckla närvårdssystem – Vård och omsorg i förändring (Developing Community Care Systems – Health and social care in transition)*.

Community care is about building up local care systems that can offer the population care interventions from a holistic perspective, regardless of the particular organisation and its form of management. The goal is to ensure healthcare to those whose need is greatest. Examples of situations when community care is vital to the elderly population include rehabilitation after a stroke, prevention of falls, home medical services to multi-morbid patients and terminal care.

The primary elements of this focus are stimulating innovation and systematic improvement efforts, and finding well-functioning forms of collaboration. Common obstacles to this are a lack of common goals and too different financial systems. Other important factors are differences in culture, rivalry between different professional categories and ignorance of each other's working conditions. A good approach to the problems is to start by asking "Who is it that we are here for?"

Who is it that we are here for?

Community care is not a clearly defined concept. Different communities have different capacities for providing community care, so naturally the solutions they develop vary. The size of the local authority, proximity to a hospital, access to staff and previous experiences of collaboration and development work are some factors that effect the choices a community makes. The common denominators are the core focus on the patient and teamwork across borders.

Terminal care

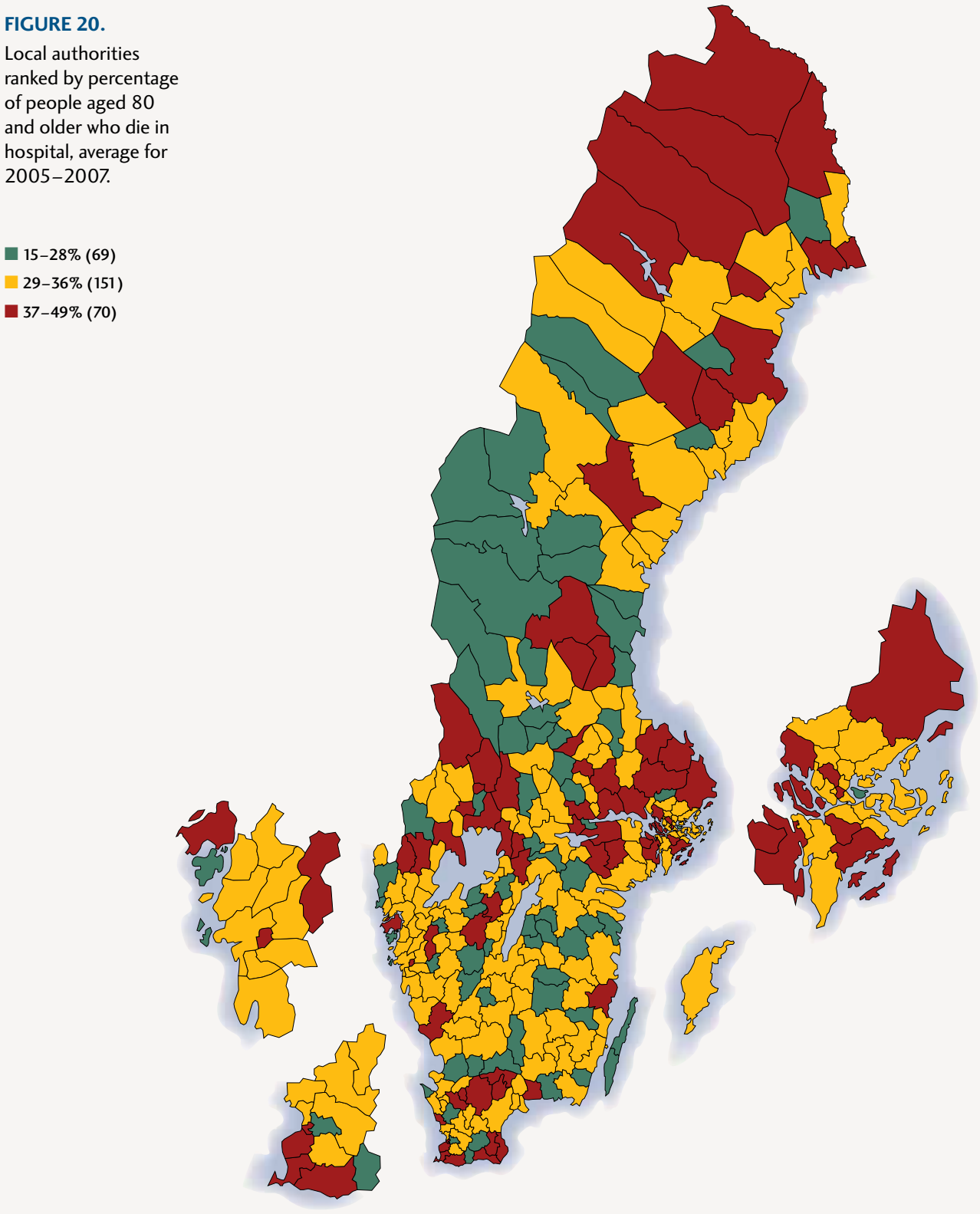
Some 91,000 people died in 2007, 60% of whom were aged 75 or older. The number of deaths per year has remained largely unchanged for the past decade. Cardiovascular diseases are the most common cause of death, followed by various cancers. Deaths from cardiovascular disease have steadily decreased in the past twenty years.

The past fifteen years have seen a significant shift of place of death from hospitals to special housing and the patients' own homes. Before the Ädel reform in 1992, about 75% of the population aged 65 and older died in a hospital, compared to 35% today. One indicator of good terminal care is that a low proportion of people aged 80 and older die at a hospital (*Öppna jämförelser 2008, Vård och omsorg om äldre (Open Comparisons 2008, Health and social care of the elderly)*, SALAR 2008). On average 34% of all people aged 80 and older died at hospitals in 2005–2007. The proportion of men who died in hospital was higher than the proportion of women – 39% and 31% respectively. The spread is great, from 19% to 56%.

Before the Ädel reform in 1992, about 75% of the population aged 65 and older died in a hospital, compared to 35% today.

According to a report from the National Board of Health and Welfare, *Vård i livets slutskede (Terminal Care)* 2006, opportunities for palliative care have increased

FIGURE 20.
Local authorities ranked by percentage of people aged 80 and older who die in hospital, average for 2005–2007.



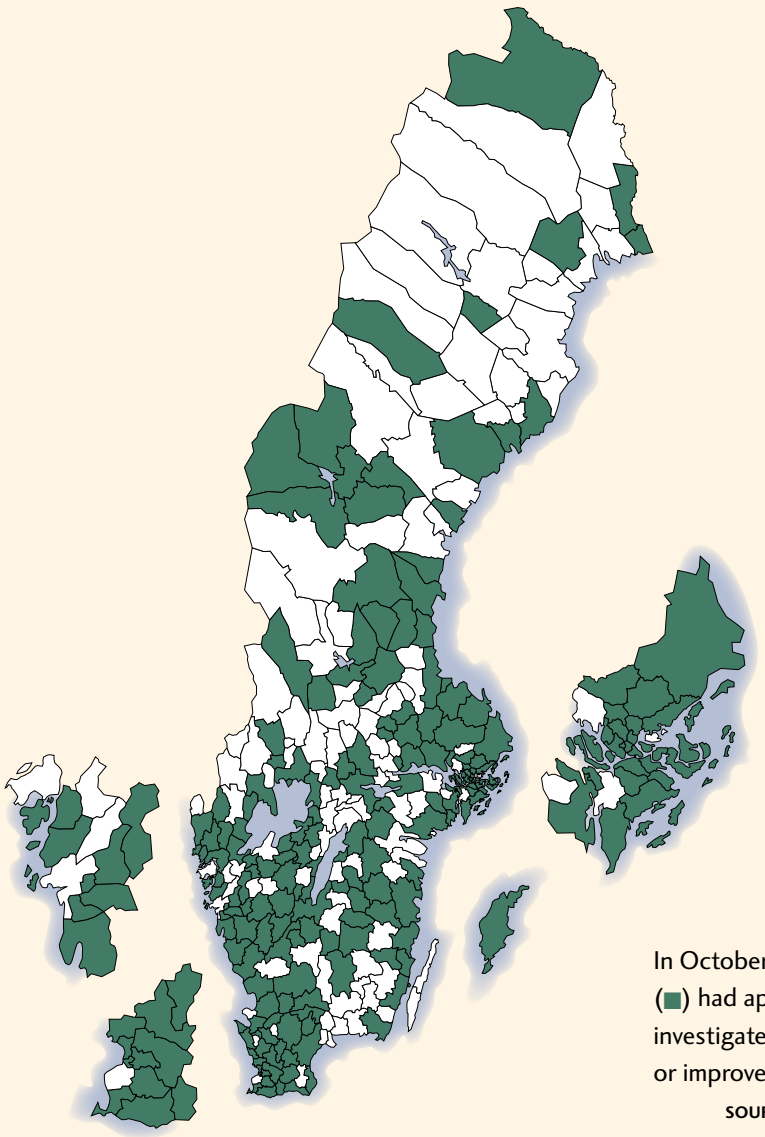
throughout the country, both in cities and in rural areas, but still has an uneven geographic distribution. Palliative teams are in place in 13 counties/regions, and all counties have beds earmarked for palliative care – an average of 11 beds per 100,000 residents. For palliative care in the home, 35 beds are available per 100,000 residents.

Part of the National Board of Health and Welfare's mission is to develop national quality indicators, including indicators for palliative care, describing patient-assessed quality and nursing quality.

The Swedish Council for Palliative Care (NRPV) is a non-profit association working to ensure co-ordinated care throughout the country according to the WHO definition of palliative care. The council's website, **www.nrpv.se**, contains a listing of all palliative facilities in the country, listed per county. A summary in the 2008 Palliative Guide showed 744 inpatient beds and 2,612 beds in home medical services for palliative care.

The national quality register for palliative care started in 2004 (**www.palliativ.se**) and today has listings from over half of the local authorities in the country. The 2008 open comparisons report on health and social care of the elderly dealt with three indicators: the occurrence of informative talks with the dying person, being alone at the moment of death and talks with the family members after the loss.

4 Freedom of choice



In October 2008, 177 local authorities (■) had applied for stimulus funds to investigate/prepare free choice systems or improve an existing system.

SOURCE: National Board of Health and Welfare.

Freedom of choice

Care of the elderly by private providers

Since the early 1990s more and more local authorities have chosen to open up parts of care of the elderly to competition. The local authorities are still responsible for funding and for granting assistance under the Social Services Act in the form of e.g. home help services or a space in special housing, but the work is carried out by a private care provider in the form of a sole proprietorship, limited company, foundation or co-operative.

Eleven percent of all people with home help services received them from a private provider on 1 October 2007. The corresponding figure in 2000 was 7%. Most of the 40 or so local authorities offering home help services via private providers are located in metropolitan areas. Fourteen percent of all people living in special housing on 1 October 2007 lived in a private facility. The corresponding figure in 2000 was 11%. Many local authorities do not have competing providers in the elderly field. In six local authorities over two-thirds of home help services have competition, and seven local authorities have privately run special housing.

Consumer choice models

In recent years various types of consumer choice models have been introduced as alternatives or complements to procurement of contractors. Consumer choice models for the elderly primarily involve home help services, including community services.

In autumn 2007 SALAR catalogued all local authorities that had implemented or were investigating implementing consumer choice systems. In total, 32 had implemented consumer choice systems for services in home help, 18 for nursing interventions, and 8 for special housing. Another 38 local authorities were planning to implement consumer choice systems for community services and 15 planned them for special housing; 7 of the latter planned this for all areas. Some 60 local authorities offer services without need for a special decision, under the act (2006:492) on the local authorities' liability to provide services to the elderly.

The Government mandated the National Board of Health and Welfare to allocate SEK 280 million in 2008 to local authorities wanting to investigate the opportunities for, or to implement, a consumer choice system in care of the elderly and disabled.

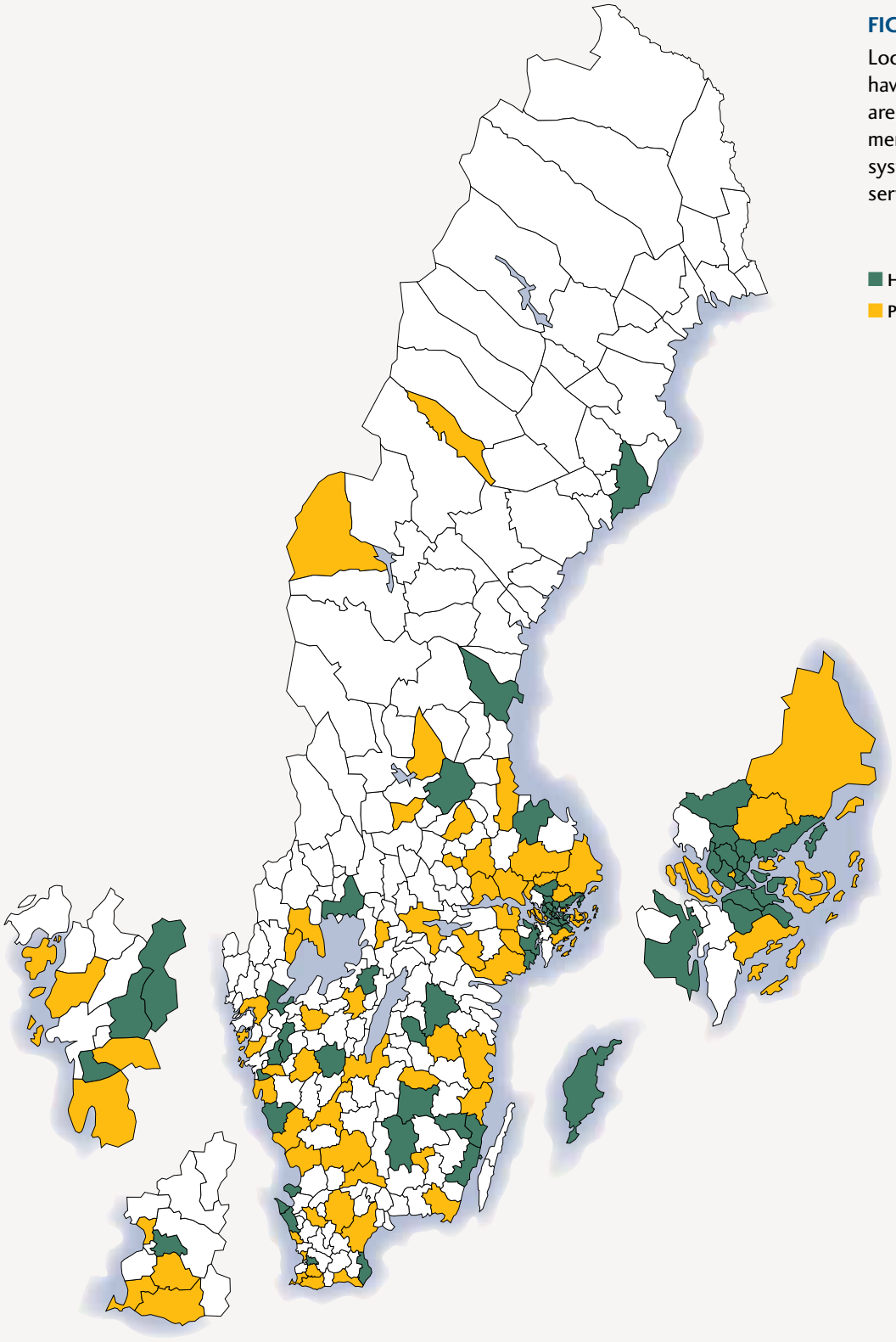
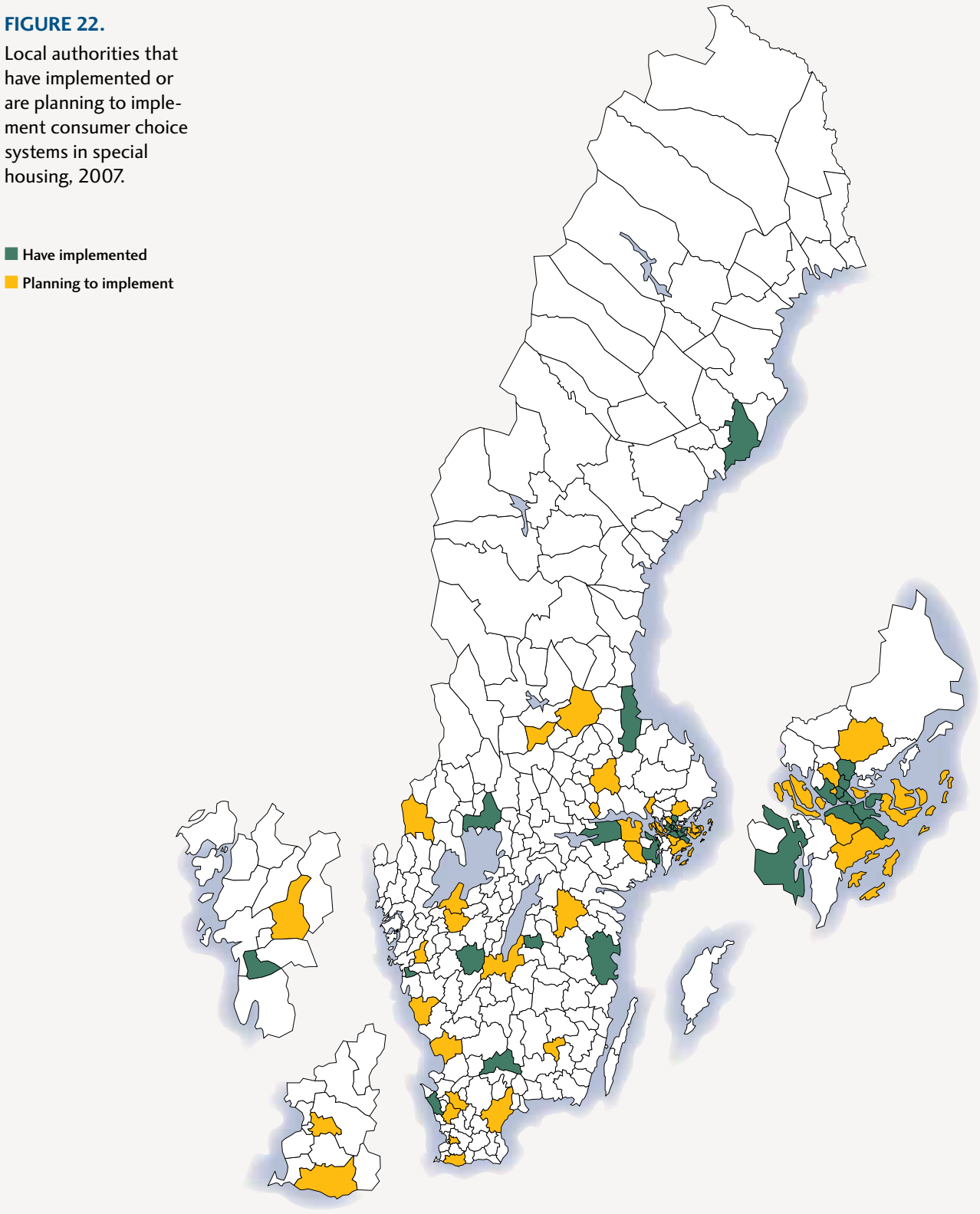


FIGURE 21.
Local authorities that have implemented or are planning to implement consumer choice systems in home help services, 2007.

Have implemented
Planning to implement

FIGURE 22.
Local authorities that have implemented or are planning to implement consumer choice systems in special housing, 2007.



On the last application day, 12 October 2008, 177 local authorities had applied for SEK 255 million.

Consumer choice means that a user who is granted aid is free to choose who will provide the granted intervention. It also means that the user has influence over how the granted services are carried out and can choose a different provider if they are not happy with the quality of the service or how they are treated. The providers compete with each other, and one key factor in the user's choice is a clear description of the quality. The local authority determines the price, which is the same for all providers, so the competition between them is one of quality. Most private service providers, such as home help companies, can offer various additional services to the user without the local authority's subsidy and therefore at market prices. Some examples of additional services are those covered by the tax deduction for household services that went into effect on 1 July 2007.

Four county councils have introduced consumer choice in primary care: Halland, Stockholm, Gotland and Västmanland. Region Skåne and Kronoberg have decided to implement consumer choice in the spring of 2009. The option is under investigation in Västra Götaland and Östergötland.

Committee on consumer choice

In the autumn of 2007 a new committee on consumer choice was established in the Swedish Association of Local Authorities and Regions. The task of the committee is to pursue programmes to support the members' efforts to create new alternatives for freedom of choice for the citizens; to monitor, document and analyse progress in the field of freedom of choice; to serve as the board's advisory body for the continuous management of issues regarding freedom of choice; and to consider ties with related issues. In the course of 2008 the committee ordered two reports: a survey of consumer choice systems in Swedish local authorities and regions and a knowledge survey.

New act on consumer choice systems, 2009

In the spring of 2007 the Government decided to appoint a special investigator to examine the possibilities for enhancing freedom of choice in healthcare, social care, support and service, including special housing, for the elderly and people with disabilities, as defined under the Social Services Act. The investigator's proposals were based on the idea of increasing freedom of choice and influence for the elderly and people with disabilities, and that the proposals should promote a diversity of care providers, both in terms of size and focus.

The Freedom of Choice in Care of the Elderly and Disabled inquiry presented its final report *LOV att välja – Lag om valfrihetssystem* (*Free to Choose – Act on Freedom of Choice*, SOU 2008:15) in February 2008. A bill was presented to the Riksdagen on

1 October 2008 proposing a new law on freedom of choice (abbreviated LOV). The proposed law regulates local authorities and county councils that want to introduce competition with their operations by allowing the user or patient to choose who provides their support, health and social care services. According to the proposed law, this freedom of choice system is an alternative to procurement under the Act on Public Procurement (2007:1091) and can be applied in activities such as care and support to the elderly and to people with disabilities, as well as social services and healthcare services.

A procuring authority wishing to apply the law must advertise continuously in a national database. Private businesses and non-profit organisations can apply to be approved as providers. Local authorities and county councils can regulate the conditions of the consumer choice system via agreements. All suppliers who have applied to participate in a consumer choice system, who meet the set demands and are approved, sign contracts with the local authority or county council. The basic concept of the law is no price competition between providers. Individuals are free to choose the provider they perceive as having the best quality. According to the bill the local authority or county council is responsible for ensuring that the user or patient receives complete information from all providers. For people who wish not to choose, there should also be a non-choice alternative. Providers considering themselves to be wrongly treated can appeal to an administrative court. The Riksdag is expected to decide on the new law in November 2008, and the law is intended to go into effect on 1 January 2009.

SALAR has received the government funds that will be provided in 2009/2010 to support local authorities that want to investigate and/or implement the new freedom of choice act. The support will include advice, legal information including the production of a "legal start-up package" document, process support through networks for local authorities that do not have consumer choice systems but want to develop them, experience networks for those which already have consumer choice systems and want to further develop them, introductory seminars for local authorities, and providing brokering services.

Free choice in primary care

In the spring of 2008 an inquiry called Patients' Rights in Healthcare presented a progress report entitled *Vårdval i Sverige* (*Consumer Choice in Care in Sweden*, SOU 2008:37). The report proposes, among other things, that it should be possible to freely establish oneself as a care provider with a right to public funding. The report has been circulated for comment and a referral was sent to the Council on Legislation in October 2008.

Staffing in health and social services 5

In her doctoral thesis *Konsten att vårda och ge omsorg (The Art of Providing Health and Social Care)*, Lotta Victor Tillberg interviews experienced health-care workers about reinforcing the law regarding healthcare situations and about situations where professional expertise necessarily includes the ability to bend the rules, improvise and take risks. They describe a job requiring improvisation, inventiveness, risk-taking and even acting skills.

Staffing in health and social services

Number of employees

In November 2007 a total of 253,300 (monthly salaried) employees worked in health and social services to the *elderly and people with disabilities* in the local authorities, which is illustrated in table 14. This is a reduction of 2,900 from the previous year. However, compared with 1997, the number of employees has increased by 38,200 or about 18%, a significantly greater increase than the total increase in employees in the local authorities, which is just over 6%. This calculation takes into account transfers between local authorities and county councils.

In the personnel statistics *employed* and *working* are two different concepts. The number of people employed also includes those who are on leave or on sick leave. The data on people who are *working* do not include these people. Of the total number of people *employed* in 2007 by SALAR, 29,500 were on some kind of leave – parental leave, a leave of absence to pursue studies, or sick leave – at least 30 days in a row. The number of people on leave decreased by 5,500, which means that the number of people *working* has increased to 223,900. In addition, 56,900 *hourly paid employees* worked in the sector.

TABLE 14.
Number of people employed by the local authorities in various occupations. People with monthly salaries, including those on leave. Rounded figures.

SOURCE: SALAR 2007.

	Employed		Working	
	Number	*Change*	*Number*	*Change*
Supervisors including home medical service inspectors	10,400	0	9,700	100
Assistant nurses, nurse's aides, etc.	181,200	-4,200	159,300	300
Nurses	11,900	-200	10,800	100
Occupational therapists	2,900	100	2,600	200
Physiotherapists	1,600	100	1,400	100
Other nursing staff, incl. personal assistants	33,400	1,200	29,100	1,600
Other staff	11,900	100	10,900	300
Total	**253,300**	**-2,900**	**223,900**	**2,500**

The number of people working increased by 2,500 between 2006 and 2007. Compared with 1997, the number of people working has increased by 34,700. In the

1997–2001 period the number of people working increased less than the number employed. This is because sick leave increased dramatically between 1998 and 2000. In the past few years, however, the trend has reversed; the number working has increased more than the number employed due to a drop in sick leave.

Among the total number of employees in care of the elderly and disabled, the percentage who are foreign-born increased from 10% to 14% in 2007. The increase consists mainly of people born outside the Nordic region and the EU. Over 90% of those working with care of the elderly and disabled are women, although the number of men has grown from 6.6–9.8% since 1997. Among permanent employees the number of men has doubled since 1997, from 14,300 to 21,600. The proportion of men is higher among temps. The highest proportion of men is found among treatment assistants, mental health support assistants and personal assistants.

Training

Nine of ten assistant nurses and nurse's aides in *care of the elderly and disabled* in 2007 had at least an upper-secondary school education, and just over 67% had nursing training, an increase from 2006 when 65% had nursing training. The majority of local authorities are around the mean value of 70% having nursing training. In many local authorities – especially those in southern and central Sweden – between 64% and 75% had such training, while the percentage is lower in the three metropolitan areas. Statistics on staff training are retrieved from Statistics Sweden's training register and include the official sources that Statistics Sweden collects. In addition, the local authorities often provide their own local or regional courses that are not included in the Statistics Sweden reports.

In special housing, an average of 81 % of staff had nursing training. In short-term care the figure was 92 %.

The National Board of Health and Welfare has a Guide for the Elderly that shows the educational level of staff in special housing units in elderly care, including short-term care in the local authorities' own activities and in private operations. In 2007 over 76% (median value) of assistant nurses and nurse's aides had nursing training, with a variation from 22% to 99%.

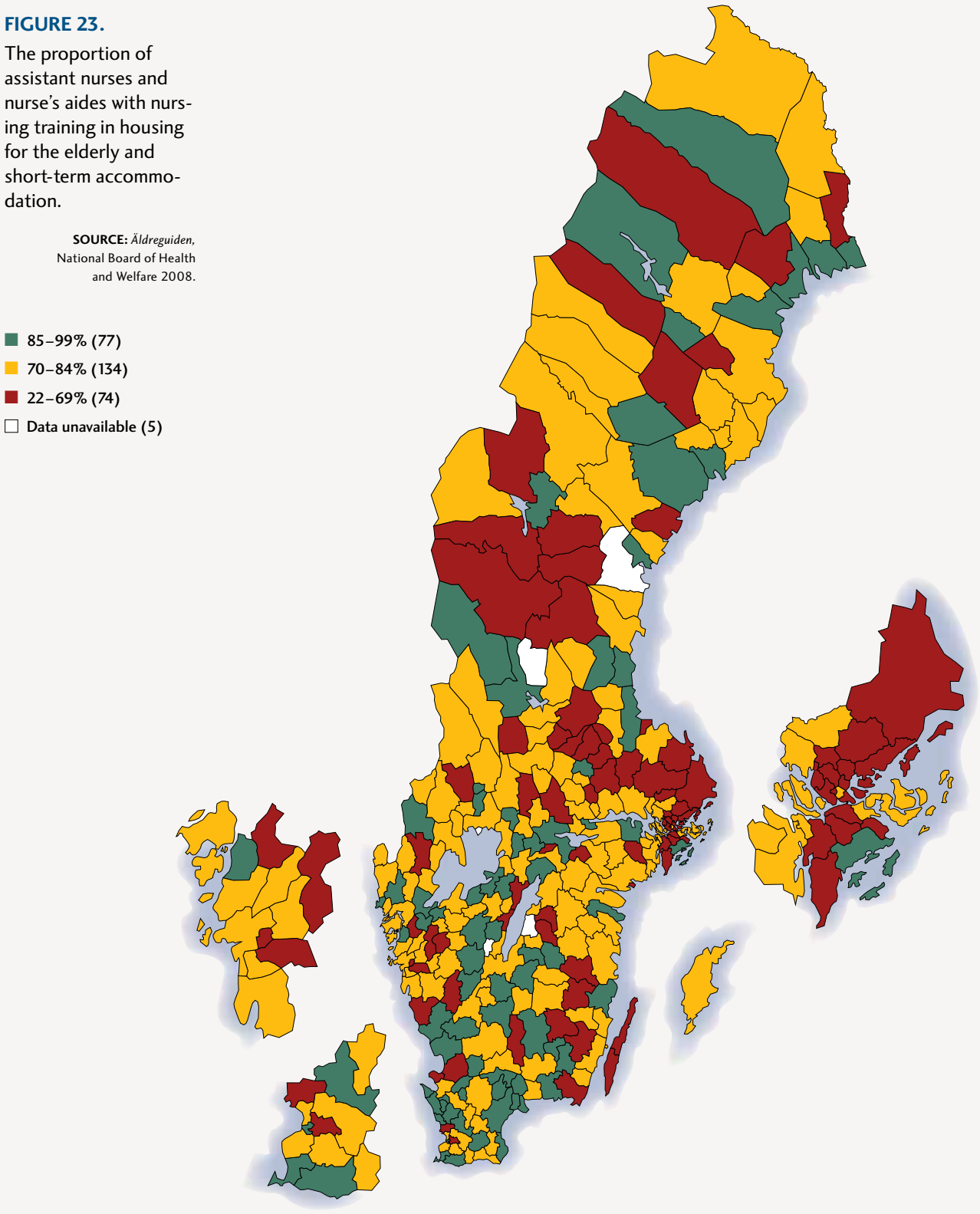
In special housing, an average of 81% had nursing training, and in short-term care 92% of nursing staff had formal training.

Of the approximately 12,000 assistant nurses and nurse's aides recruited in 2007, 59% had nursing training. Of those who had no nursing training, 32% had other upper-secondary schooling and 9% had not attended upper-secondary school.

FIGURE 23.

The proportion of assistant nurses and nurse's aides with nursing training in housing for the elderly and short-term accommodation.

SOURCE: *Äldreguiden,* National Board of Health and Welfare 2008.



Payroll

Table 15 shows pay levels and pay distribution in full-time salaries for a number of caring professions. Since work in these fields goes on 24 hours a day, seven days a week, a relatively large percentage of staff also receives additional pay for unsocial working hours. For example, 90% of assistant nurses receive an average of SEK 1,700 a month in additions for unsocial working hours.

Profession	Monthly pay for full time, minus floating additions		
	10th percentile	*median pay*	*90th percentile*
Assistant nurse	17,000	18,600	19,800
Nurse's aide	15,900	17,800	19,200
Nurse	22,000	24,500	28,000
Physiotherapist	21,000	23,600	26,200
Occupational therapist	21,000	23,100	25,600
Supervisor	24,100	28,200	32,700

TABLE 15.
Pay levels for full-time employment in certain health and social care professions in November 2007.

SOURCE: SALAR.

Median pay means that 50% of the individuals in the group have equal or lower pay. In the 10th and 90th percentiles, 10% or 90% of the individuals in the group have the same or lower pay, respectively.

Full and part-time employees

The percentage of full-time employees in care of the elderly and disabled remains at 46.5% in 2007. The percentage among all local authority employees is just over 68%. However, many choose to work part-time, so in practice only 39% of those working in health and social services work full-time.

Another way to express the scope of work time is to calculate the *average activity level*. In 2007, this level was 84% calculated based on all full and part-time employees in health and social services. Among part-time workers alone the figure is 73%. The average activity level for hourly employees is about 37% of full time.

Leaves of absence and sick leave

The percentage of employees who were completely absent for more than 30 days in a row – who were on parental leave, study leave or sick leave – dropped drastically in 2007.

Absence is higher in health and social services than in other community operations. In November 2007, 12.5% of permanently employed staff in health and social

TABLE 16.
Reasons for leave in health and social services, percentage.

Reason for leave	1997	2006	2007
Parental leave	3.4	3.3	3.3
Illness	4.0	6.5	5.8
Training	3.6	1.8	1.6
Other reason	2.3	3.2	1.8
Total	**13.4**	**14.8**	**12.5**

services were completely absent for at least one month. Of all local authority employees, 10.1% were absent. Absenteeism varies per department, profession and age.

The proportion of assistant nurses and nurse's aides who were completely absent in 2007 was 13%, which is clearly lower than in 2006 when the figure was 15%. Absenteeism is higher among younger employees, just over 25%. This is mainly explained by parental leave and various types of further training. Absence is significantly lower among older employees in this category at 9%. Sick leave is the most common reason.

Variations can be found between men and women. Among all local authority employees, the absence rate for women in 2007 was 11%, while it was only 6% for men. One explanation for this trend is that mainly women take parental leave. In care of the elderly and disabled, the total absenteeism was 13.2% among women and 9.5% among men.

Sick leave still decreasing

The proportion of local authority employees who were on full sick leave for at least 30 days in a row has decreased successively since 2002, both for the entire workforce and for staff in health and social services. The reduction has been mainly in the number of new cases.

The percentage of people on *full-time sick leave* is higher in health and social services than the average for local authority employees, regardless of age.

TABLE 17.
Percentage of permanent employees on full sick leave in November 2007, percentage.

SOURCE: SALAR.

Age	All local authority employees	All employees in social care	Assistant nurses & nurse's aides	Nurses
16–34	2.5	3.7	3.9	2.1
35–54	4.2	5.9	6.3	4.0
55–	5.4	7.3	7.7	7.0
Total	**4.3**	**5.8**	**6.2**	**4.9**

Staffing

Currently the local authorities are largely recruiting the staff they need for care of the elderly, and the concern is mainly recruiting people with the necessary skills and offering skills development to existing staff. Instituting the Health and Social Services (VO) College has turned out to be an excellent model for recruiting and training.

In 2007 the local authorities recruited 19,900 new employees to health and social services. That is fewer than in 2006, but corresponds to about the average for the past five years. In the period prior to this (1997–2003) significantly more were recruited, between 25,000 and 30,000 employees annually. The decrease in absence due to sickness is the most important explanation for this trend.

About 20% of those recruited were born outside of Sweden. That figure has doubled in ten years. The increase has mainly consisted of staff born outside the Nordic countries and the EU. In 2007, 14% of employees were born elsewhere. The corresponding figure ten years ago was 5%.

The fact that the proportion of elderly people is high in general and in certain professional categories indicates a coming need for recruiting. For example, 32% of nurse's aides and assistant nurses are older than 55. The percentage aged 55 and older is also high among nurses.

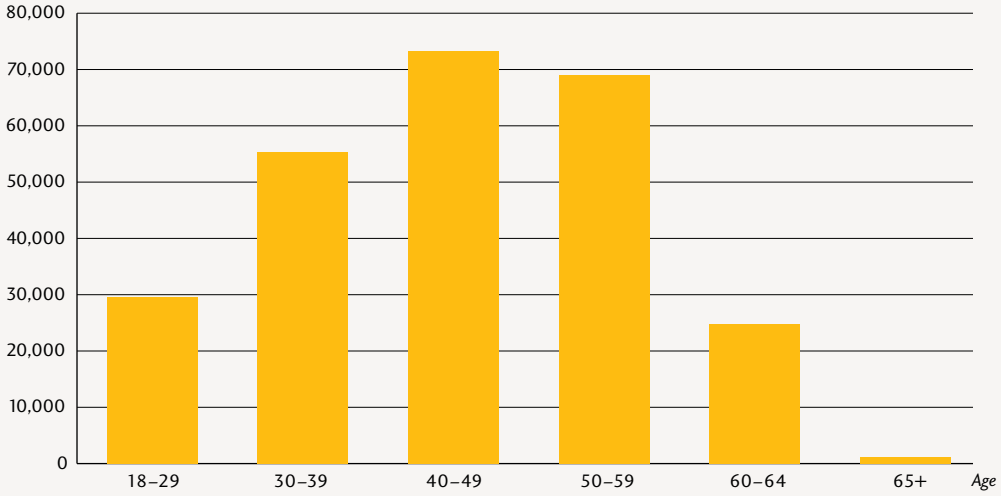


FIGURE 24.
All employed staff – numbers per age group.

The need for more staff in the care of the elderly will increase by 2020, when many people born in the 1940s will turn 80. A projection of the current trend shows that the labour market is expanding in the metropolitan regions and shrinking in rural areas, and that an increasing proportion of young people are moving from small communities to larger ones where more jobs are available. If the forecasts in the projection of current trends are correct, some parts of Sweden can expect significant population drops. In addition, the proportion of elderly people is growing in society as a whole and particularly in small communities in parts of the country. As a result,

care of the elderly will need to utilise a larger share of the working population in the depopulated communities. Staffing needs in care of the elderly will differ substantially in certain parts of Sweden from the trend in the working-age population.

Skills development

Steps for Skills

The Swedish Government invested SEK 1 billion in 2005–2007 to support the local authorities' long-term quality and skills development efforts. The project was called Steps for Skills. In November 2007 the committee presented its report *Att lära nära, stöd till kommunerna för verksamhetsnära kompetensutveckling inom omsorg och vård av äldre* (*Teaching Locally, support for local authorities to provide skills development in health and social care of the elderly*, SOU 2007:88). The committee and its administrative office, employing seven, have worked extensively with contacts and dialogues with the participating local authorities. Twenty county-wide conferences were held in the autumn of 2006 to stimulate an exchange of experiences and network building. The result was a popular website with news, articles and information. Some 118,000 people have participated in Steps for Skills, which corresponds to 62% of the total number of employees. The majority of the participants are nurse's aides or assistant nurses. Above all the local authorities chose to focus on the following skills areas:

About 118,000 people have participated in Steps for Skills.

- Approach to patients, ethics and basic values – 150 local authorities
- Dementia disorders – 150 local authorities
- Validation and basic training – 110 local authorities
- Rehabilitation – 100 local authorities
- Terminal care – 80 local authorities
- Meals and nutrition – 80 local authorities

The committee highlights three areas where skills development of the staff is of strategic importance to quality: enhanced professionalism, organisation, and basic values/approach to the patients. The committee points out that training measures should be closely related to operations, sustainable in the long run and individually adapted, and that the local authorities know best the needs of their employees, elderly residents and their family members. Therefore, the government support for skills development should be based on the greatest possible flexibility and respect for local conditions and the local authorities' own agendas.

At the start of 2008, the Steps for Skills website was turned over to SALAR and is being further developed over the course of the year into a meeting place for exchange of experiences and spreading good examples of quality and development work in the elderly field, for both local authorities and county councils – the portal for the elderly, **www.aldreportalen.se**.

The VO College

The Health and Social Services (VO) College is a form of collaboration on the regional and local level between course arrangers and professionals in health and social services. Local authorities, county councils, private care providers and union organisations collaborate on the upper-secondary and higher education level. For employers and course arrangers, the task is to provide health and social services with highly trained staff.

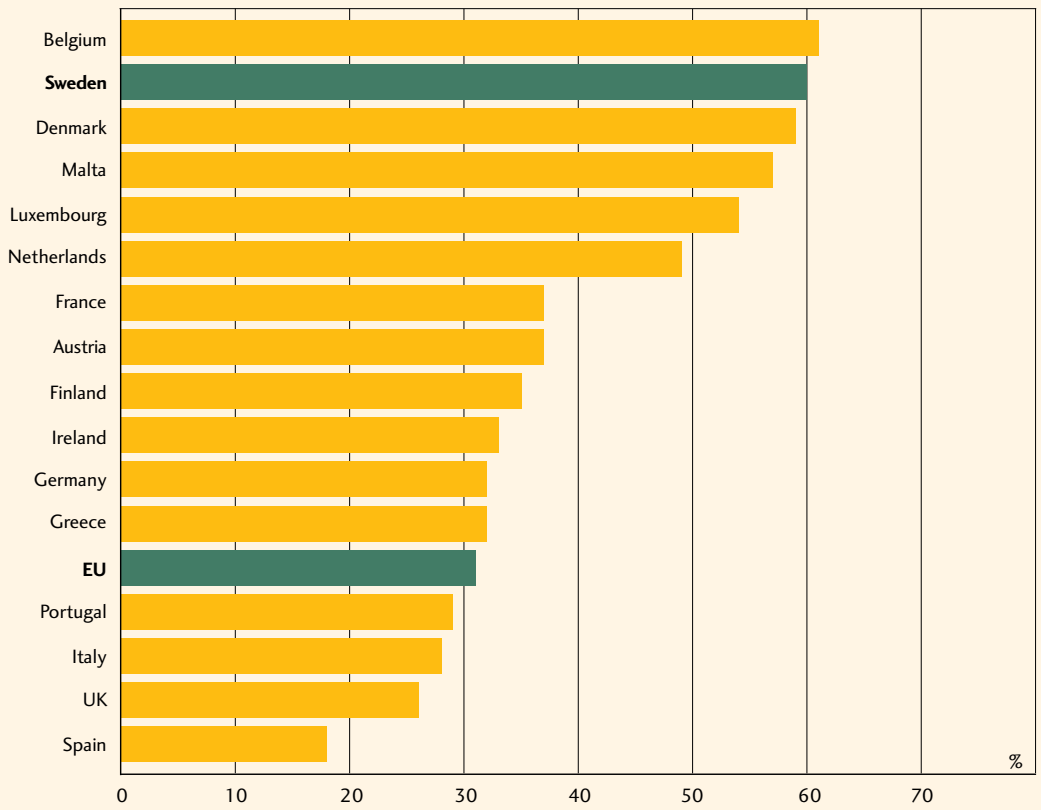
The VO College varies in format due to regional and local differences. Its courses are intended to give the students modern training with clear career paths. Practice with competent advisors and a training method involving real influence over the course of study ensures status and high quality. With a training method that resembles working life, the students obtain a good education that will make them attractive on the job market if the student does not choose to go on to further education. Employees of the VO College are also offered skills development.

The VO College is a protected trademark that may be used at the regional or local level when certain quality criteria are met. SALAR is a part of a national council in connection with the Swedish Municipal Workers' Union (Kommunal), the Association of Private Care Providers and the Swedish Organisation for Local Enterprises. The council has generated quality criteria and certifies approved colleges according to them. It also has a co-ordinating function on the national level. About 15 regions are in the process of forming VO Colleges, of which three have been certified. Applications from local VO Colleges have also come in to the national council, one of which is close to certification (**www.vo-college.se**).

Skills assessment in care of the elderly

In the autumn of 2007 the Government decided to commission an inquiry into skills provision in the care of the elderly, *Yrkeskrav i äldreomsorg* (*Professional Requirements in Care of the Elderly*, dir. 2007:155). Some of the results of the inquiry will be a proposed formulation of uniform criteria for professional skills, a skills certificate and professional titles for care staff working in the local authorities' health and social care of the elderly. The investigator will also propose professional requirements for such care staff and propose how professional titles and requirements should be implemented smoothly in the operations. The inquiry will be completed on 30 November 2008.

Costs and financing 6



According to a survey on public opinions about elderly care, only 31% of Europeans, on average, agree that professional care in the home is available at an affordable cost. The figures vary widely among nations – in Belgium, Denmark and Sweden, more than 60% of the population agree that affordable care in the home is available compared to 18% in Spain.

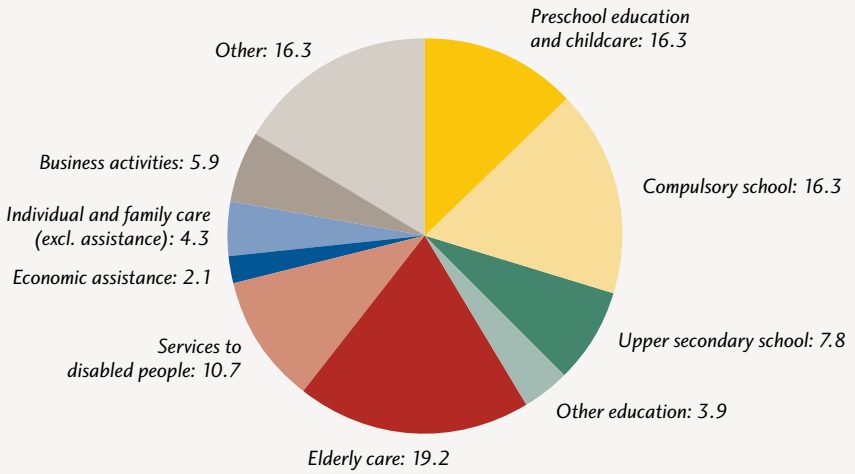
SOURCE: Health and long-term care in the European Union, 2007.

Costs and financing of elderly care

Local authorities' total costs for elderly care were SEK 452 billion in 2007. Figure 25 shows how local authority costs are allocated among various operations. Social welfare services – childcare, education and health and social care – combined account for 76% of local authorities' total costs, essentially on a par with 2000 (75%). The percentage of local authorities' expenditures that went to services for disabled people increased from 8% to 11% during the same period.

FIGURE 25.
Distribution of local authority costs for operations in 2007 (SEK 452 billion). Percentage.

SOURCE: Statistics Sweden 2008, *Räkenskapssammandrag år 2007 (Accounting Summary for 2007)*, SALAR 2008..



Compared to 2006, total costs for elderly care rose 4.3% to SEK 87 billion in 2007. Of the cost increase, 2.6% is explained by pay and price increases, while the increase at fixed prices was 1.6%. Costs to local authorities for health services – home medical care, rehabilitation and assistive devices – are included in the cost of elderly care.

The percentage of total local authority costs attributable to elderly care has declined by 1 percentage point since 2000 to slightly more than 19% (see Table 18). This decline can be explained by several factors, including that costs for upper secondary school and services to disabled people have risen faster than the costs of elderly care. The rapid cost increase in these areas is due to a growing upper secondary student population and higher numbers of people granted services under LSS.

	Total costs to local authorities		Elderly care		Percentage
Year	*Current prices*	*2007 prices*	*Current prices*	*2007 prices*	*Current prices*
2000	333.1	409.3	67.3	87.9	20.2
2001	350.3	415.3	71.4	89.4	20.4
2002	371.2	423.8	75.7	90.6	20.4
2003	389.1	424.1	78.3	89.9	20.1
2004	398.1	428.5	79.5	85.8	20.0
2005	410.5	432.6	80.3	84.4	19.6
2006	431.4	442.4	83.5	85.6	19.4
2007	452.2	452.2	87.0	87.0	19.2

TABLE 18.
Operational cost trends for local authorities, total and for elderly care, 2000–2007 (SEK billion in current prices and 2007 prices).

SOURCE: Statistics Sweden 2008, *Räkenskapssammandrag år 2007 (Accounting summary for 2007)*, SALAR 2008.

Health and social care to residents in special housing accounted for the majority of costs at 61%. Health and social care to residents in regular housing accounted for 37% and preventive activities for 2%.

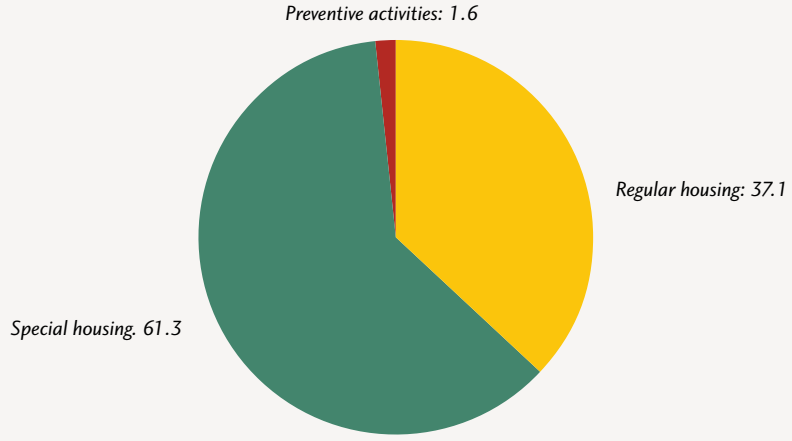


FIGURE 26.
Distribution of costs for elderly care in 2007. Percentage.

SOURCE: Statistics Sweden 2008, *Räkenskapssammandrag år 2007 (Accounting summary for 2007)*, SALAR 2008.

Costs for health and social care in special housing accounted for almost 70% in 2002, while costs for care to residents in regular housing accounted for 27%. Thus the trend shows a shift of resources from special to regular housing over the years.

As shown in Figure 28, local authorities' costs vary widely among recipient age groups. People of working age cost the least on average. Costs for children and adolescents are relatively high, but are still considerably lower than costs for the oldest age groups. Local authorities' costs per person are highest for people over age 85. This age group is now growing at a relatively moderate rate, due to the relatively small number of children born after the mid-1920s and in the 1930s. When the large groups of children born in the 1940s begin reaching age 85 in the 2020s, the demographic pressure on the costs of care for the elderly will rise considerably faster.

FIGURE 27.
Distribution of elderly care costs between regular and special housing and preventive activities, 2002–2007. Percentage.

SOURCE: Statistics Sweden, Accounting summary for local authorities.

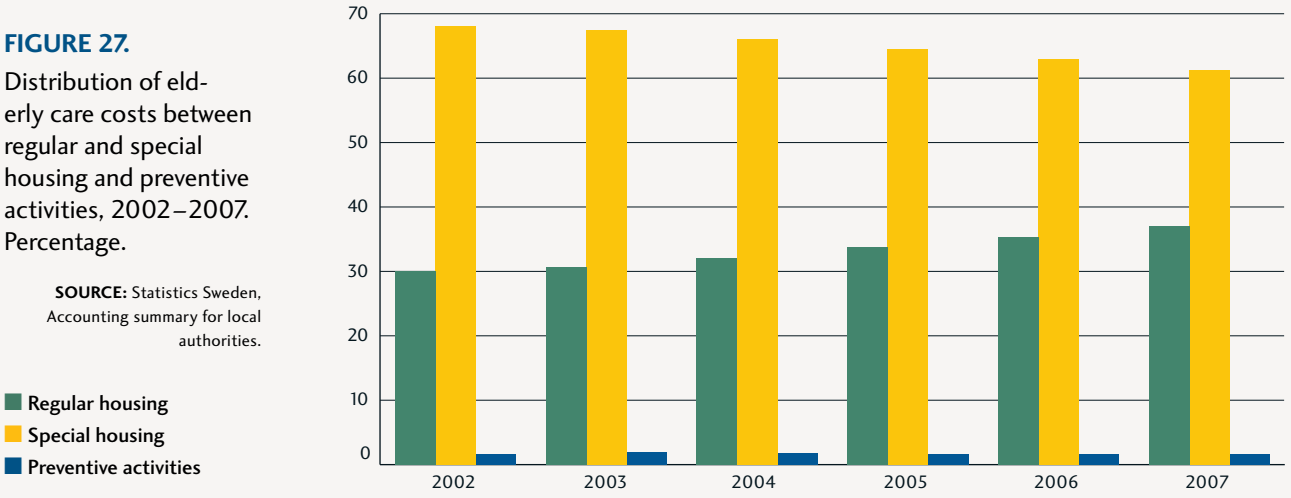
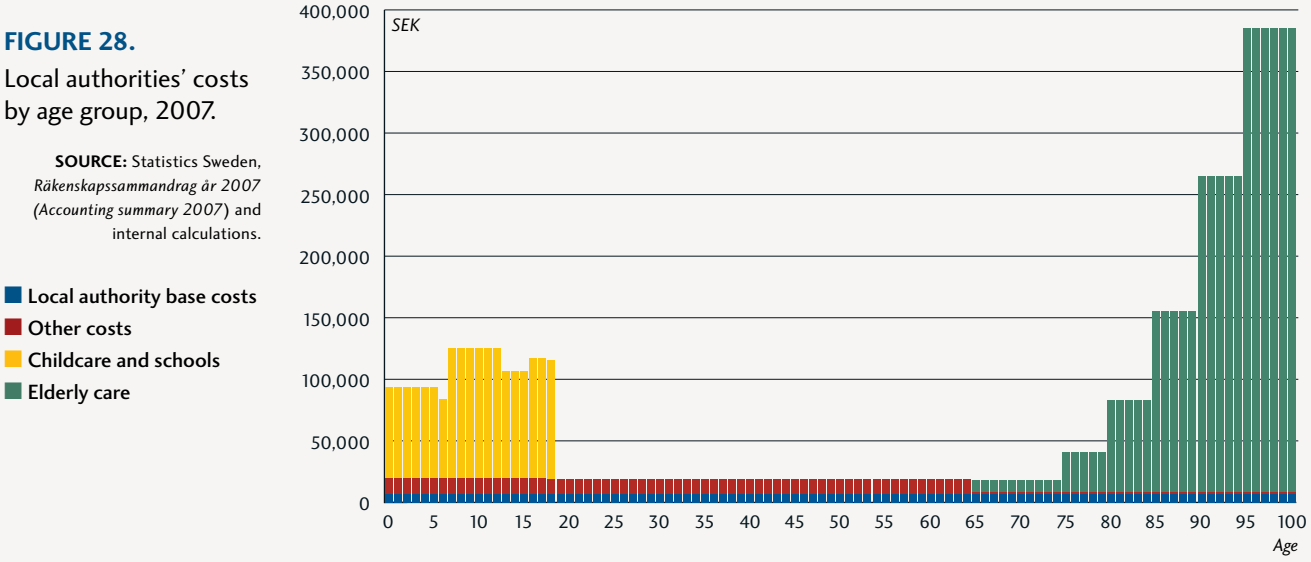


FIGURE 28.
Local authorities' costs by age group, 2007.

SOURCE: Statistics Sweden, *Räkenskapssammandrag år 2007 (Accounting summary 2007)* and internal calculations.



The demographic age structure varies relatively widely from one local authority to the next. Aimed at giving local authorities equivalent financial conditions for meeting their obligations, financing is equalised to adjust for differences, including age structure. The cost equalisation system is based on a number of sub-models, including childcare and elderly care. Local authorities assessed as having a favourable structure overall pay into the system, while local authorities with an unfavourable structure receive subsidies.

Equalisation subsidies to cover the need for elderly care are based on the percentage of elderly people in the community. The elderly population is divided into six age groups whose care needs are presumed to increase with age. The equalisation system also takes the sex, marital status, ethnicity and occupational history of eld-

erly residents into account. A special supplementary grant is also paid for elderly residents of rural local authorities. These factors are weighted to arrive at a standard cost for elderly care. The local authority's standard cost for elderly care reflects the cost the local authority would have if costs corresponded to a national average, given the structure found in the local authority.

Population structure and cost per resident

The local authority's standard cost for elderly care is the basis of cost equalisation in the local authority economic equalisation system and reflects differences in the age structure among elderly people, distribution by sex, the percentage of single-person households and former occupational history (which is thought to reflect health/illness). These factors affect the need for services and generate structural costs that are beyond the local authority's control. Local authorities whose standard costs are high can be expected to have higher actual costs than those whose standard costs are low.

The map in Figure 29 shows the deviations from the standard cost in all local authorities. Those shown in green have low costs relative to the standard cost (the 25% of local authorities with the lowest costs) and those shown in red have high costs (the 25% with the highest costs). Yellow indicates the 50% of local authorities where actual costs are closest to standard costs.

Deviations from the standard cost vary widely among local authorities. The map shows that most local authorities whose costs for elderly care are high in relation to their structure are found in northern Sweden and near the large cities of Stockholm and Göteborg (shown in red). Local authorities whose costs are relatively low (green) are found in eastern Götaland, for instance, but most local authorities are found in the interval of +/- 10% deviation from the standard cost. There is no direct explanation for the geographical pattern.

Costs for regular and special housing

The average cost per care recipient in regular housing decreased in current prices by SEK 5,100 (2.3%) between 2006 and 2007. The method used to collect statistics related to elderly people was changed in 2007 and the decline in the measured average cost is attributable to this change. People whose services are limited to meals on wheels and/or snow removal were also included as of 2007. Since the cost of these services is included in the figures for earlier years, the average cost declines when it is allocated among more people.

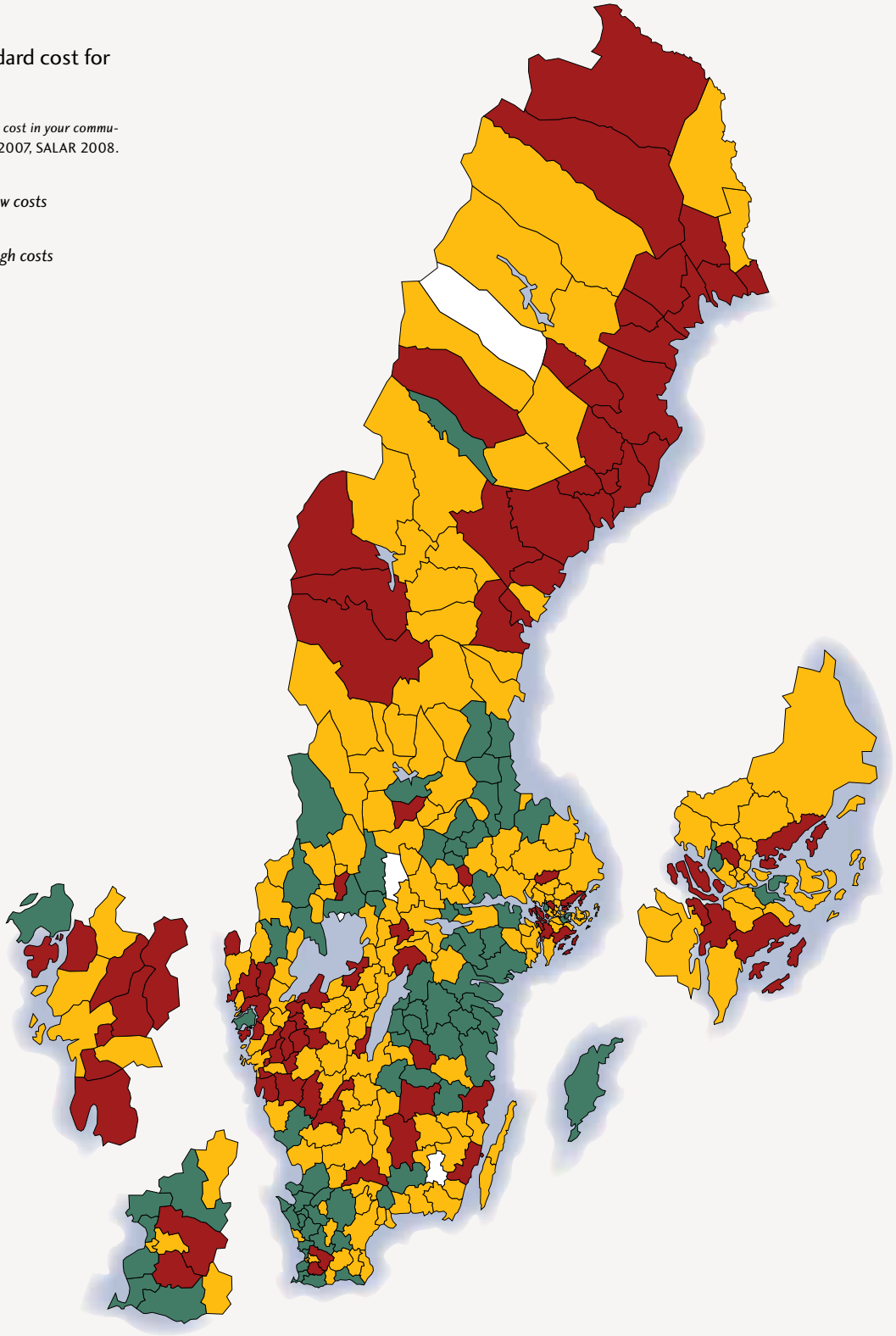
The average cost per care recipient in special housing has increased by SEK 31,100 (6.5%) in current prices. As Table 19 shows, the cost per care recipient is approximately twice as much in special housing as in regular housing. A progressive decline in the rate of cost increases can be seen between 2001 and 2006 with respect to costs

FIGURE 29.

Deviation from standard cost for elderly care, 2007.

SOURCE: *What do services cost in your community?* Annual Accounts 2007, SALAR 2008.

- -27 to -6.3% (71) *Low costs*
- -6.2 to 8.3% (143)
- 8.4 to 65.1% (72) *High costs*
- Data unavailable(4)



for both regular and special housing, but the rate of increase for special housing accelerated in 2006 and 2007.

Year	Regular housing	Special housing
2000	169,100	335,100
2001	183,500	363,700
2002	198,900	389,800
2003	208,500	420,900
2004	214,800	438,400
2005	218,000	453,500
2006	224,700	480,400
2007	219,600	511,500

TABLE 19.
Cost per care recipient in regular and special housing between 2000 and 2007, current prices (unweighted mean excluding costs of premises).

SOURCE: SALAR's key indicators, online at *www.webor.se*

Costs of health and medical care for the elderly

People aged 65+ make up one-sixth of the population and consumed slightly more than half of bed-days in 2006. According to a report by the National Board of Health and Welfare, county council costs for healthcare provided to people aged 65+ increased by 7.7% between 2002 and 2006. The National Board of Health and Welfare estimated these costs at SEK 87.6 billion in 2006, equal to 46% of total county council costs for healthcare.

Costs of physical inpatient care for elderly people

Specialised physical healthcare accounts for slightly more than half of total county council healthcare costs. See Figure 30.

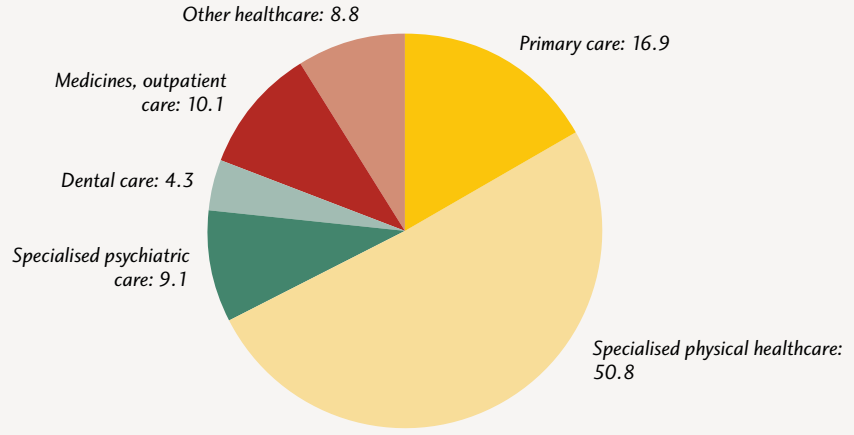


FIGURE 30.
County council costs for healthcare in 2007 (SEK 200 billion). Percentage.

SOURCE: SALAR.

Computed on physical *inpatient* care alone, including medicines, healthcare costs for people aged 65+ were SEK 30 billion in 2007, which corresponds to about half of total county council costs for physical inpatient care. See Table 20.

TABLE 20.
County council costs for physical inpatient care in 2007, distributed by age group.

SOURCE: National Board of Health and Welfare's patient register and SALAR's cost per patient (CPP) database.

	Percentage of total cost				SEK million			
	Age 0–64	*Aged 65–79*	*Age 80+*	*All*	*Age 0–64*	*Aged 65–79*	*Age 80+*	*All*
Men	24.4	14.8	8.5	47.7	15,357	9,274	5,337	29,970
Women	26.9	13.0	12.4	52.3	16,929	8,136	7,785	32,851
Total	**51.4**	**27.7**	**20.9**	**100.0**	**32,286**	**17,410**	**13,122**	**62,821**

The diagnosis groups that generate the highest costs for people aged 65+ are hip replacement surgery, stroke and heart failure. See Table 21. Combined, these diagnosis groups accounted for 14% of total costs for physical inpatient care provided to elderly people.

TABLE 21.
Share of total costs for physical inpatient care for the three costliest diagnosis groups, distributed by age group. Percentage.

SOURCE: National Board of Health and Welfare's patient register and SALAR's CPP database.

	Age 0–64	Aged 65–79	Age 80+	Age 65+	Total
Hip replacement	1.8	6.0	4.8	5.4	**3,6**
Stroke	1.4	4.2	6.6	5.2	**3,3**
Heart failure	0.4	2.1	4.7	3.2	**1,7**

As age groups go up, these three diagnosis groups account for an increasing percentage of costs for physical inpatient care. They account for about 4% of costs for the population up to aged 65. The figure is 12% for the 65–79 age group and 16% for the 80+ population.

Differences between the sexes are relatively minor with respect to the percentage of costs for physical inpatient care allocated to the various diagnosis groups. Stroke care accounts for the highest cost of healthcare for elderly men, followed by hip replacement surgery. The order is reversed for women.

Financing of local authority and county council operations

Local authority revenues for operations increased in 2007 by 4.2% to SEK 462 billion. A reduction of the average tax rate by SEK 0.05 reduced tax revenues by nearly SEK 800 million.

Local government taxes and central government grants account for 84% of local authority revenues for operations; see Figure 31. Fees, which account for 7%, are mainly attributable to business operations. Only a relatively insignificant portion of social welfare services (4% for elderly care) are financed by fees.

County council operations are mainly financed by county council tax (70%) and central government grants (19%), with only 3% generated by fees.

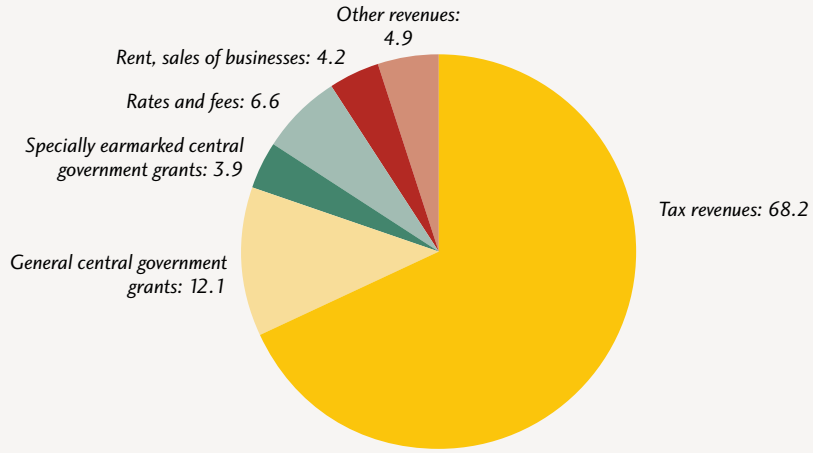


FIGURE 31.
Distribution of local authorities' operating revenues in 2007 (SEK 462 billion). Percentage.

SOURCE: Statistics Sweden 2008, *Räkenskapssammandrag år 2007 (Accounting summary for 2007)*, SALAR 2008.

County council costs for health and medical care

Total county council costs for operations were SEK 219 billion in 2007. The majority – SEK 200 billion or 91% – was spent on healthcare. See Figure 32.

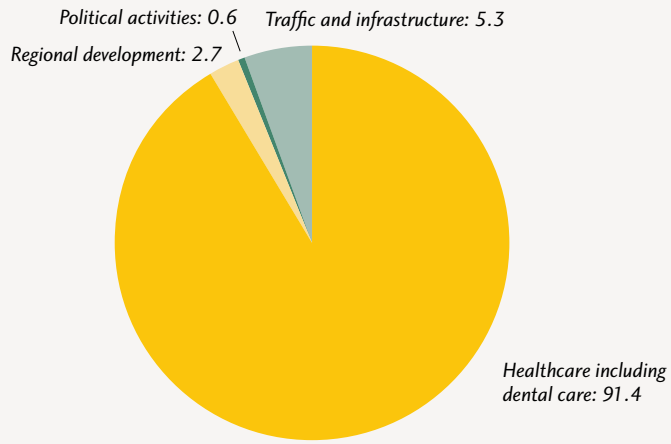


FIGURE 32.
County council costs for operations in 2007, distributed by operation. Percentage.

SOURCE: SALAR.

Local authority and county council finances

According to SALAR's economic report in autumn 2008, Sweden is entering an economic downturn, exacerbated by international turbulence and global credit worries, which have characterised the national economy. This is having an adverse impact on prospects for growth in local authority tax revenues and resources are increasing more slowly than in recent years. Combined with the Government's notice in the budget bill that there are no plans to increase general central government grants, this

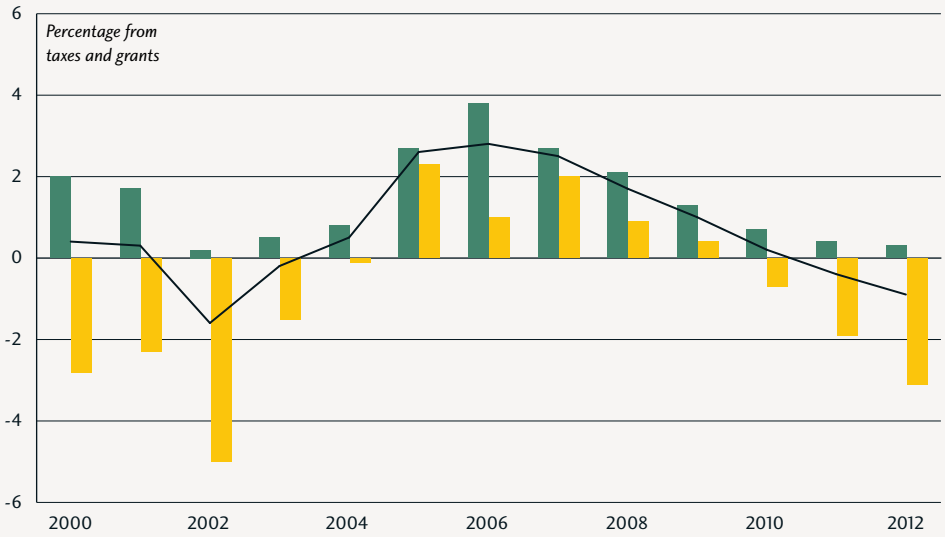
will cause rapid deterioration in local authority and county council finances from the current surplus level, which is relatively good. In parallel, costs are expected to increase relatively slowly, so the weaker finances cannot be described as the result of rapid operational expansion (*Economic Report on Local Authority and County Council Finances*, October 2008, SALAR).

The economic downturn and credit worries are both examples of why local authorities and county councils need to maintain a surplus. The rule of thumb for sound financial management in local authorities and county councils is a surplus equal to 2% of tax revenues, general central government grants and equalisation subsidies. With no increases in central government grants or other income reinforcements, there is risk of increasingly widespread deficits in the next few years.

FIGURE 33.
Local authority and county council net income* 2000–2012. Percentage of taxes and grants.

** Income before extraordinary income and expenses.*

SOURCES: Statistics Sweden and SALAR.

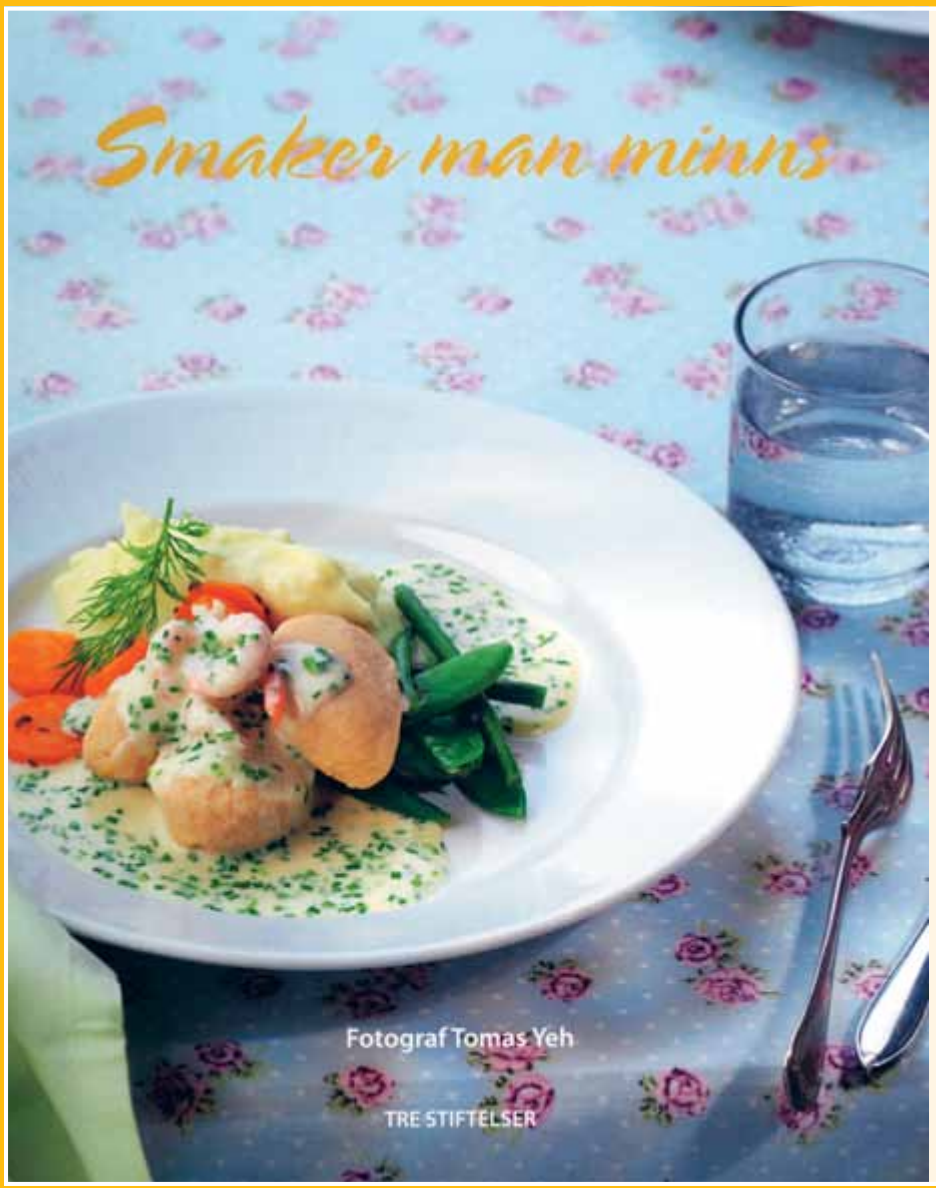


The starting position is relatively good for the local authorities. Net surpluses are expected to exceed the 2% rule of thumb on average. However, this will be impossible in future years, despite certain cost adjustments to slower revenue increases. The situation will be difficult for many local authorities. Total demographic pressure will be minor in the next few years and thus facilitate cost adjustments, but relatively large shifts between different operations will be required, which entails a risk of conversion costs. For instance, needs for elderly care and preschools are increasing, while needs within compulsory school are decreasing.

The situation is already difficult for the county councils this year and will be next year as well, due to high cost pressure. Demographic pressure is rising relatively quickly in the healthcare system. Technical and medical advances are also making it possible to treat diseases to a new extent. In addition, the county councils are more dependent on general central government grants, which are being kept at a nominally unchanged level, despite rising costs. As a result, net deficits are expected soon. Half of all county councils already expect to report deficits this year. As a result, greater demands are being put on local authorities and county councils to continue

and intensify efforts to improve efficiency. This requires setting priorities and making operational adjustments. However, the spread between different local authorities and county councils is very wide. Local authorities and county councils that have had surpluses in the recent good years now have better prospects going into the more difficult times ahead.

Quality and efficiency 7



In the autumn of 2008, Tre Stiftelser i Göteborg – a collective name for three foundation-run special housing facilities for the elderly with a total of 400 guests – presented a cookbook for care of the elderly entitled *Flavours We Remember*. The message is: it's perfectly possible to make tasty, attractive food even at a care facility; it simply takes a new way of thinking, serving the food in creative ways, having fun in the kitchen and seeing the meal not just as a source of sustenance, but as an important part of a meaningful, dignified life.

Quality and efficiency

Introduction

Publicly financed community care of the elderly, including interventions by the healthcare system for the elderly population (65+) amounts to SEK 170–180 billion a year. Over 263,000 people aged 65 and older received measures under the Social Services Act or the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS) on 1 October 2007, and over 253,000 were employed in local-authority run care of the elderly and disabled. The 65+ age group makes up just over 17% of the population and uses over 55% of the bed-days in the healthcare system. Health and social care is a significant element of the welfare society, and requires continuous development of knowledge on quality, results and effects.

The perception of good quality is highly subjective, and what is valued highly differs depending on life situation. Quality aspects that are important on entering the elderly care system are clarity and accessibility; knowing where to turn, obtaining information on what rules apply and what things cost. Even when a person receives help several times a day, it is important to be able to influence the way home help services conduct their work; ensure that they come when expected or phone if they can't; be able to lodge complaints and if necessary change care staff.

Presumably all people are more enticed by good food served attractively, whether in our own homes, at a fancy restaurant or in a residential care centre. It may well be the last interest we really throw ourselves into and live for. When life is in its final stages, we want someone to make sure our pillow is fluffed, that we receive food from cheerful staff, that someone understands where we're in pain even when we cannot express ourselves clearly, that pain relief works and that we are not alone at the moment of death.

Professionals on the local and national levels are working intensely to improve and monitor quality in the care of the elderly, and in particular clarify the links between quality, results and costs. This section gives an overview of activities on the national level regarding the improvement and monitoring of quality and efficiency in the health and social care of the elderly.

Open comparisons – healthcare and care of the elderly

In 2006 SALAR and the National Board of Health and Welfare published the first open comparison of the county councils' healthcare using 57 different indicators. The report from 2007 shows comparisons based on 75 indicators, and the 2008 report has 101 indicators.

In the autumn of 2008, SALAR presented the second open comparison report on the local authority level with 21 indicators in the elderly area, *Öppna jämförelser 2008 Vård och omsorg om äldre (Open Comparisons 2008, Health and social care of the elderly)*. The 2008 report is based on data from official statistics, the National Board of Health and Welfare's patient listing, the National Pharmacy Register, the Comparison Project, the Guide for the Elderly and more. The main goal of reporting on open comparisons is to support the local authority and county council managements to improve the quality of care of the elderly. Several figures in this report are based on the data from Open Comparisons 2008.

National Quality Register

The Swedish healthcare system has been compiling national quality registers for more than 25 years. A quality register contains information on individual patients' problems, measures implemented and results in such a way that data can be compiled for all patients and analysed on a facility level. By maintaining national registers, the entire country strives after the same indicators of good care, which allows comparison between different facilities. In addition to the facility level, the registers are increasingly used in overall planning and management. Opportunities for use increase further when more and more registries include patient-assessed quality and quality of life in addition to medical data.

All National Quality Registers contain personal data on problem/diagnosis, treatment and results. When a register is fully developed, it is possible to follow up what the healthcare system achieves for all patients in the country in the register's field. The registers allow us to monitor what individual county councils, hospitals or clinics achieve and provide a basis for comparisons that allow us to learn and continuously improve efforts.

Several of the registers reflect diagnosis groups and treatment forms that more specifically affect the elderly population. The Swedish Hip Prosthesis Register started in 1979, the National Hip Fracture Register in 1988, the National Cataract Register in 1992 and the National Stroke Register in 1994. The Swedish Dementia Register and the Swedish Palliative Register both started in 2005 and are being compiled. SeniorAlert is another newly started national quality register that works preventively with the health and social care of the elderly in the fields of nutrition, falls and pressure ulcers.

The registers are compiled by professional categories that will use them in their work. Many clinics throughout the country are in charge of operating the registers. SALAR works with the National Board of Health and Welfare on a central level and supports the development of the registers financially and in other ways. On the

national level, the Swedish Society of Medicine and the Swedish Society of Nursing participate as well. The administrative work, such as applying for funds for the registers, was transferred at the turn of 2007 from the National Board of Health and Welfare to SALAR.

A document from SALAR gives an overview of all the quality registers and centres for excellence that received support in 2007, *Nationella Kvalitetsregister inom hälso- och sjukvården 2007 (National Quality Registers in Healthcare 2007)*, **www.kvalitetsregister.se**.

Quality indicators in the elderly field

The National Board of Health and Welfare has a mission to work with SALAR to generate national quality indicators that describe quality aspects regarding the structures, processes and results of the operations. This work began in 2006 and proposed indicators will be presented in 2008/2009 with a focus on pharmaceuticals, prevention of malnutrition, falls and pressure wounds, and terminal care. These indicators were created in collaboration with the Senior Alert and Swedish Palliative Registers, among others. A project is planned in 2009 to collect the indicators that the facilities already register and which facilities can provide information in 2010.

The Comparison Project

This collaborative project between SALAR, the Ministry of Finance and the Council for Local Government Affairs began in 2007 and is funded with SEK 12 million over the course of three years from the Ministry of Finance.

Participating local authorities work together in networks of 5–10 local authorities. The goal of the networks is to develop efficient methods using comparisons of costs and qualitative results in order to make practical improvements in the operations. The networks also aim to create a work culture in which continuous comparisons are a regular part of steady improvements. The networks are to consist of leading politicians and officials working with a project group that generates results. The work of the local network is supported and organised by a process manager from SALAR.

In the autumn of 2008, 184 networks had joined, of which 25 had worked with comparisons in the elderly field encompassing 106 local authorities. A specific range of measures with definitions is established in the elderly care field. They have been tested, generated and decided on by about 100 of the nation's local authorities. All measures and results are presented on **www.jamforelse.se** and make up a part of the data for Open Comparisons 2008 – Health and social care of the elderly.

What the results clearly show is that there is no connection between costs and quality. Some networks also demonstrate a clear political ambition regarding the structure of care of the elderly – i.e. if the local authority focuses on home help services and allowing elderly people to live at home longer, or if the emphasis is on offering residential care facilities.

Statistics based on social registration numbers

In 2007 the National Board of Health and Welfare radically changed its collection of information for official social services statistics, which also includes data on health and social care of the elderly and disabled. Switching from quantitative statistics to social registration number-based data as of 1 October 2007, the register now covers people who are receiving interventions according to the Social Services Act and home medical services according to the Act on Health Services. As of 1 July 2008 the local authorities must be able to regularly provide social registration number-based data. The statistics must clearly indicate all decisions on interventions, including changes made during the course of the year for individuals. The goal is to collect social registration number-based statistics on a yearly basis in all local authorities starting in 2009. In connection with this adjustment of the statistics, the amount of data requested was expanded. The idea is to gradually expand the statistics, for example with national quality indicators.

For the first time, the data for the National Board of Health and Welfare's annual statistical report *Äldre – vård och omsorg 2007* (*The Elderly – Health and social care 2007*, Social Care 2008:7) comes primarily from social registration number-based data.

Guide for the Elderly

Part of the National Board of Health and Welfare's government mandate on Open Comparisons comprises a questionnaire to local authorities and county councils, whose results were presented on a new website, **www.aldreguiden.se**, in spring 2008. The long-term goal is for open comparisons to serve as a basis for the users' free choice of provider. A new questionnaire was sent out in the spring of 2008 with a summarising report *(Öppna jämförelser inom vården och omsorgen om äldre (Open Comparisons in the Health and Social Care of the Elderly)*, National Board of Health and Welfare 2008) presented to the Government in August and in an updated Guide for the Elderly a month later. In the future the Guide for the Elderly will be updated annually with questionnaires to local authorities and county councils and a summarising report in August. The final report for this mandate will be submitted to the Government in 2010.

User surveys

User surveys are a way of capturing various aspects of subjectively experienced quality. Most local authorities have been conducting such surveys for many years, but they are difficult to compare as the survey questions are not co-ordinated. At the request of SALAR, about 60 local authorities introduced three standardised questions in their own user surveys. The questions are based on Statistics Sweden's client satisfaction index and are also used in the Comparison Project.

- How satisfied are you with your home help service/your special housing as a whole

- How well does your home help service/special housing meet your expectations
- Compare your home help service/special housing with an ideal one

In June 2006 the Government established a directive for national user surveys, which must be formulated in such a way that it is possible to make comparisons between local authorities, between the sexes, between various socio-economic and ethnic groups, national minorities and different points in time. Statistics Sweden conducts the survey with a questionnaire in the post, which was sent out in autumn 2008 to 155,000 users of home help services and residential care homes. At the same time, another questionnaire is being discussed to be sent to 15,000 non-users of elderly care.

Healthcare index – Patient survey

The Healthcare Index is a rolling population survey of Swedes' knowledge of, experience with and attitudes towards healthcare. Sweden's county councils and regions are behind the Healthcare Index. Each year about 0.5% of the adult population in all county councils/regions except for Gotland are interviewed by telephone. The goal is to give politicians, officials and representatives of the healthcare system an idea of what the population thinks of it. The survey started in autumn 2001 and is conducted by Ipsos.

A national patient survey is under procurement. The patient survey will cover primary and specialist care, both inpatient and outpatient. The purpose is to provide a basis for local improvement efforts and comparisons on various levels, such as National Indicators and Open Comparisons. The first national survey will be conducted in early autumn 2009 in primary care. As the National Patient Survey is implemented, the Healthcare Index will develop into a general population survey (**www.vardbarometern.nu**).

Needs and interventions

The National Board of Health and Welfare was asked to generate a proposal for a structured system for registering documentation in the process of managing patients and in the implementation of social services. Having structured documentation will make it possible to describe needs, decisions on interventions, performed interventions and how they interrelate. Terms, concepts and models to be used in the trial, based in part on the ICF classification system, will be generated in 2008 and tested in a few local authorities in 2009. The template for the documentation is based on the National Board of Health and Welfare's guides on co-ordination and documentation in the social services and a management system for quality in facili-

ties under the Social Services Act, the Care of Young Persons act, the Care of Alcoholics and Drug Abuser Act and the Act concerning Support and Service for Persons with Certain Functional Impairments. The trial is being conducted in collaboration with the Centre for Epidemiology, which has a mandate to develop national professional terminology for health and social care. The purpose of that project is to support the development of a common professional language in health and social services in order to obtain clear, uniform, comparable information.

Costs and efficiency

In this subproject in the framework of Open Comparisons, the National Board of Health and Welfare intends to develop proposals for key financial ratios describing costs and efficiency. The project involves theoretical/methodological work to link financial terms to interventions, needs, quality and results. It also includes a survey and choice of key ratios with both current data and new information being tested in trial operations.

Inquiry for knowledge-based social services

The Inquiry for Knowledge-Based Social Services (dir. 2007:91) was initiated in the autumn of 2007 with the task of reviewing government support to skills development in the social services. Director General Kerstin Wigzell was appointed special investigator. Another task of the inquiry was to analyse and make suggestions for measures promoting the generation, spread and practical application of new knowledge. The inquiry has noted the funds the government has set aside for local authorities and principals for knowledge enhancement and development work in the social services. In total, the granted funds amount to nearly SEK 2 billion (SEK 1,918,583,000 in 2006), and much of this funding was targeted to care of the elderly.

A report presented early in 2008 entitled *Evidensbaserad praktik inom socialtjänsten – till nytta för brukaren (Evidence-Based Practice in Social Services – of benefit to the user)*, SOU 2008:18, shows that social services are not sufficiently based on actual knowledge of the effects of various interventions and methods. Government support for knowledge enhancement in the social services is largely project based, short term and occurs with no clear co-ordination between research, practice, training and implementation. The inquiry proposes that the Government and SALAR in the future sign agreements on common goals and strategic efforts to support long-term knowledge development in care of the elderly and other social services. The proposal is being prepared in the Government Offices, and the Government has expressed its support in the budget bill for 2009.

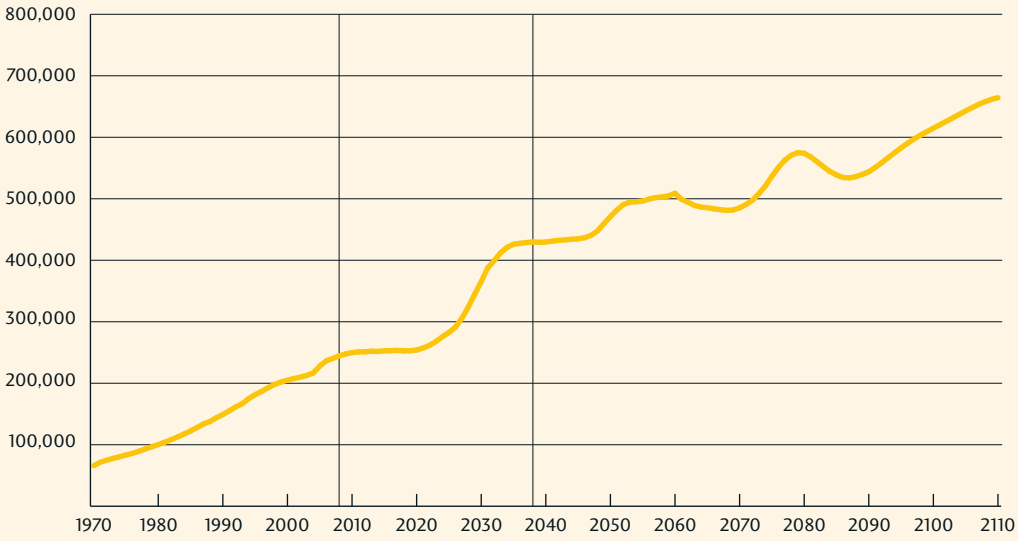
Inquiry on Dignity in Care of the Elderly

In the spring of 2007 an inquiry was initiated to generate proposals for a dignity guarantee for health and social care of the elderly. Director Torbjörn Larsson was appointed special investigator. The inquiry's report, *Värdigt liv i äldreomsorgen* (*Dignity in Care of the Elderly*, SOU 2008:51), was presented in May 2008. Among other things, it proposed a new regulation on a national set of basic values to be added to the Social Services Act.

SALAR's statement on the report objected to detailed legislation, but recommends an addition to the preamble to the Social Services Act like the one in the Act concerning Health Services, clearly indicating that social services must always respect the individual's dignity and therefore apply to everyone affected by social service interventions. This clarification forms a basic set of values for all work under the Social Services Act, not just in care of the elderly. With this proposal SALAR objects to the introduction of a new regulation on special values solely for care of the elderly.

Future funding of welfare

8



In the coming 30 years, the number of Swedish residents aged 85 and older will increase by 75%, while the total population increases by 10%. This rise in the number of elderly people is not temporary, but will continue on to 2100.

SOURCE: Statistics Sweden.

Future funding of welfare

Background

Several long-term studies clearly show that the claims on local authorities' and county councils' operations will continue to increase faster than revenues do with the current model of funding. From the turn of the century and several years into the 2010s, the demographic pressure will be relatively low compared to the trend of the last two decades of the 20th century. In 2020 the demographic pressure will increase, in part due to the 1940s generation reaching an age where they will require more care. This means that the 2010s will open the door for dialogue among policymakers and for the implementation of a broader, sustainable funding model for welfare, which today is publicly funded.

Committee on welfare funding

With this in mind, SALAR's board of directors created a special committee in autumn 2007 to investigate options for the future funding of the local authorities' and county councils' obligations and to contribute to public debate on the matter.

By autumn 2009 the committee is to generate data to highlight the long-term balance between local authorities and county councils, the distribution of the tax bases between the state and the local government sector, and the allocation of responsibility for welfare services and alternative funding options, **www.skl.se/valfard**.

The following sections describe the challenge of the future as regards funding of the welfare sector.

Importance of demographics

In the coming 30 years, the number of Swedish residents aged 85 and older will increase by 75%, while the total population will increase by 10%. This rise in the number of elderly people is not temporary, but will continue on to 2100.

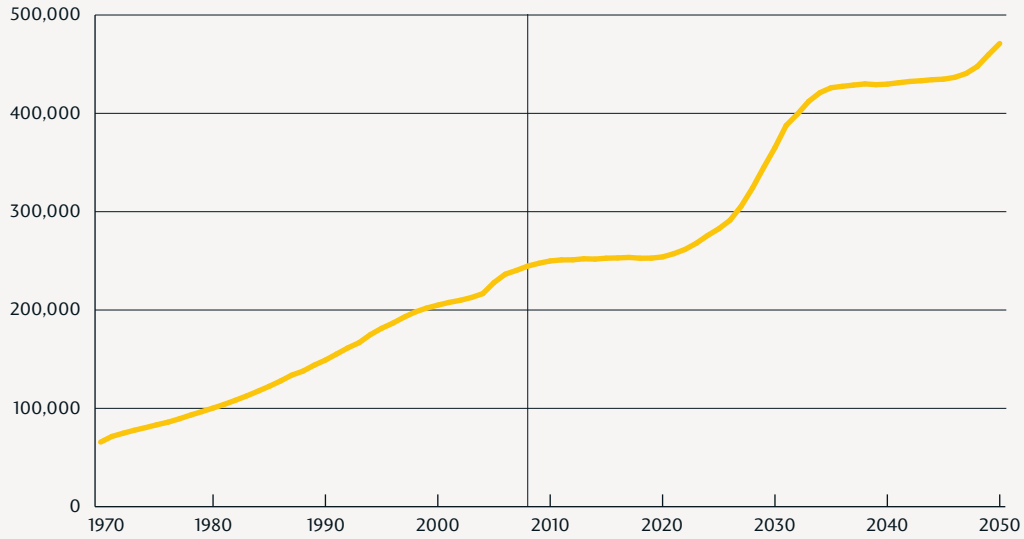


FIGURE 34.
Number aged 85+. Forecast for 2050.

SOURCE: Statistics Sweden.

Many more must be supported

Another way to illustrate the future challenge is to compare the number of gainfully employed people in relation to the total population. The figure below represents gainfully employed people aged 20–64. After a relatively long period of growth, Sweden is now peaking at nearly 59% in the 20–64 age group, but we are at the beginning of a downhill slope with a predicted 54% at the end of the 2030s.

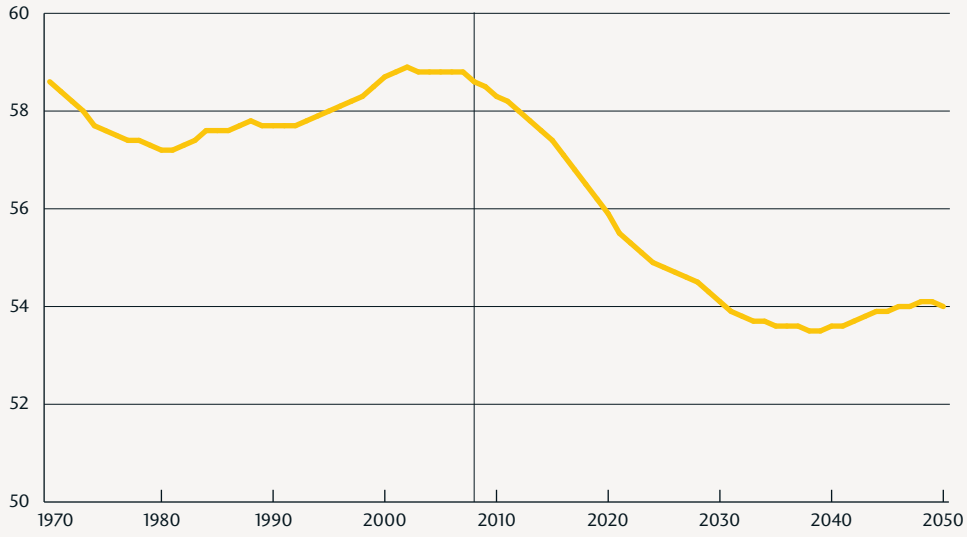


FIGURE 35.
Residents aged 20–64 out of the total population. Percentage.

SOURCE: Statistics Sweden.

The population increase in different age groups also gives a concrete illustration. As table 22 indicates, the total population will grow by nearly 9% by 2030, while the

number of 20–64-year-olds will increase by 0.3% and the number of people aged 80 and older will grow by 36%.

TABLE 22.
Population in various age groups in 2008 with forecast for 2030.

SOURCE: Statistics Sweden.

	2008	2030	Increase	Increase,%
Total	9,243,000	10,050,000	807,000	8.7
Aged 20–64	5,419,000	5,434,000	15,000	0.3
Age 80+	491,000	763,000	272,000	36.0

The demographics itself is a challenge, but is not insurmountable. By 2020 the demographic-related cost increase for the local authorities' and county councils' operations will be about 3 percentage points of local taxes. With "normal" economic growth this should be covered by the increase in the tax base in real terms, assuming that the government contributions increase at the same rate.

A retrospective

Between 1980 and 2005 the cost of welfare services provided by the local authorities and county councils increased by 50% while the demographic needs increased by 12%.

Between 1980 and 2005 the cost of welfare services provided by the local authorities and county councils increased by 50% while the demographic needs increased by 12% (*Välfärdsmysteriet (The Welfare Mystery)*, SALAR 2008). On the national level, performance increased more than the demographics demanded, while the costs per performance have also increased – although the trend looks different in different operations.

The number of elderly people increased in the last decades of the 20th century, while the proportion who have home help services or live in special housing has decreased. Yet, while fewer people receive care, the actual costs have increased by 60%, which means a very significant increase per care recipient.

One lesson for the future is that a purely demographic projection based on unchanged costs per resident in various age groups may turn out very wrong. The costs can also be projected based on the expected increase in the tax base in real terms – which in the past 25 years has led to underestimates of the cost trend. The higher cost trend has been managed through tax increases during the period as well as increases in fees, larger government contributions and changing the priority of non-mandatory activities.

The public sector faces great future challenges, including increased expectations of the availability and standard of welfare services. In the long term the costs for these services must increase faster than tax revenues at the given tax rate can be expected to do.

The gap between needs and resources

An estimate based on developing the resources for welfare services as the standard in society (GDP growth) rises shows cost increases corresponding to a tax increase of 0.40–0.45 percentage points per year, an unrealistic growth in the long term. This estimate clearly highlights the magnitude of the problem. Figure 36 shows the average tax rate growth to date.

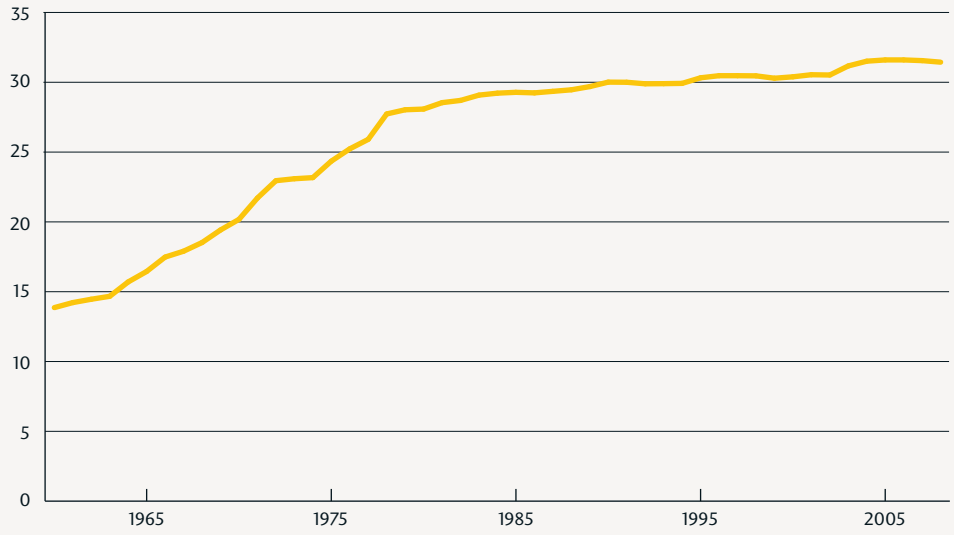


FIGURE 36.
Average tax rates 1960–2008.

Increases in productivity and efficiency have occurred and must continue to occur, but there are difficulties in measuring the importance of these factors, particularly in the public sector. Enhanced productivity in the business sector allows salaries to increase without affecting total costs, which in turn makes salaries rise in the public sector. Because much of public service consists of services between people, it is difficult to increase productivity here at the same rate. This means that labour-intensive activities will become relatively more expensive. The tax base is increasing, but due to salary increases in the local authorities and county councils it is only enough to cover an unchanged scope and quality of services. This means that services cannot be improved to the same degree as services in the business sector, given the tax rates and degree of funding through fees. This funding problem in public activities, caused by higher productivity in the economy as a whole, is called Baumol's Cost Disease.

Increased employment is the ideal for tax-funded welfare. Increased employment in the business sector leads to higher tax revenues without increasing costs to local authorities and county councils. But historically, welfare improvements have meant fewer working hours due to shorter work weeks, longer paid holidays, longer parental leave and so on. It is difficult to know if that trend will be broken; however there are some hopes regarding more efficient study time and higher actual retirement age. Considering the downhill slope in figure 35, we face a much tougher situation in the coming 25 years than in the past 25 years.

Taxes are the primary funding source for the Swedish welfare system. Fees cover about 7% and 3% of the local authorities' and county councils' respective revenues. An increase in fees could contribute a bit. One option is to eliminate the price ceilings in childcare and care of the elderly and return to the previous system.

The future will soon be here

The global financial crisis that began in the autumn of 2008 will very probably affect the world economy and employment in Sweden in the future. Even without this development, the long-term funding of welfare services has been of concern. Political choices and difficult priority decisions will become necessary regardless of how large the contributions are from partial solutions in the current system.

We know from experience that change processes of this type take time. For example, the pension reform and the housing policy reform each took decades to implement. In his book *Reform eller reträtt – Välfärdspolitikens vägval (Reform or Retreat – Choices in Welfare Policy)*, Per Borg, Ph.D., states that the greatest threat to the welfare systems is our own unwillingness to adapt them to new conditions. A recurring historical pattern is that policies are locked into established systems even when surrounding conditions change. "There is a risk that we will move backwards into the future – a disordered retreat – if we cling too long to established systems." The book discusses what future policies should focus on and how reform processes should be shaped in order to solve the problems of the future.

References

References

National Housing Administration www.boverket.se
- *Bostadsanpassningsbidragen 2007 (Home Modification Grants in 2007)*
- *Bostadsmarknaden 2008–2009 Slutsatser av Bostadsmarknadseenkäten (The Housing Market in 2008–2009, Conclusions of the Housing Market Survey)*

EU
- *Gateway to the European Union http://europa.eu/index_en.htm*
- *Eurostat epp.eurostat.ec.europa.eu/*

FOCUS Regional Council in Kalmar County www.fokus.regionforbund.se
- *Beviljad ansökan. Om flyttningar till särskilt boende (Application Granted. On moving to special housing). FOCUS report 2006:1*

Swedish National Institute of Public Health www.fhi.se
- *Hälsan på spåret – Medellivslängd och ohälsotal utmed spårtrafiken i Stockholm (On the Track of Health – Average life expectancy and incapacity rates along the rail lines in Stockholm)*
- *Hälsan och dess bestämningsfaktorer i olika typer av kommuner, 2003:49 (Health and its determinants in different types of local authorities)*
- *Folkhälsoenkäten, 2007 (Public Health Survey, 2007)*

Forum för frivilligt socialt arbete (Forum for voluntary social work)
- *Samhället är större än staten (Society is Bigger than the State), 2006*

Swedish Institute of Assistive Technology www.hi.se
- *Fallolyckor bland äldre. En kunskapssammanställning med koppling till hjälpmedel och anpassningar av hemmet (Falls Among the Elderly. A compilation of expertise related to assistive devices and home modifications), 2007*
- *Teknik och demens i Norden (Technology and Dementia in the Nordic Region), 2008*

Department of Social Work, Stockholm www.socarb.su.se
- *Batljan, Ilija. Demographics and Future Needs for Public Long-Term Care and Services among the Elderly in Sweden: The Need for Planning (2007)*

Läkartidningen (Swedish medical journal)
- *Issue 43, 2005 (Mats Thorslund)*

National Centre for Excellence – Family carers
- *www.anhoriga.se*

Swedish Rescue Services Agency www.srv.se

- *Fallolyckor bland äldre – samhällets direkta kostnader (Falls Among the Elderly – direct costs to society), 2003*
- *Skadeförebyggande arbete för äldre (Preventing Injuries among the Elderly), Swedish Rescue Services Agency NCO 2008:2 and SALAR*

Swedish Institute for Transport and Communications Analysis (SIKA)
www.sikainstitute.se

- *Färdtjänst och riksfärdtjänst 2007 (Special Transport Service and National Special Transport Service 2007)*

Swedish Tax Agency www.skatteverket.se

- *Skattereduktion för hushållsarbete (Tax Deduction for Household Services)*

Sköndal Institute www.esh.se

- *Medborgarnas insatser och engagemang i civilsamhället: några grundläggande uppgifter från en ny befolkningsstudie (Citizens' Efforts and Commitments in Civilian Society: some basic information from a new population study), 2005*

National Board of Health and Welfare www.socialstyrelsen.se

- *Äldres levnadsförhållanden 1988–2002 Hälsa, funktionsförmåga och vård- och omsorgsmönster (Living Conditions of the Elderly in 1988–2002: Health, functional capacity and patterns of health and social care), 2004.*
- *Äldre – vård och omsorg 2007 (The Elderly – Health and social care in 2007), and the stated years*
- *Funktionshindrade personer – insatser enligt LSS år 2007, samt respektive år (Functionally Impaired People – Interventions under LSS in 2007), and the stated years*
- *Omsorg människor emellan, en översikt över omsorgsgivare i den svenska befolkningen (Care Between People, an overview of carers in the Swedish population), 2006*
- *2006, 2007 och 2008 års stimulansmedel riktade till vård och omsorg om äldre personer (The 2006, 2007 and 2008 stimulus funds for health and social care of the elderly), 2008*
- *Frivilligcentraler i Sverige – en kartläggning (Volunteer Centres in Sweden – a survey), 2007*
- *Kommunernas anhörigstöd 2007 (Local Authority Support to Family Members 2007)*
- *Kundval inom äldreomsorgen (Customer Choice in Care of the Elderly), 2007*
- *Systematiskt arbete för äldres säkerhet – om fall, trafikolyckor och bränder (Systematic Work for the Safety of the Elderly – on falls traffic accidents and fires), IMS and the Swedish Rescue Services Agency, 2007*
- *Hemsjukvård i förändring. En kartläggning av hemsjukvården i Sverige (Swedish Home Medical Care in Transition), 2008*
- *Inventering av utskrivningsklara patienter och vårdplanering i samband med utskrivning (Survey of Ready-for-Discharge Patients and Care Planning on Discharge), 2007*
- *Vård och omsorg om äldre. Lägesrapport 2007 (Health and social services to the Elderly. Status Report 2007)*
- *Vård i livets slutskede 2007 (Terminal Care 2007)*
- *Guide for the Elderly*

Swedish Government Official Reports www.sou.gov.se

- *Regler för skydd och rättssäkerhet inom demensvården (Rules for Safety and Legal Protection in Dementia Care, SOU 2006:110)*
- *Vård med omsorg – möjligheter och hinder (Healthcare with Care – opportunities and obstacles, SOU 2007:37)*

- *Beviljats men inte fått (Granted but not Received, SOU 2004:118)*
- *Nationell utvecklingsplan för vård och omsorg om äldre (National Improvement Plan for Health and Social Care, Government bill 2005/06:115)*
- *Möjlighet att leva som andra. Ny lag om stöd och service till vissa personer med funktionsnedsättning (Able to Live like Everyone Else. New Act concerning Support and Service for Persons with Certain Functional Impairments SOU 2008:77)*
- *Bo för att leva – seniorbostäder och trygghetsbostäder (Accommodation for Life, OAP Flats and Sheltered Housing SOU 2007:103)*
- *LOV att välja – Lag om Valfrihetssystem (Free to Choose – Act on Freedom of Choice, SOU 2008:15)*
- *Vårdval i Sverige (Consumer Choice in Care in Sweden, SOU 2008:37)*
- *Att lära nära, stöd till kommunerna för verksamhetsnära kompetensutveckling inom omsorg och vård av äldre (Teaching Locally, support for local authorities to provide skills development in health and social care of the elderly, SOU 2007:88)*
- *Evidensbaserad praktik inom socialtjänsten – till nytta för brukaren (Evidence-Based Practice in Social Services – of benefit to the user, SOU 2008:18)*
- *Värdigt liv i äldreomsorgen (Dignity in Care of the Elderly. SOU 2008:51)*

Swedish Council on Technology Assessment in Health Care www.sbu.se
- *Demenssjukdomar – en systematisk litteraturöversikt (Dementia Disorders – a systematic literature review), 2006*

Statistics Sweden www.scb.se
- *Från folkökning till folkminskning, Befolkningsutvecklingen i världen 1950 till 2050 (From Population Growth to Population Decline, population development in the world from 1950 to 2050.). Demographic reports, 2005:4*
- *Äldres levnadsförhållanden – Arbete, ekonomi, hälsa och sociala nätverk 1980–2003 (Living Conditions of the Elderly: work, finance, health and social networks 1980–2003), Report 112, 2006*
- *Statistical database*

Stockholm Gerontology Research Centre www.aldrecentrum.se
- *Vårdbehov och insatser för äldre 2001–2005 (Need for Care and Interventions for the Elderly in 2001–2005), Report 2006:8*
- *Hälsosamtal och förebyggande hembesök (Health Talks and Preventive Home Visits), 2007:3*

Swedish Dementia Centre (SDC)
- *www.demenscentrum.se*

Äldre i centrum (Focus on the Elderly) magazine www.aldreicentrum.se
- *Guldbröllopslavinen och dess konsekvenser (The Golden Anniversary Avalanche and its consequences), Gerdt Sundström & Åke Nilsson, Äldre i centrum 2004:3*

Swedish Code of Statutes, SFS www.riksdagen.se
- *Act on Home Modification Grants, etc. (1992:1574)*
- *National Special Transport Services Act (1997:736)*
- *Act (2006:492) on the Local Authorities' Liability to Provide Services to the Elderly*
- *Social Services Act (2001:453)*
- *Act on Health Services (1982:763)*
- *Prescription Medicines Registration Act (2005:258)*

Swedish Association of Local Authorities and Regions, SALAR www.skl.se

- *Aktuellt på äldreområdet (Developments in Elderly Policy) 2007*
- *Öppna jämförelser Vård och omsorg om äldre (Open Comparisons – Health and Social Care of the Elderly) 2008*
- *Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet – Jämförelser mellan landsting 2008 (Open Comparisons of Medical Quality and Effectiveness – comparisons between county councils)*
- *National Quality Register on Healthcare, 2007*
- *Matdistribution, trygghetslarm, service m.m. (Meals on Wheels, Personal Safety Alarms, Service, etc.) 2006*
- *En Bättre Demensvård (Better Dementia Care)*
- *Förbättra läkemedelsanvändning och livskvalitet hos äldre (Improving Use of Medications and Quality of Life for the Elderly) 2006*
- *SÄLMA-projektet – Säker läkemedelsanvändning för en bättre livskvalitet hos äldre (The SÄLMA Project – Safe Use of Medicines for an Improved Quality of Life for the Elderly)*
- *Närvårdssamverkan i praktiken, Från ord till handling (Community Care Collaboration in Practice, from words to action), 2007*
- *Att utveckla närvårdssystem – Vård och omsorg i förändring (Developing Community Care Systems – Health and social care in transition), 2006*
- *Quality Register for Palliative Care, www.palliativ.se*
- *Sju steg för att lyckas (Seven Steps to Success), 2006*
- *Seniorbostäder, En kartläggning (OAP Flats, a survey), SALAR 2005, 2008 under publication*
- *Läkemedelsförteckningen – utvärderingsrapport (Prescription Medicines Registration Act – Evaluation Report), SALAR 2007*
- *Ekonomirapporten, om kommunernas och landstingens ekonomi (Financial Report, on local authorities' and county councils' finances), October 2008*
- *Äldreportalen (Portal for the Elderly) www.aldreportalen.se*
- *Välfärdsmysteriet (The Welfare Mystery), under publication*

Vårdal Institute

- *www.vardalsinstitutet.net*

Association of Private Care Providers www.vardforbundet.se

- *Senior-Alert – National quality register for health and social care of the elderly, under development*

Danish Knowledge Centre on Ageing www.aeldreviden.dk

- *Portrætter af gamle ensomme – gør boligen en forskel? (Portraits of Lonely Elderly People – does housing make a difference?) Copenhagen 2006*

Developments in Elderly Policy in Sweden

This document can be downloaded
and/or ordered from **www.skl.se/publikationer**.

You can also order a copy from:
Phone 020-31 32 30 (within Sweden only)

Price
1–4 copies SEK 100 each
5–9 copies SEK 80 each
10 or more copies SEK 50 each
VAT and shipping not included.

ISBN 978-91-7164-448-0

Swedish Association
of Local Authorities
and Regions

118 82 Stockholm
Street address Hornsgatan 20
Phone +46 8 452 70 00, *Fax* +46 8 452 70 50
Info@skl.se, www.skl.se, www.skl.se/aldre