Sweden

Health Care & Long-Term Care Systems

An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

Economic and Financial Affairs
Economic Policy Committee

Sweden

Health care systems

1.27. SWEDEN

General context: Expenditure, fiscal sustainability and demographic trends

General country statistics: GDP, GDP per capita; population

GDP per capita (32.2 thousand PPS in 2013) is well above the EU average (27,9 thousand PPS in 2013).

The Swedish population was estimated in 2013 to be 9.6 million and is projected to increase significantly to 13.1 million by 2060, a 36% rise compared to the more modest 3.1% change of the EU average for that period.

Total and public expenditure on health as % of GDP

Total expenditure ([324]) on health as a percentage of GDP (9.7% in 2013) is slightly below the EU average ([325]) (10.1%). It has been fluctuating between 9% and 10% roughly for the last decade (2003-2013). Public expenditure on health as a percentage of GDP is, however, comparable with the EU average (7.9% for both in 2013), having increased from 7.2% in 2001. Total (3,250 PPS in 2013) and public (2,648 PPS in 2013) per capita expenditure is above the EU average (2,988 PPS and 2208 PPS in 2013), having consistently increased since 2001 (2,181 PPS and 1,742 PPS).

Expenditure projections and fiscal sustainability

As a result of ageing ([326]), health care expenditure is projected to increase by 0.4 pps of GDP (much below the average change in the EU of 0.9 pps). Good health (translated by a constant health scenario) could reduce the projected expenditure increase to zero, highlighting the importance of improving health behaviour.

Risks also appear to be low in the medium-term from a debt sustainability analysis perspective due to the relatively low stock of debt at the end of projections (2026), even when considering possible shocks to nominal growth and interest rates. Medium sustainability risks appear over the long run due to both the relatively unfavourable initial budgetary position and the projected impact of age-related public spending (in particular, long-term care spending).

Health status

Life expectancy (83.8 years for women and 80.2 years for men in 2013) is above the EU average (83.3 and 77.8) and among the highest in the world. Healthy life years (66.0 years for women and 66.9 for men in 2013) are above the EU average (61.5 and 61.4 respectively).

There are two major causes of death in Sweden. Mortality and morbidity due to diseases of the circulatory system has been significantly reduced during the last 30 years and this is one of the major causes contributing to the rise in life expectancy but they are still the most common cause of death for both women and men, being the underlying cause in 38% of all deaths among women and 37% of all deaths among men in 2012.

The second most common cause of death is neoplasm (cancer), corresponding to 23% of all deaths among women and 27% among men in 2009. Out of all deaths due to cancer, breast cancer used to be the most common form among women. For women that is now lung cancer. Prostate cancer is the most common cause of deaths due to cancer among men.

The number of traffic-related deaths decreased from 16.2 to 3.5 deaths per 100 000 inhabitants between 1970 and 2012. Sweden has the world's lowest rate of mortality due to road traffic accidents among children aged 0–17 years.

([324]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([325]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units or units of staff where relevant. The EU average for each year is based on all the available information in each year.

([326]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

System characteristics

System financing, revenue collection mechanism, coverage and role of private insurance and out of pocket co-payments

The level of taxes to be earmarked to the health sector is defined by the central government (general taxation), the counties or regions (county taxation) and the municipalities (for local taxes). The Parliament, the central government, the county government and the municipal government set the public budget for health, in each respective responsibility. The central government determines resource allocation across regions (based on demographic and mortality/morbidity data and historic costs). The funds to be allocated to each sector/ type of care are determined by the counties or regions and the municipalities given their respective responsibilities. Hospitals then exercise their autonomy to recruit medical staff and other health professionals and negotiate salaries. The Ministry of Social Affairs and Health defines general policy guidelines and regulation.

This suggests a rather complex and decentralised decision making and resource allocation process, within a nationally agreed regulatory framework but in the presence of a not explicitly defined basic benefit package. Nevertheless, the level of expenditure in administering such a system is not high. Public (0.13%) and total (0.14%) expenditure on health administration and health insurance as a percentage of GDP is below the EU average (0.27% and 0.47% respectively in 2013), as is public and total expenditure on health administration and health insurance as a percentage of current health expenditure (1.4% and 1.3% vs. 3.5% and 4.9% in 2013), falling behind by a substantial margin as well.

This decentralised tradition has however also led to regional differences in terms of cost-sharing, type of treatment, access to new medicines and inequalities in avoidable care and mortality. These regional differences as well as care coordination difficulties between counties and municipalities have been the focus of debate in the 2000s. ([327])

Interestingly, while in the 1990s mostly counties were using a purchaser-provider split, they now appear to have gone back to the more traditional way of public provision and administration. In some counties there has been a move towards integrating each hospital with primary care and municipal services.

There is a strict health budget defined annually by regions and for different health services. Budget deficits in the sector have occurred in the past and have resulted in a number of cost-containment policies and stricter budget rules. ([328])

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

On the basis of legal provisions (harmonised legislation and guidelines) and under the supervisor role of the Government through the Ministry of Health and Social Affairs, the counties or regions (18 counties, 2 regions and one independent island community) and the municipalities are responsible for providing or funding a wide range of health related services. Regionally organised services include primary, specialist outpatient and hospital care, health promotion, disease prevention and rehabilitation.

Coverage (population)

A regionally based National Health Service (NHS), funded on the basis of taxes (central, county and municipal taxes), provides full population coverage.

To improve access and reduce the waiting times for primary care, legislation was introduced to allow for the choice of primary care physician and the contracting with private primary care providers. To reduce waiting times for hospital surgery and reduce important regional variations in the waiting time, which are seen as a problem in Sweden (e.g. for hip replacement and cataracts), a law from July 2010 regulates the waiting time guarantee which provides a national time guarantee for care (i.e. care must be provided

([327]) WHO/Europe (2012b),

([328]) According to the OECD, Sweden scores 6 out of 6 in the OECD scoreboard due to the very stringent budget controls.

within 3 months) and an optional agreement between the councils allows patients a free choice of hospital ([329]). In addition, the Swedish Association of Local Authorities and Regions together with the National Board of Health and Welfare publish comparisons of the quality and efficiency of health care in different counties or regions and hospitals. Waiting times - reported by the county/regional level to the national administration according to agreed guidelines - have seen a reduction since these systems have been implemented.

Hence, some efforts to improve access may help explain the increase in public and total expenditure observed in the last decade though it does not appear to be the main explanation.

Role of private insurance and out of pocket co-payments

Most services (primary, outpatient specialist care, hospital day care and inpatient care, dental care, physiotherapy) involve a co-payment at the point of use. This fee may vary across services and across counties or regions. In addition, eyeglasses and contact lenses and physiotherapist services are not funded or provided by counties or regions and high cost-sharing applies to dental care, dental prostheses and pharmaceuticals. It is not clear whether the current cost-sharing design induces a greater use of more cost-effective services (e.g. primary care vs. specialist care when this is not necessary). Children, those with certain medical conditions and those who have reached an upper limit for out-of-pocket payments are exempted from cost-sharing. 2.3% of the population buys supplementary private insurance (to cover the services not covered by public provision/ funding). In 2013, private expenditure and out-of-pocket expenditure were 18.5% and 16.3% of total health expenditure and therefore respectively below and above the EU average (22.6% and 14.1%). The share of private expenditure was lower in 2013 than in 2001. Out-of-pocket expenditure was nevertheless slightly higher (16.3% in 2013 and 15.9% in 2001).

([329]) The formula is 0-7-90-90. Contact with primary care immediately, visit with doctor in primary care within 7 days, visit with doctor in specialised care within 90 days and access to care (for example an operation) within 90 days from the doctors decision.

Types of providers, referral systems and patient choice

As care provision is defined at the county level, there are some differences in the way the various types of care are organised. In general, primary care is provided by general practitioners (GPs) in public health centres while outpatient specialist care is provided in outpatient departments in public hospitals. There are 79 hospitals in Sweden, many of which are local hospitals with limited specialisation, some of which are regional hospitals offering a wider range of specialties and 7 are regional highly specialised university hospitals. About 98% of all hospital beds are public. Provision has traditionally been public but private provision notably in terms of private primary care providers, with whom the councils or regions establish contracts, has been encouraged. Some hospitals are run by private companies but are financed by public funds. There are also some private practices of physiotherapists or psychiatric care. Private provision is more common in densely populated urban areas. Still, dual practice of private physicians should be of minor significance, since private practitioners who are reimbursed according to a national tariff are prevented by law to also occupy public-sector employment.

The number of practising physicians per 100 000 inhabitants (401 in 2012) is above the EU average (341 in 2012) and showing a consistent increase since 2003 (338.2). The number of GPs per 100 000 inhabitants (64 in 2012) is below the EU average (78 the same year), but showing an increase from 2001. The number of nurses per 100 000 inhabitants (1,115 in 2012) is well above the EU average (829 in the same year) having consistently increased throughout the decade, by a bit more than 10% since the beginning of the millennium. The authorities acknowledge shortages of physicians in some specialties and in some counties. In particular, they acknowledge a general shortage of GPs, especially significant in certain municipalities, which results in longer waiting times to see a GP. As a consequence, patients tend to see specialists or go to emergency care directly but unnecessarily. This has forced some counties to recruit GPs from abroad or pay higher wages, increasing the costs of health care delivery. These elements suggest that a comprehensive human resources strategy may be necessary in order to ensure that the skill mix goes

in the direction of a primary care oriented provision, which the authorities wish to pursue, that training, recruitment and bringing licensed but non-practising physicians back into the sector can compensate for staff shortages and losses due to retirement. Staff supply is regulated in terms of quotas for medical students and by speciality but not in terms of the location of physicians, which explains the disparities in staff availability across counties or regions.

Authorities' efforts to encourage the use of primary care vis-à-vis specialist and hospital care have included contracting with private primary care providers and allowing patient choice of GP. These may not have yet proven very successful because a stronger emphasis on primary care requires sufficient numbers of staff and the right skill mix, which are currently lacking. This means that residents are free to choose and register with a GP but there is no compulsory referral system from primary care to specialist doctors i.e. GPs acting as gatekeepers to specialist and hospital care. Choice of GP, specialist and hospital is allowed and a priority for the authorities, ([330]) and even seen as possibly strengthening the role of primary care. Indeed, experience from recent primary care reform in Stockholm County Council "Vårdval Stockholm" shows that increased elements of patient choice and competition has led to, with respect to the impact on other subsectors and ancillary services, the observation of no "spill-over" effects. On the contrary, primary care has increased its share of total ambulatory care and utilisation of medical services declined slightly. There has also been a relatively large proportion of new entrants into the primary care sector. The implementation of the customer choice reform within primary care across the country, as one part of a new national legislation, may thus strengthen the role of primary care. ([331]) Moreover, authorities have been introducing a number of ICT and eHealth solutions to allow for nationwide electronic exchange of medical data (including patient electronic medical records) to support care coordination, reduce medical errors and increase cost-efficiency.

([330]) According to the OECD, the level of choice of provider in Sweden has indeed a score of 6 out of 6, while gatekeeping scores 0 out of 6.

([331]) There is indeed a national regulation that all counties should have a "patient/care choice system" for the selection of primary care provider ("Vårdvalssystem").

The number of acute care beds per 100 000 inhabitants (194 in 2013) is far below the EU average of 356 in 2013 and displaying a decreasing trend over the last decade and is one of the lowest in the EU. However, structural differences have to be taken into account when analysing these figures. For instance, the "Ädel-reform" of 1992 transferred the responsibility for those considered medically treated to the social care sector (especially the elderly, who instead receive social care in the elderly care sector), which had a significant impact on demand for health care beds. In addition, the average length of stay has been effectively shortened in Sweden by utilising open specialised care to a larger extent than previously. Still, in some areas there may be a shortage of follow-up/long-term care beds/ facilities which creates bed-blockages in acute care (unnecessary and long use of acute care beds) and may contribute to longer waiting times for surgery. While counties or regions plan for the number of hospitals and the provision of specific specialised services, there appears to be no regulation in terms of the number of beds or the supply of high cost equipment capacity, which may explain county/ regional and even hospital differences in the numbers of units of high-cost equipment. Hospitals have autonomy to recruit medical staff and other health professionals and to determine their remuneration level.

Pricing, purchasing and contracting of healthcare services and remuneration mechanisms

Public sector physicians (GPs and specialists) are paid a salary. Salaries are determined at hospital level. Physicians appear not to be eligible to receive bonuses regarding their activity or performance. ([332]) It would perhaps be interesting to investigate if an element of performance-based payment related to health promotion, disease prevention or disease management actions or treatment of vulnerable patients by GPs could be used more widely, to render primary care more

([332]) As for the private practitioners, they are reimbursed according to a national tariff, and thus compensated on a fee- for-service basis. A small portion of the private health care production is in fact conducted by private practitioners. Other private health care production is instead based on local contractual arrangements where decisions on doctors' payment in large are decentralised to the private healthcare provider.

attractive in general and in the regions where the more severe shortages are felt in particular.

When looking at hospital activity, inpatient discharges - per 100 inhabitants - are below the EU average (1,499 vs. 1,649) and the number of day case discharges is well below the EU average (2,038 vs. 7,031 in 2013). The proportion of surgical procedures conducted as day cases (12%) is far below the EU average (30.4% in 2013). Overall hospital average length of stay (5.6 days in 2012) is also below the EU average (6.3 days in 2012). These figures suggest that there may be some room to increase hospital throughput/efficiency by improving the way surgical treatments are conducted (i.e. more use of day case surgery) and by providing alternative care services for long-term care patients in particular psychiatric patients. These figures may explain why waiting times for elective surgery may be deemed long.

The market for pharmaceutical products

Total (1.11%) and public (0.58%) expenditure on pharmaceuticals as a percentage of GDP ([333]) was below the EU average (respectively 1.44% and 0.96%) in 2013. This is similar for total (10.1% vs. the average of 14.9% in 2013) and public (6.3% vs. EU average 12.5% in 2013) pharmaceutical expenditure as a percentage of total and public current health expenditure respectively. The low shares probably relate to the large number of policies in place in this area.

The authorities have implemented a number of policies to control expenditure on pharmaceuticals, although some policies have been discontinued in recent years (e.g. reference pricing which was discontinued in 2002, making Sweden one of the few countries in Europe (with Denmark and the United Kingdom). Initial price is based on economic evaluation. The authorities use price volume agreements with pharmaceutical companies. There is a positive list of reimbursed products which is based on health technology assessment information/ economic evaluation. Authorities promote rational prescribing of physicians through treatment and prescription guidelines complemented with monitoring of prescribing behaviour and education and information campaigns on the prescription and use of medicines. There are monthly, quarterly and annual evaluations at county level on prescriptions and co-payments and physicians receive feedback. These are coupled with pharmaceutical budgets at county level. There are also information and education campaigns directed at patients and cost-sharing to encourage a rational use of medicines on the patients' side. Patients pay the full price up to a certain cost level (1100SEK), after which there are some stepwise reductions in the additional costs. In a year the maximum amount a patient can pay in reimbursable medicines is 2200 SEK. There is an explicit generics policy. Generic substitution takes place i.e. pharmacies are obliged to dispense the cheaper product and to replace the prescription by a generic medicine when available. If patients refuse a generic they will have to pay the difference between the reimbursement price of the branded drug and the pharmacy retail price of the cheapest available generic. Moreover, this cost is deemed extra and will not be considered in the computation of the maximum costs a patient can incur in a year on medicines. Although prescription by active element is not compulsory, doctors are encouraged to prescribe generic alternatives. Generics face a fast track registration and speedy decision.

Use of Health Technology Assessments and cost-benefit analysis

The Swedish Council on Health Technology Assessment conducts and gathers information on health technology assessment and conducts economic evaluation and cost-effectiveness analysis which is used to define whether new medicines are covered by the health system and to what extent (level of reimbursement) as well as to define clinical guidelines for medicines.

Health and health-system information and reporting mechanisms

Sweden has extensive information management and statistics systems and comprehensive data is gathered on physician and hospital activity and quality and health status. Data is provided at county/ region and municipal level and compiled by the Swedish Association of Local Authorities

([333]) Expenditure on pharmaceuticals used here corresponds to category HC.5.1 in the OECD System of Health Accounts. Note that this SHA-based estimate only records pharmaceuticals in ambulatory care (pharmacies), not in hospitals.

and Regions together with the National Board of Health and Welfare. Some of this information is published, and allows for public comparisons of counties/ regions and hospitals in terms of both activity and quality. Physicians are monitored and are given feedback on their prescription behaviour.

Public health promotion and disease prevention policies

The central Government, through the Ministry of Health and Social Affairs, sets and monitors public health priorities in terms of process, outcomes and the reduction of health inequalities. As section 1 suggests there are some risk factors that can translate into an important burden of disease and financial costs. Authorities have emphasised health promotion and disease prevention measures in recent years. Promotion and prevention are seen by the authorities as a means to ensure long-term sustainability of the health budget: they reduce the development of disease and therefore the need for care and therefore the need for funding. Public and total expenditure on prevention and public health services as a % of GDP are both above the EU average (0.29% and 0.34% in 2013). Similarly, as a % of total current health expenditure, both public and total expenditure on prevention and public health services are higher than the EU average (3.1% for both vs. 2.1% in 2013).

Recently legislated and/or planned policy reforms

Recent policy response

A top priority has been related to a number of initiatives aimed at strengthening the position of patients and to stimulate patient engagement. Freedom of choice of providers has been a priority and this requires increased information and knowledge for patients. It is important that the information is available and easy for everyone to understand and to use, so that nobody is disadvantaged in a system that rewards freedom of choice and increases the demand for self-care. There have been several important policy initiatives in this direction.

A new Patients Act that is as accessible, transparent and pedagogical as possible for both patients and health care personnel was implemented in 2014. The new Act is an important piece of legislation in helping the on-going shift in Sweden, from a health care perspective to a patient perspective. The proposal includes a number of ideas to further strengthen the patients' choice of providers all over the country, as well as increased information for patients.

Patients and citizens should receive electronic access to their health care information and a tool that helps them to actively engage in their own health and health development. The Government has taken the initiative to develop an online personal health account. It will give individuals comprehensive access to information and other services related to their health. The account holder can store medical records, drug prescription and vaccination lists, or results from health and fitness applications that the user may connect to the account. The role of the government has been to create a secure technical platform in which public health care providers, private health care providers and companies can provide new interactive services.

Patients' experiences and opinions of the health care services are important inputs in health care development and improvement. The National Patient Survey is a recurring measurement of patient-perceived quality, which is conducted each year. In the Agreement on the development of the quality registries, development of Patient Reported Outcome Measures linked to the registries is rewarded, as a means of gaining knowledge of how patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.

A second top priority has been the care of vulnerable populations, and patient groups with complex needs. These include patients with psychiatric illnesses, elderly with multi-morbidity, chronical diseases, women’s health and cancer.

One of the initiatives is directed towards elderly with multiple diseases. The government is investing SEK 4.3 billion during this electoral period to improve the health and social care of older adults with complex health conditions. The aim is to have home care, elderly care, primary care and hospital care collaborate more effectively in the care of older adults.

So far the strategy has led to a number of results, for example a significant decrease in use of inappropriate medications, within all of the county councils as well as an increased number of preventive interventions in the municipalities.

Policy changes under preparation/adoption

A primary objective of the Swedish health care system is the provision of high-quality care on equal terms, irrespective of the person receiving it. Reception, care, and treatment shall be offered on equal terms to everybody – irrespective of age, gender, sexual orientation, disability, place of residence, education, social status, country of birth or religious beliefs. Equality and equity of care are at the very heart of the Swedish Health and Medical Services Act.

The Government's support to public performance reports has laid the foundation for systematically following up and highlighting developments of disparities in health and medical care. This information helped form the basis for the Government's decision to develop a strategy for equality in health care.

One question which has attracted a great deal of interest in recent years is how men and women are treated within the health service. Several studies have shown that there are systematic and significant differences in the way men and women are treated. The latest follow ups by the National Board of Health and Welfare show that there have been some improvements in this area. On the other hand, there are differences in access to care and treatment between different socioeconomic groups, counties and between those born in Sweden and those born abroad.

Furthermore, the government's focus on analysis and open comparisons revealed increasing regional disparities across the country. The different county councils make a number of decisions that might lead to the situation that patients do not receive the same treatment in different part of the countries. There are currently discussions on how care could be more effectively organised in order to guarantee good care all over Sweden. A government committee has for example been given the task to study how highly specialised care can be concentrated to ensure quality and equality.

Six regional cancer centers have been established, which work across counties in order to optimise care. This model might serve as an example of how to improve care also for other patient groups. There is also a comprehensive initiative to shorten the waiting times in cancer care. This builds on the Danish example with specially designed tracks for different kind of cancers.

Challenges

The analysis above has shown that a range of reforms has been implemented in recent years. For example, the reduction of waiting times, improvements to hospital efficiency, improved data collection and monitoring and the control of pharmaceutical expenditure, some to a large extent successful, and which Sweden should continue to pursue. The main challenges for the Swedish health care system are as follows:

- To ensure the coherence of resource allocation to different types of care in different regions controlling for demographic and mortality/morbidity characteristics of the population.

- To ensure consistency in access to health care in different regions, ensuring that different fees and remuneration mechanisms do not impact on the health outcomes of the population.

- More generally, to develop a comprehensive human resources strategy that tackles current shortages in primary care staff and ensures sufficient numbers of staff in general and in the future in view of staff and population ageing.

- To enhance primary care provision by increasing the numbers and spatial distribution of GPs and primary care nurses. To couple these measures with a referral system to specialist care either through financial incentives (reimbursement levels higher if a referral takes place) or by making it compulsory. At the same time exploring if current cost-sharing arrangements can be adjusted to render primary care more attractive. This could improve access to care while reducing unnecessary use of hospital care and therefore overall costs.

- To increase hospital efficiency by increasing the use of day case surgery and increasing the supply of follow-up care for long-term care patients so as to reduce the unnecessary use of acute care settings for long-term care patients, notably psychiatric patients. To consolidate the measures pursued in recent years to reduce duplication and improve efficiency and quality in the hospital sector (e.g. concentration and specialisation of hospitals within regions), notably through the finalisation of the current administrative reform.

- To ensure a greater use of health technology assessment to determine new high-cost equipment capacity as well as the benefit basket and the cost-sharing design across medical interventions as is currently done with medicines.

- To consider whether it is worth introducing some element of performance related payment in physicians' remuneration (e.g. through the use of mixed payment schemes) to encourage health promotion, disease prevention and disease management activities or the treatment of vulnerable populations and increase outpatient output.

- To take into account the potential drivers of fiscal sustainability particularly with ageing potentially increasing public healthcare spending in the long-run.

Table 1.27.1: **Statistical Annex – Sweden**

General context

GDP	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
GDP, in billion Euro, current prices	293	307	313	335	356	352	310	369	405	423	436	9289	9800	9934
GDP per capita PPS (thousands)	30.6	32.5	32.2	33.6	35.2	33.8	30.1	31.8	32.6	32.9	32.2	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	2.0	3.8	2.7	3.7	2.6	-1.4	-5.8	5.7	2.2	0.2	0.8	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	2.1	1.3	2.4	2.4	2.3	2.0	1.4	0.7	2.4	1.2	2.2	3.2	-0.2	-0.4

Expenditure on health*	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Total as % of GDP	9.3	9.1	9.1	9.0	8.9	9.2	9.9	9.5	9.5	9.6	9.7	10.4	10.1	10.1
Total current as % of GDP	8.9	8.3	8.3	8.2	8.1	8.3	8.9	8.5	10.6	10.8	11.0	9.8	9.6	9.7
Total capital investment as % of GDP	0.4	0.8	0.8	0.8	0.9	0.9	1.0	1.0	-1.1	-1.2	-1.3	0.6	0.5	0.5
Total per capita PPS	2356	2410	2480	2601	2738	2889	2996	3028	3127	3158	3250	2828	2911	2995
Public as % of GDP	7.6	7.4	7.4	7.3	7.3	7.5	8.1	7.7	7.8	7.8	7.9	8.1	7.8	7.8
Public current as % of GDP	7.3	6.8	6.8	6.7	6.6	6.8	7.3	6.9	9.0	9.1	9.3	7.9	7.7	7.7
Public per capita PPS	1764	1794	1848	1935	2028	2126	2202	2216	2553	2565	2648	2079	2218	2208
Public capital investment as % of GDP	0.3	0.6	0.6	0.6	0.7	0.7	0.8	0.8	-1.2	-1.4	-1.3	0.2	0.2	0.1
Public as % total expenditure on health	82.0	81.4	81.1	81.1	81.3	81.5	81.5	81.5	81.7	81.2	81.5	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	12.6	12.4	12.4	12.5	12.9	13.3	13.5	13.4	13.8	13.7	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	16.6	17.0	17.4	17.3	17.2	17.2	17.2	17.3	17.1	17.5	16.3	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Population, current (millions)	9.0	9.0	9.0	9.0	9.1	9.2	9.3	9.3	9.4	9.5	9.6	502.1	504.5	506.6
Life expectancy at birth for females	82.5	82.8	82.9	83.1	83.1	83.3	83.5	83.6	83.8	83.6	83.8	82.6	83.1	83.3
Life expectancy at birth for males	78.0	78.4	78.5	78.8	79.0	79.2	79.4	79.6	79.9	79.9	80.2	76.6	77.3	77.8
Healthy life years at birth females	62.2	60.8	63.2	67.5	66.8	69.0	69.6	66.4	65.5	:	66.0	:	62.1	61.5
Healthy life years at birth males	62.5	62.0	64.5	67.3	67.7	69.4	70.7	67.0	67.0	:	66.9	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	65	62	57	56	53	55	52	49	112	108	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	3.1	3.1	2.4	2.8	2.5	2.5	2.5	2.5	2.1	2.6	2.7	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	2.54	2.36	2.30	2.28	2.21	2.24	2.40	2.27	2.28	2.31	2.35	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.13	0.13	0.15	0.16	0.17	0.18	0.21	0.19	0.20	0.21	0.22	0.18	0.18	0.19
Out-patient curative and rehabilitative care	3.14	2.87	2.89	2.86	2.87	2.98	3.21	3.10	3.11	3.20	3.21	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.27	1.23	1.15	1.14	1.11	1.13	1.21	1.13	1.09	1.11	1.11	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.25	0.26	0.27	0.26	0.25	0.25	0.27	0.26	0.25	0.26	0.26	0.31	0.31	0.32
Prevention and public health services	0.29	0.28	0.30	0.27	0.30	0.32	0.36	0.33	0.35	0.36	0.34	0.25	0.25	0.24
Health administration and health insurance	0.12	0.12	0.12	0.12	0.13	0.14	0.16	0.16	0.17	0.17	0.14	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	2.50	2.32	2.25	2.24	2.17	2.21	2.37	2.24	2.24	2.27	2.32	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.13	0.12	0.15	0.16	0.16	0.18	0.20	0.19	0.20	0.20	0.22	0.16	0.16	0.18
Out-patient curative and rehabilitative care	2.39	2.17	2.16	2.17	2.18	2.26	2.44	2.37	2.37	2.44	2.43	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.80	0.73	0.71	0.69	0.67	0.67	0.70	0.66	0.64	0.61	0.58	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.09	0.10	0.11	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.11	0.13	0.12	0.13
Prevention and public health services	0.22	0.20	0.22	0.20	0.22	0.24	0.28	0.25	0.27	0.27	0.29	0.25	0.20	0.19
Health administration and health insurance	0.10	0.10	0.10	0.10	0.11	0.11	0.13	0.13	0.14	0.13	0.13	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.27.2: **Statistical Annex - continued – Sweden**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	28.5%	28.6%	27.8%	27.9%	27.4%	27.0%	26.8%	26.8%	21.6%	21.4%	21.4%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.5%	1.6%	1.8%	2.0%	2.0%	2.2%	2.3%	2.3%	1.9%	1.9%	2.0%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	35.2%	34.7%	34.9%	35.0%	35.6%	35.9%	35.9%	36.6%	29.5%	29.6%	29.2%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	14.3%	14.9%	13.9%	14.0%	13.8%	13.6%	13.5%	13.3%	10.3%	10.3%	10.1%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.8%	3.1%	3.3%	3.2%	3.1%	3.0%	3.0%	3.0%	2.4%	2.4%	2.4%	3.2%	3.3%	3.3%
Prevention and public health services	3.3%	3.4%	3.6%	3.3%	3.7%	3.9%	4.0%	3.9%	3.3%	3.3%	3.1%	2.6%	2.6%	2.5%
Health administration and health insurance	1.3%	1.5%	1.5%	1.5%	1.6%	1.7%	1.8%	1.9%	1.6%	1.6%	1.3%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	34.1%	34.2%	33.3%	33.6%	32.9%	32.5%	32.4%	32.3%	25.0%	24.8%	25.1%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	1.7%	1.8%	2.2%	2.4%	2.4%	2.7%	2.8%	2.7%	2.2%	2.2%	2.3%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	32.6%	32.0%	32.0%	32.5%	33.0%	33.2%	33.3%	34.1%	26.5%	26.7%	26.3%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	10.9%	10.8%	10.5%	10.3%	10.2%	9.9%	9.6%	9.5%	7.1%	6.7%	6.3%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.3%	1.5%	1.6%	1.5%	1.4%	1.4%	1.4%	1.5%	1.1%	1.1%	1.1%	1.6%	1.6%	1.6%
Prevention and public health services	3.0%	2.9%	3.3%	3.0%	3.3%	3.5%	3.8%	3.6%	3.0%	3.0%	3.1%	3.2%	2.7%	2.5%
Health administration and health insurance	1.4%	1.5%	1.5%	1.5%	1.7%	1.7%	1.8%	1.9%	1.5%	1.5%	1.4%	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.1
Proportion of the population that is obese	9.7	9.8	10.7	9.6	10.2	10.3	10.9	11.3	11.0	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	17.2	15.9	15.7	15.2	13.8	14.6	14.0	13.6	13.1	12.8	10.7	23.2	22.4	22.0
Alcohol consumption litres per capita	6.9	6.6	6.5	6.5	6.9	6.9	7.3	7.3	7.4	7.3	7.4	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	338	345	352	361	369	375	382	389	396	401	:	329	335	344
Practising nurses per 100 000 inhabitants	1041	1054	1074	1089	1100	1104	1103	1110	1113	1115	:	840	812	837
General practitioners per 100 000 inhabitants	57	58	59	61	62	62	63	63	63	64	:	:	78	78.3
Acute hospital beds per 100 000 inhabitants	223	223	218	212	211	207	204	202	201	195	194	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	2.8	2.8	2.8	2.8	2.8	2.9	2.9	2.9	3.0	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	14.7	14.8	14.9	15.0	15.1	15.1	15.2	15.2	:	:	15.0	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	1,213	1,247	1,296	1,291	1,334	1,335	1,391	1,398	:	:	2,038	6368	6530	7031
Acute care bed occupancy rates	:	:	:	:	:	:	:	:	:	:	:	72.0	73.1	70.2
Hospital curative average length of stay	6.5	6.4	6.3	6.3	6.2	6.2	6.1	5.9	5.7	5.6	:	6.5	6.3	6.3
Day cases as % of all hospital discharges	7.6	8.0	8.2	8.1	:	:	8.4	8.4	:	:	12.0	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	6.9	7.0	7.2	7.2	7.3	7.3	0.4	0.9
AWG risk scenario	6.9	7.2	7.6	7.8	8.0	8.0	1.2	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	9.6	10.2	11.0	11.8	12.5	13.1	36.3	3.1

Sources: EUROSTAT, OECD and WHO

Sweden

Long-term care systems

2.27. SWEDEN

General context: Expenditure, fiscal sustainability and demographic trends

Sweden had a population of almost 9.6 million inhabitants in 2013, which is expected to reach 13.1 million in 2060. This is a 36% increase that is contrast with the 3% overall increase in the EU over this period. With a GDP of more than EUR 436 billion, or 32,200 PPS per capita, it is above the EU average of 27,900 PPS per capita.

Health status

Life expectancy at birth for both men and women is respectively 80.2 years and 83.8 years and is above the EU average (77.8 and 83.3 years, respectively). Even more so, the healthy life years at birth for both sexes are 66.0 years (women) and 66.9 years (men) and substantially higher than the EU-average (61.5 and 61.4, respectively). At the same time the percentage of the Swedish population having a long-standing illness or health problem is slightly higher than in the EU as a whole (35.3% and 32.5%, respectively). The percentage of the population indicating a self-perceived severe limitation in its daily activities has been decreasing in the last few years, and is lower than the EU-average (7.0% against 8.7%).

Dependency trends

The amount of people that depend on others to carry out activities of daily living increases significantly over the coming 50 years.([464]) From less than 620 thousand residents living with strong limitations due to health problems in 2013, an increase of 62% is envisaged until 2060 to slightly more than 1 million. That is a steeper increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 6.5% to 7.7%, an increase of 19%. This is nevertheless less than the EU-average increase of 36%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing, from 3.6 percent in 2013, to 5.1 percent in 2060 in the "AWG reference scenario", corresponding to a 41% increase, about the same level as the EU. In the "AWG risk scenario", expenditure is projected to grow from 3.6 to 7.5, attaining a differential of 106%, lower than the EU average of 149%.

Risks also appear to be low in the medium-term from a debt sustainability analysis perspective due to the relatively low stock of debt at the end of projections (2026), even when considering possible shocks to nominal growth and interest rates. Medium sustainability risks appear over the long run due to both the relatively unfavourable initial budgetary position and the projected impact of age-related public spending (in particular, long-term care spending). ([465])

System Characteristics ([466])

According to the Social Services Act (1982), Swedish older people have the right to claim public service and help to support themselves in their day-to-day existence “if their needs cannot be met in any other way”. The Swedish system of LTC is under the responsibility of municipalities and is mainly financed from local taxation. According to 2013 data from the OECD, some 10% of the total cost of LTC is financed through co-payments and charges, while the rest is covered by public funds, mainly through local taxes. Around 10% of the local authorities' total funding (not only LTC) comes from central government grants. Some 5% of the total cost of LTC is financed through co-payments and charges, while the rest is covered by public funds, mainly through local taxes with some 10-12% funding coming from central government grants to municipalities.

Public spending on LTC reached 3.7% of GDP in 2012, above the average EU level of 1.0% of GDP. 96.4% of the benefits were in-kind, while 3.6% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 83.4% much higher in Sweden. Overall, 5.4% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU:

([464]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([465]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([466]) This section draws on WHO/Europe (2012), Fukushima et al (2010) , OECD (2011b) and ASISP (2014).

4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 50.3% of public in-kind expenditure (EU: 61%), 49.7% being spent for LTC services provided at home (EU: 39%).

Administrative organisation

At central government level, the Ministry of Health and Social Affairs (Socialdepartementet) is responsible for developing legislation on health care, social insurance and social issues. These laws and regulations are the basis for the planning, funding and provision of LTC services through the cooperation of 20 county councils and 290 municipalities. The central government is in constant dialogue with the Swedish Association of Local Authorities and Regions (SALAR), a co-operative national organisation that represents all county councils and municipalities.

County councils and municipalities are highly autonomous with respect to central government. Both have elected assemblies and have the right to levy and collect taxes. County councils and municipalities can, within the limits established in legislation, decide what level of priority they will assign to the elderly versus other age groups. The fact that LTC is mainly funded by local taxation underlines the independence of the local authorities from national government.

County councils are responsible for providing healthcare (whether through family doctors, hospitals, health centres, or other providers). Municipalities offer a number of social services to assist elderly living at home, including home help services, daytime community activities, etc. With the 1992 reform municipalities were also handed responsibility over local nursing homes and other forms of institutional LTC. In contrast, the responsibility for health care belongs to the county councils. In local nursing homes the municipalities are by law responsible for providing home health care including all medical staff and excluding doctors only. Over the years, all county councils and municipalities, except the municipalities within Stockholm county, have formed agreements on transferring the responsibility for home health care also in all ordinary homes from the county councils to the municipalities. This has led to a more coherent organisation. However, county councils are still responsible for patients until they are discharged from hospital. The responsibility of medical care and rehabilitation for elderly in ordinary homes is shared between municipalities and county councils. This places high demands on the coordination of care between municipalities and county councils. Lack of coordination may lead to an inefficient use of resources, cooperation issues and lack of continuity as well as attempts by county councils and municipalities to transfer both responsibilities and costs to one another.

From 1 January 2010, local authorities have to draw up an individualised care plan for each recipient. The care plan states clearly each step of the required services and treatment. The plan also identifies the official in charge of the case and specifies which authority is responsible for which component of the services and care provided.

Types of care

The primary LTC service is home care, comprising help with daily activities such as shopping, cooking, cleaning and laundry. It also includes personal care, such as help with bathing, going to the toilet, getting dressed and getting in and out of bed.

As well as home care, the following LTC services are also available in Sweden: institutional care, day care, home nursing care, meal services, home adaptation and personal safety alarms. There are also transportation services for care recipients who are unable to use public transport. In addition, the local authorities also provide non-means tested grants to assist the disabled to use their homes in an efficient manner (Fukushima, 2010).

The expenditure on LTC for older people in 2006 ([467]) was distributed as follows: about 60% was spent on nursing homes, almost 39% on home care and less than 2% allocated to "other services".

Public provision of home care in Sweden was at its highest in 1978, with 352 000 clients. Since the

([467]) WHO/Europe, 2012.

1980s, a decrease in public involvement in the provision of LTC was driven by a significant improvement in the health status of the elderly and their standard of living as well as the will to avoid the oversupply of the previous decade. In the 1990s, Sweden suffered its deepest recession since the 1930s. This economic crisis gave rise to serious public sector financial problems. As a result, the public provision of long-term-care continued to fall, and the provision of care focused on those with the greatest need. At the same time, the Swedish model based on the monopoly of public sector provision was challenged and share of private caregivers increased by 100% in the 1990s.

Eligibility criteria

Permanent residents who suffer from some degree of dependency are eligible for care, determined only by an assessment of their need for care. There is therefore no means-testing criterion applied to the provision of long-term care. Need for care is either assessed by a general practitioner or through a request for assessment by the relevant local authority. For direct requests to the authority, the potential recipient as well any eventual relatives are interviewed by an evaluator in order to determine the extent of support required, and whether the care can be provided in recipient’s own home or not.

Nowadays, even relatively severe dependency cases needing extensive medical care can be treated in the home of the recipient. Home help is offered in flexible hours, in some cases including up to seven visits per day or more. In some cases, however, home care will not be advisable (for instance due to the inadequacy of the home) and institutional care will be considered as a last resort policy. The National Board of Health and Welfare (NBHW) introduced a standardised instrument for needs assessment in 2012. The tool for needs assessment is based on the International Classification of Functioning, Disability and Health (ICF) standard. The government have commissioned the NBHW to implement the new tool and financially supported activities such as training of process-leaders. In cases where citizens disagree with the care-manager's decisions, they can appeal to an administrative court. The number of successful appeals is very low, but the right to appeal is perceived as providing personal security to individuals.

Co-payments, out of the pocket expenses and private insurance

Cost-sharing for LTC services is set according to the Social Services Act with the aim of protecting recipients from excessive fees. A ceiling fee is set annually by the government, representing the maximum amount that a recipient can be charged. This ceiling is set without means-testing in principle, although it may be reduced if the recipient's monthly income is below the minimum cost of living as defined by the government (also on an annual basis).

Within these rules, each municipality will determine their own schedule of cost-sharing fees for recipients. In 2006 ([468]), around 19% of recipients of home care did not pay any fees, as their income was below the threshold.

There are no private insurances for the cost of LTC in Sweden, so care is financed exclusively from taxation, cost-sharing and other out-of-pocket payments.

Role of the private sector

Municipalities and county councils can decide on how to organise the provision of LTC, including collaboration with different providers. Institutional and home care may be provided either by a municipality or a private provider (which can include private companies but also trusts and co-operatives). However, even when care is actually provided by the private sector, municipalities and country councils still have the exclusive responsibility for ensuring financing, provision and ensuring an adequate level of quality.

The introduction of choice for the individual is by far the main driving force behind the expansion of privately run (but publicly financed) institutions. Another reason has been the assumption that competition will be good for quality, effectiveness and the career possibilities for the mainly female staff in elderly care.

([468]) Fukushima et al, 2010.

Formal/informal caregiving

Municipalities are required by law (since 1 July 2009) to provide support to informal carers. According to the Social Services Act, municipalities need to respect and cooperate with informal carers, offering support tailored to their needs. The aim is to alleviate the workload of carers and its impact on their health status, as well as providing them with necessary information and knowledge. The Act also aims to provide recognition of the work provided by carers and acknowledge its importance.

In accordance with the above, support for informal carers takes different forms. Carers have the right in some circumstances to take leave from their work in order to provide care for an elderly or terminally ill relative. Some municipalities have cash benefits that the recipients of care can use to compensate the carer. Municipalities can also compensate informal carers directly under certain circumstances. In 2003, around 5500 people aged 65 years and over were entitled to this type of cash benefits. Additionally, 2000 people received help from relatives that were employed by the municipalities. ([469])

Municipalities also provide support groups or centres for carers, which can be a source of mutual support. Municipalities can provide "Respite leave", giving carers temporary leave from their caring responsibilities, with the latter being taken over by home care providers or charities over that period (provided for free in about 50% of municipalities, in others a small charge is required) or by institutional providers on a temporary basis.

In addition, there are different services that provide informal carers with advice, including one-on-one sessions, websites and assistance from volunteers. Some municipalities also organise services for carers, including spa treatments, massage and health consultations. ([470])

Prevention and rehabilitation policies/measures

Prevention is dealt with by the public health system in Sweden.

([469]) WHO/Europe (2012).
([470]) Fukushima et al. (2010).

Recently legislated and/or planned policy reforms

The Act on System of Choice in the Public Sector

In order to stimulate a greater variety of LTC providers and increase the quality of services provided, the government introduced a new law in 2009, the "Act of System of Choice in the Public Sector". Its aim was to make it easier for a variety of commercial providers to enter the market of service and care for the elderly. The law worked as a voluntary tool for those municipalities who wanted to let recipients choose suppliers, and to expose public sector providers to competition from the private sector. The law is an alternative to the Swedish Public Procurement Act (2007:1091) for public sector provision and may be implemented regarding elderly and disabled care as well as health and medical services (where it is mandatory).

The act ensures equal opportunities for all providers, and it facilitates the provision of LTC and health care by for small companies and non-profit organisations.

The local municipality must specify in the contract the requirements that providers must meet. The requirements need to be compliant with community law principles, such as, non-discrimination, transparency, and proportionality. The contract does not in itself guarantee any volume or compensation and the latter depends exclusively on the number of recipients the provider is able to attract.

Choice is presented as an opportunity for the user. Recipients who are not able or who do not want to choose are also not obliged to do so. A no-choice alternative should be presented in advance to recipients. The providers presented as the no-choice alternative need to fulfil the same quality requirements as the rest.

By October 2013, 181 of the country’s 290 municipalities had introduced or decided to introduce free choice of providers within at least one service area. Before the act entered into force, only 40 municipalities offered various forms of customer choice. The reform is financed through taxation.

Currently, some 900 providers are active within this system. They provide a variety of services, with providers specialising and including provision in different languages, others focusing on specific treatments or diets, and some offering services for particular cultural or religious groups.

A greater diversity of providers increases the possibility for recipients to find providers that suits their preferences and needs, which can also improve the quality of the services. The legislation has the purpose of promoting freedom of choice for recipients and to increase their power to make their own choices. The reform is based on a clear ideological view that recipients of LTC should remain in charge of their own life. Evaluations have so far shown that users do value this aspect.

Dignity – National set of values for elderly care

The national set of values for the elderly is expressed in the Social Services Act (2001:453) since 2010. The Social Services Act also clarifies that the elderly should be given increased opportunities for influence on the social services.

The national set of values basically means that care services for the elderly should focus on enabling elderly to live with dignity and to experience well-being. This means among other things that the elderly care services should uphold and respect everyone's right to privacy and bodily integrity, autonomy, participation and personalisation.

Health and social care should help the individual to feel safe and experience meaningfulness. Services within elderly care must be of good quality.

Older people should have influence over when and how services should be carried out.

The right for older couples to continue to live together

Today spouses can choose to continue to live together even when one of the spouses is in need of care in special housing. The right came into force in 2012 after an amendment to the Social Services Act.

Government grant to support increased staffing

A sufficient level of staffing is recognised by the government as a crucial part of quality in elderly care. It is important to create safety and quality to the elderly, as well as good working conditions for the staff. A government grant to the municipalities of two billion SEK yearly, under the period 2016-2018, is supposed to increase the number of staff working closest to the elderly. The staff is supposed to have relevant education or should be offered introduction and at work education. The grant will be offered provided that this is approved by the Parliament.

Possible future changes

An inquiry chair is to propose measures to secure good quality in the future elderly care. The inquiry is to focus on quality, efficiency, improved prevention and rehabilitation, secured work force supply for elderly care and need for special housing. The analysis is to be done from a gender equality perspective, as well as equality in general. The inquiry report will be presented no later than 31 March 2017.

Challenges

- **Improving the governance framework:** To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To deal with cost-shifting incentives across health and care.

- **Improving financing arrangements**: To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore advantages, disadvantages and preconditions of private LTC insurance as a supplementary financing tool; To determine the extent of user cost-sharing on LTC benefits; To include assets in

the means-test used to determine individual cost-sharing (or entitlement to public support) for B&L costs better reflects the distribution of economic welfare among individuals.

- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To provide targeted benefits to those with highest LTC needs.

- **Encouraging independent living:** To provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care; To seek options to increase the productivity of LTC workers;

- **Ensuring coordination and continuity of care:** To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care**: To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer LTC users towards appropriate settings.

- **Changing payment incentives for providers:** To consider fee-for-service to pay LTC workers in home-care settings and capitation payments; To consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money:** To encourage competition across LTC providers to stimulate productivity enhancements; To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.27.1: **Statistical Annex – Sweden**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	293	307	313	335	356	352	310	369	405	423	436	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	30.6	32.5	32.2	33.6	35.2	33.8	30.1	31.8	32.6	32.9	32.2	26.8	27.6	28.0	28.1	27.9
Population, in millions	8.9	9.0	9.0	9.0	9.1	9.2	9.3	9.3	9.4	9.5	9.6	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	3.8	3.7	3.7	3.6	3.6	3.7	3.8	3.7	3.7	3.7	:	1.0	1.0	1.0	1.0	:
Per capita PPS	950.7	984.1	975.9	1030.0	1093.3	1122.2	1083.1	1102.8	1146.7	1185.2	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	6.9	6.8	6.9	7.0	7.1	7.0	7.1	7.2	7.2	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	82.5	82.8	82.9	83.1	83.1	83.3	83.5	83.6	83.8	83.6	83.8	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	78.0	78.4	78.5	78.8	79.0	79.2	79.4	79.6	79.9	79.9	80.2	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	62.2	60.8	63.2	67.5	66.8	69.0	69.6	66.4	65.5	:	66.0	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	62.5	62.0	64.5	67.3	67.7	69.4	70.7	67.0	67.0	:	66.9	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	49.9	41.8	35.2	34.8	33.0	32.4	30.7	32.4	34.1	35.3	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	14.0	11.2	8.2	7.8	7.0	6.1	7.7	7.4	:	7.0	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	97	140	184	227	230	232	87	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	222	223	224	225	227	229	206	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	3.5	4.0	4.4	4.8	4.8	4.9	3.1	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	186	:	200	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	218	218	223	224	224	222	217	221	222	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.27.2: **Statistical Annex - continued – Sweden**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	9.6	10.2	11.0	11.8	12.5	13.1	37%	3%
Dependency								
Number of dependents in millions	0.62	0.70	0.79	0.86	0.94	1.00	62%	40%
Share of dependents, in %	6.5	6.9	7.2	7.3	7.5	7.7	19%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	3.6	3.9	4.4	4.6	4.8	5.1	41%	40%
AWG risk scenario	3.6	4.1	4.9	5.7	6.4	7.5	106%	149%
Coverage								
Number of people receiving care in an institution	86,795	96,502	121,831	143,436	159,973	179,065	106%	79%
Number of people receiving care at home	206,253	231,777	283,148	317,277	347,962	379,217	84%	78%
Number of people receiving cash benefits	223,843	251,336	303,892	347,310	380,103	420,009	88%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	5.4	5.7	6.4	6.9	7.1	7.5	39%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	83.4	82.9	89.7	93.5	94.6	97.4	17%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	96.4	96.4	96.5	96.4	96.4	96.5	0%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	3.6	3.6	3.5	3.6	3.6	3.5	-2%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	50.3	50.5	50.7	51.8	52.0	52.5	5%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	49.7	49.5	49.3	48.2	48.0	47.5	-5%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	194.0	199.6	193.1	190.0	187.1	189.1	-3%	-2%
Unit costs of home care per recipient, as % of GDP per capita	80.8	81.6	80.7	80.0	79.3	80.6	0%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	5.6	5.6	5.6	5.6	5.6	5.6	0%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)