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 June 2019
as Institutional Paper 105
Country Documents - 2019 Update

Economic and Financial Affairs
Economic Policy Committee

Sweden

Health care systems

From: *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability,* prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group), Country Documents – 2019 Update

2.27. SWEDEN

General context: Expenditure, fiscal sustainability and demographic trends

General country statistics: GDP, GDP per capita; population

Sweden had a population of almost 9.9 million inhabitants in 2016, which is expected to reach 13.9 million in 2070. This is a 40% increase that is contrast with the 2% overall increase in the EU over this period. With a GDP of more than €449 billion, or 33,700 PPS per capita, it is above the EU average of 29,600 PPS per capita in 2015.

Total and public expenditure on health as % of GDP

Total expenditure ([404]) on health as a percentage of GDP (11.6% in 2015) is above the EU average ([405]) (10.2%). It has grown gradually from 8.7% in 2005, although it has been relatively flat since 2012 ([406]). Public expenditure on health as a percentage of GDP is, at 9.6% in 2015 also above the EU average of 8%. Looking at health care without long-term care ([407]) reveals a different picture, with public spending at the EU average (6.9% vs 6.8% in 2015).

Total (4,314 PPS in 2015) and public (3,580 PPS in 2015) per capita expenditure is above the EU average (3,305 PPS and 2,609 PPS in 2015), having consistently increased since 2005 (2,514 PPS and 1,985 PPS). Again, this is likely to be influenced by the costs of LTC, which underlines the importance of considering this when making cross-country comparisons.

Expenditure projections and fiscal sustainability

As a result of ageing ([408]), health care expenditure is projected to increase by 0.7 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.

Fiscal sustainability risks appear to be low in Sweden over the low, medium and long-term ([409]).

Health status

Life expectancy (84.1 years for women and 80.4 years for men in 2015) is above the EU average (83.3 and 77.9) and among the highest in the world. Healthy life years (73.8 years for women and 74 for men in 2015) are above the EU average (63.3 and 62.6 respectively).

There are two major causes of death in Sweden ([410]). 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 37% of all deaths among women and 36% of all deaths among men in 2014.

The second most common cause of death is neoplasm (cancer), corresponding to 23% of all deaths among women and 27% among men in 2014.

Alzheimer's and other dementia conditions have taken the place of stroke in the top three causes of death in Sweden. To some extent this reflects the ageing of the population, improvements in diagnosis of these conditions but not in terms of

([404]) 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.

([405]) 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.

([406]) Please note that there was a break in the series in 2011.

([407]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

([408]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([409]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([410]) State of Health in the EU: Sweden Country Health Profile 2017, European Commission, OECD and European Observatory on health systems and policies. https://ec.europa.eu/health/sites/health/files/state/docs/chp_sv_english.pdf.

effective treatments to cure them as well as more precise coding as cause of death.

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 county councils or regions (county council taxation) and the municipalities (for local taxes). The Parliament, the central government, the county councils and the municipalities set the public budget for health, in each respective responsibility. 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 (0.17%) and total (0.19%) expenditure on health administration and health insurance as a percentage of GDP is below the EU average (0.26% and 0.38% respectively in 2015), as is public and total expenditure on health administration and health insurance as a percentage of current health expenditure (1.7% and 1.8% vs. 3.8% and 3.4% in 2015), 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 and access to health care have been the focus of debate in the 2000s ([411]).

([411]) WHO/Europe (2012b).

Interestingly, while in the 1990s mostly county councils 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 several cost-containment policies and stricter budget rules ([412]).

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 county councils or regions 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 by taxes (central, county and municipal taxes), provides universal population coverage.

To improve access and reduce the waiting times to health care, the national time guarantee for care (i.e. care must be provided within 3 months) has been sharpened. The government has also invested SEK 2 billion between 2015 and 2018 to increase access to cancer care. The funds have been used to stimulate the implementation of standardised patient pathways in cancer care. This builds on the Danish example with specially designed tracks for different kind of cancers.

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

Hence, some efforts to improve access may help explain the increase in public and total expenditure observed since 2012 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 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 2015, private expenditure and out-of-pocket expenditure were 17% and 15.2% of total health expenditure and therefore respectively below and above the EU average (21.6% and 15.9%).

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 102 hospitals in Sweden, many of which are local hospitals with limited specialisation, some of which are regional hospitals offering a wider range of specialties. In addition, 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 (419 in 2014) is above the EU average (343 in 2014) and showing a consistent increase since 2005 (352). The number of GPs per 100 000 inhabitants (65 in 2014) is below the EU average (79 the same year), but showing a gradual increase from 2005. The number of nurses per 100 000 inhabitants (1,114 in 2014) is well above the EU average (829 in the same year) having consistently increased throughout the decade. 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. The government have invested several billion SEK the past years to strengthen the provision of skills in health care. The funds can e.g. be used to improve the skill mix in health care. Staff supply is regulated in terms of quotas for medical students and by speciality but not in terms of the location of physicians, which may help explain the disparities in staff availability across counties or regions.

The number of acute care beds per 100 000 inhabitants (226 in 2015) is far below the EU average of 402 in 2015, displaying a decreasing trend over the last decade and is one of the lowest in the EU ([413]). 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

([413]) This phenomenon has intensified in the last few years and the latest figures show even lower bed numbers.

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

Salaries for public sector physicians (GPs and specialists) are determined at hospital level. Physicians appear not to be eligible to receive bonuses regarding their activity or performance ([414]). 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 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 (14.1 vs. 16.2) and the number of day case discharges is well below the EU average (1,364 vs. 7,635 in 2015). The proportion of surgical procedures conducted as day cases (8.6%) is far below the EU average (32.3% in 2015). Overall hospital average length of stay (5.9 days in 2015) is also below the EU average (7.6 days in 2015). 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 (1.1%) and public (0.6%) expenditure on pharmaceuticals as a percentage of GDP ([415]) was below the EU average (respectively 1.4% and 1%) in 2015. This is similar for total (9.8% vs. the average of 14.6% in 2015) and public (6.1% vs. EU average 12.7% in 2015) pharmaceutical expenditure as a percentage of total and public current health expenditure respectively.

When it comes to the out-patient sector, the authorities have implemented several policies to control expenditure on pharmaceuticals. There is a positive list of reimbursed products. Decisions on pricing and reimbursement of pharmaceuticals need to be in-line with the ethical platform, which is legislated and applies to all prioritising of publicly funded health care in Sweden. The three principles: the human value principle, the need and solidarity principle and the cost-effectiveness principle. Managed Entry Agreements between pharmaceutical companies and county councils are used for some products to dampen the cost and provide better conditions for early and equal access. 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 council level on prescriptions and co-payments and physicians receive feedback. These are coupled with pharmaceutical budgets at county level. Patients pay the full price up to a certain cost level (SEK 1125), 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 SEK 2300. There is an

[414] 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.

[415] 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.

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. 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 and Regions (SALAR) 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 (0.17% and 0.26% in 2015). 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 1.8% for both vs. 3.4% in 2015).

Recently legislated and/or planned policy reforms

Recent policy response

In an effective healthcare, patients receive care at the right level. The structure in Swedish health care has been a contributing factor to inefficiency in the healthcare system. There has therefore been a need for profound structural changes in all levels of health care, and primary care has been needed to be strengthened. Less focus should be put on hospital care. Primary care should be the natural first choice for anyone seeking care, especially when in need for regular care contacts. To this end, primary care must be changed and be able to meet the challenges it faces, including a demographic development with an aging population and increasing numbers of people living with chronic diseases. In order to achieve increased quality, better accessibility and more efficient use of resources, changes in the structure and the way of organising care are being put forward. The foundation is a good and close care that is based on the patient's needs. The “health care guarantee” has also been strengthened, as stated above. The government has also proposed a new provision in the Health Care Act regarding how the health care is organised. The Swedish parliament thas enacted this provision into new legislation.

Furthermore, the government has taken steps to concentrate highly specialised care on fewer units in the country. This type of care can be developed to give patients access to a more equal and safe care of good quality regardless of their place of residence. The National Board of Health and Welfare has been commissioned to lead the work with concentrating highly specialised health care.

A top priority for the government has been to strengthen the position of patients and to stimulate patient engagement. Taking advantage of the opportunities provided by digitalisation, improving quality registers, strengthening women's health and maternity care have been other important reform areas.

Six regional cancer centres were established in 2010. They work across counties to develop cancer care. This model is now serving as an example of how to improve care also for other patient groups.

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.

A new government took office in Sweden at the end of January 2019. In the agreement between the parliamentary parties supporting the new government there are several points concerning health care.

An updated queue billion is introduced covering the entire care chain, taking special account of the needs of chronically ill patients. A master plan for shortening queues will be produced together with the county councils. Ambulance care, cancer care and maternity care should be strengthened.

The system with patient contracts will continue to be implemented. The aim is that people should know who to contact in health care and what the plan for your treatment looks like.

Transparency and follow-up regarding information on waiting times, availability and quality in health care should increase. The patients right to information and the right to choose should be protected and developed.

The responsibility for children's health, from maternity care until 18 years old need to be coordinated better. A public inquiry is to be appointed concerning how the coordination can be strengthened around the health around the children and the youth.

The right to a permanent medical doctor should be secured. It should become more attractive for physicians to work in primary care and thereby increasing accessibility and freedom of choice. It should be easier to be care provider in rural parts of Sweden.

A long-term plan for national coordination of skills supply in health care is implemented.

Psychiatry and school health care should be strengthened. A public inquiry will be appointed into how to create a new type of care where patients is provided help quicker for lighter forms of mental illnesses.

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 2.27.1: **Statistical Annex - Sweden**

General context

GDP	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
GDP, in billion Euro, current prices	313	335	356	352	310	369	405	423	436	433	449	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	32.3	34.0	35.7	34.2	30.5	31.8	32.6	33.0	32.5	32.6	33.7	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	2.4	4.1	2.6	-1.3	-6.0	5.1	1.9	-1.0	0.4	1.6	3.4	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	2.5	1.9	2.0	1.1	0.4	27.2	1.0	1.8	2.0	2.3	3.7	0.2	0.2	4.1

Expenditure on health*	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Total as % of GDP	8.7	8.6	8.5	8.8	9.4	9.0	11.3	11.5	11.7	11.7	11.6	10.2	10.1	10.1	10.2
Total current as % of GDP	8.3	8.2	8.1	8.3	8.9	8.5	10.7	10.9	11.1	11.1	11.0	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.6	0.6	0.9	0.6	0.2	0.3
Total per capita PPS	2,443	2,562	2,688	2,726	2,555	2,883	3,918	4,150	4,297	4,246	4,314	2,745	2,895	2,975	3,305
Public total as % of GDP	7.1	7.0	6.9	7.2	7.7	7.4	9.4	9.6	9.7	9.7	9.6	8.0	7.8	7.8	8.0
Public current as % of GDP	6.8	6.7	6.6	6.8	7.3	7.0	9.0	9.1	9.3	9.3	9.2	7.7	7.6	7.6	7.8
Public total per capita PPS	1,985	2,081	2,187	2,223	2,086	2,349	3,276	3,454	3,571	3,514	3,580	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.29	0.27	0.31	0.36	0.38	0.40	0.45	0.43	0.42	0.39	0.40	0.2	0.2	0.2	0.2
Public as % total expenditure on health	81.3	81.2	81.4	81.5	81.6	81.5	83.6	83.2	83.1	82.7	83.0	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	12.7	12.9	12.8	12.0	14.8	14.3	14.0	13.6	12.9	13.2	13.4	14.8	14.8	15.2	15.0
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	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	17.1	17.0	16.9	16.9	16.9	16.9	15.0	15.4	15.5	15.5	15.2	14.6	14.9	15.9	15.9

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	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
Population, current (millions)	9.0	9.0	9.1	9.2	9.3	9.3	9.4	9.5	9.6	9.6	9.7	502.1	503.0	505.2	508.5
Life expectancy at birth for females	82.9	83.1	83.1	83.3	83.5	83.6	83.8	83.6	83.8	84.2	84.1	82.6	83.1	83.3	83.3
Life expectancy at birth for males	78.5	78.8	79.0	79.2	79.4	79.6	79.9	79.9	80.2	80.4	80.4	76.6	77.3	77.7	77.9
Healthy life years at birth females	63.2	67.5	66.8	69.0	69.6	66.4	65.5	:	66.0	73.6	73.8	62.0	62.1	61.5	63.3
Healthy life years at birth males	64.5	67.3	67.7	69.4	70.7	67.0	67.0	:	66.9	73.6	74.0	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	57	56	53	55	52	49	106	102	102	98	97	64	138	131	127
Infant mortality rate per 1 000 live births	2.4	2.8	2.5	2.5	2.5	2.5	2.1	2.6	2.7	2.2	2.5	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics

Composition of total current expenditure as % of GDP	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data 2009	2011	2013	2015
Inpatient curative and rehabilitative care	2.3	2.3	2.2	2.2	2.4	2.3	2.3	2.3	2.3	2.3	2.3	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	2.9	2.9	2.9	3.0	3.2	3.1	3.1	3.2	3.2	3.3	3.2	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.2	1.1	1.1	1.1	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4
Prevention and public health services	0.3	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.2	0.3	0.3
Health administration and health insurance	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	2.3	2.2	2.2	2.2	2.4	2.2	2.2	2.3	2.3	2.3	2.2	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	2.2	2.2	2.2	2.3	2.5	2.4	2.4	2.5	2.5	2.5	2.5	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.7	0.7	0.7	0.7	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Prevention and public health services	0.2	0.2	0.2	0.2	0.3	0.2	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.3
Health administration and health insurance	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

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

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	27.8%	27.9%	27.4%	27.0%	26.8%	26.7%	21.3%	21.1%	20.8%	20.8%	20.6%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	1.8%	2.0%	2.1%	2.2%	2.3%	2.2%	1.9%	1.9%	2.0%	1.7%	1.8%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	34.9%	35.0%	35.6%	35.9%	35.9%	36.6%	29.1%	29.3%	29.2%	29.6%	29.2%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	13.9%	14.0%	13.8%	13.6%	13.5%	13.3%	10.2%	10.1%	9.8%	9.8%	9.8%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	3.3%	3.2%	3.1%	3.0%	3.0%	3.1%	2.3%	2.4%	2.4%	2.3%	2.5%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	3.3%	2.9%	3.2%	3.4%	3.7%	3.4%	2.9%	2.9%	3.2%	3.0%	3.1%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	1.1%	1.1%	1.4%	1.3%	1.6%	1.5%	1.2%	1.5%	1.4%	1.5%	1.7%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	33.2%	33.5%	32.8%	32.5%	32.3%	32.2%	25.0%	24.8%	24.5%	24.5%	24.3%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	2.2%	2.4%	2.4%	2.6%	2.7%	2.7%	2.2%	2.2%	2.3%	2.0%	2.2%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	32.1%	32.5%	33.0%	33.4%	33.4%	34.1%	26.4%	26.8%	26.6%	27.3%	27.1%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	10.5%	10.3%	10.1%	9.9%	9.5%	9.5%	7.1%	6.7%	6.3%	6.0%	6.1%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	1.6%	1.5%	1.5%	1.5%	1.4%	1.4%	1.1%	1.1%	1.2%	1.1%	1.2%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	3.1%	2.8%	3.2%	3.4%	3.7%	3.5%	2.8%	2.8%	3.1%	3.0%	3.1%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	1.3%	1.3%	1.5%	1.5%	1.8%	1.7%	1.3%	1.6%	1.6%	1.6%	1.8%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	:	0.1	:	:	:	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	0.1	0.1	0.2	0.2
Proportion of the population that is obese	10.9	9.0	10.6	10.3	10.9	11.3	11.0	11.8	11.7	13.4	12.3	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	15.7	15.2	13.8	14.6	14.0	13.6	13.1	12.8	10.7	11.9	11.2	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	6.5	6.5	6.9	6.9	7.3	7.2	7.4	7.2	7.3	7.3	:	10.4	10.3	10.1	10.2
Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	352	361	369	375	382	389	397	405	413	419	:	324	330	338	344
Practising nurses per 100 000 inhabitants	1074	1089	1099	1102	1102	1109	1111	1114	1116	1114	:	837	835	825	833
General practitioners per 100 000 inhabitants	59	61	62	62	63	63	63	64	65	65	:	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	2.8	2.8	2.8	2.9	2.9	2.9	3.0	2.9	2.9	2.9	2.9	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	15	15	15	15	15	15	:	:	15	15	14	17	16	16	16
Day cases discharges per 100 000 inhabitants	1,296	1,291	1,334	1,335	1,391	1,398	:	:	2,038	1,392	1,364	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	:	:	:	:	:	:	:	:	:	:	:	77.1	76.4	76.5	76.8
Hospital average length of stay	6.3	6.3	6.5	6.5	6.5	6.0	5.9	5.8	5.8	5.8	5.9	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	8.2	8.1	:	:	8.4	8.4	:	:	12.0	8.7	8.6	28.0	29.1	30.9	32.3

Population and Expenditure projections

													Change 2016-2070, in pps.	
Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Sweden**	**EU**
AWG reference scenario	6.9	7.0	7.1	7.2	7.3	7.4	7.4	7.5	7.5	7.6	7.6	7.7	0.7	0.9
AWG risk scenario	6.9	7.1	7.3	7.5	7.7	7.8	8.0	8.1	8.2	8.3	8.4	8.5	1.5	1.6

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

													Change 2016-2070, in %	
Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Sweden**	**EU**
Population projections until 2070 (millions)	9.8	10.3	10.8	11.2	11.6	12.0	12.3	12.7	13.0	13.3	13.6	13.8	40.5	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Sweden

Long-term care systems

3.27. SWEDEN

General context: Expenditure, fiscal sustainability and demographic trends

Sweden had a population of almost 9.9 million inhabitants in 2016, which is expected to reach 13.9 million in 2070. This is a 40% increase that is contrast with the 2% overall increase in the EU over this period. With a GDP of 33,700 PPS per capita in 2015, it is above the EU average of 29,600 PPS per capita.

Health status

In 2015, life expectancy at birth for both men and women was respectively 80.4 years and 84.1 years, above the EU average (77.9 and 83.3 years, respectively). Even more so, the healthy life years at birth for both sexes were 74.0 years (women) and 73.8 years (men) and substantially higher than the EU-average (63.3 and 62.6, respectively). At the same time the percentage of the Swedish population having a long-standing illness or health problem was slightly higher than in the EU as a whole (35.9% and 34.2%, 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 was far lower than the EU-average (3.7% against 8.1%).

Dependency trends

The amount of people that depend on others to carry out activities of daily living increases significantly over the coming 50 years ([599]). From around 510 thousand residents living with strong limitations due to health problems in 2016, an increase of 63% is envisaged until 2070 to 840 thousand. That is a steeper increase than in the EU as a whole (25%). Also as a share of the population, the dependents are becoming a bigger group, from 5.2% to 6.0%, an increase of 17%. This is nevertheless less than the EU-average increase of 21%.

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 3.2 percent in 2016, to 4.9 percent in 2070 in the "AWG reference scenario", corresponding to a 63% increase, about double the same increase as the EU. In the "AWG risk scenario", expenditure is projected to grow from 3.2 to 5.7, attaining a differential of 77%, lower than the EU average of 170%.

Fiscal sustainability risks appear to be low in Sweden over the low, medium and long-term ([600]).

System Characteristics ([601])

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 2016 Eurostat data, some 7% of the total cost of LTC (including both social and health-related 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 ([602]) reached 3.2% of GDP in 2016, above the average EU level of 1.6% of GDP. 99.9% of the benefits were in-kind, while 0.1% were cash-benefits (EU: 84.4 vs 15.6%).

In the EU, 50% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 100% much higher in Sweden. Overall, 5.4% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.6%). On the one hand, low shares of coverage

([599]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([600]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

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

([602]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

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 66.1% of public in-kind expenditure (EU: 66.3%), 33.9% being spent for LTC services provided at home (EU: 33.7%).

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).

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. In June 2018 the Government passed a new legislation on Assisted Security Housing to the parliament. The purpose of the new legislation is to encourage local municipalities to design special housing for elderly so it will better meet the needs of elderly people who need only lighter support but who no longer feel safe to stay in their own homes. 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 ([603]), 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.

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 a terminally ill relative.

([603]) Fukushima et al, 2010.

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 ([604]).

Prevention and rehabilitation policies/measures

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

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 is to make it easier for a variety of commercial providers to enter the market of service and care for the elderly. The law works as a voluntary tool for those municipalities who want 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).

In July 2016, the Government introduced government grants for arranging and providing housing for older people. The purpose of the grants is to encourage renovation of existing residential properties for elderly people and the construction of new ones, as well as covering modifications to properties in order to enable older people to remain in their homes through improved accessibility and safety. SEK 150 million was allocated for this purpose in 2016, SEK 300 million in 2017 and from 2018 SEK 400 million is allocated on a yearly basis. The Parliament decided in April 2018 to adopt the government's proposal for a new law on Housing adjustment contributions. The new legislation entered into force in July 2018 and aims at providing housing for disabled people giving them the opportunity to live an independent life in their own housing.

The government has introduced increased license requirements and special rules for procurement in the welfare sector, including home help services for elderly. The legislation aims at ensuring that private performers have sufficient prerequisites for conducting business with good quality and another goal is to strengthen the confidence in the sector. The proposals are also considered to simplify both procuring authorities and suppliers and promoting NGO’s participation in procurement. The new legislation will enter into force in January 2019.

A new provision has been introduced in the Social Services Act which makes it possible for local Social Services Committee to offer home services to older people without an individual need assessment. The purpose is to provide local municipalities with the opportunity to grant older women and men home help services in an easier way and with greater scope for participation and self-determination from the user’s perspective.

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.

([604]) Fukushima et al. (2010).

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 only 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 seven billion SEK under the period 2015-2018, has increased 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

In June 2018 the Government reported to the Parliament its view on elderly care in Sweden (SKr. 2017/18: 280) and the work done to adapt the ageing population to demographic and technological development. The report also specifies the areas that should be prioritised during the forthcoming mandate period: A wider range of housing for the elderly, prevention and rehabilitation efforts, better interaction between health care, to create more attractive workplaces within social care for elderly with stronger professional proficiency, increased use of welfare technology and e-health, and the importance of gender equality and equal care.

Challenges

- **Improving the governance framework:** 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.
- **Encouraging independent living:** To provide effective home care, ITC 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, 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.
- **Improving value for money:** 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 3.27.1: **Statistical Annex – Sweden**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	313	335	356	352	310	369	405	423	436	433	449	12,451	13,213	13,559	14,447
GDP per capita, PPS	32.3	34.0	35.7	34.2	30.5	31.8	32.6	33.0	32.5	32.6	33.7	26.8	28.1	28.0	29.6
Population, in millions	9.0	9.0	9.1	9.2	9.3	9.3	9.4	9.5	9.6	9.6	9.7	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.6	0.6	0.6	0.6	0.7	0.6	2.6	2.7	2.7	2.7	2.7	1.1	1.2	1.2	1.2
Per capita PPS	178.3	192.5	202.5	201.7	197.9	195.3	845.5	883.3	872.3	895.9	936.8	264.1	283.2	352.1	373.6
As % of total government expenditure	1.2	1.2	1.2	1.2	1.2	1.2	5.1	5.2	5.2	5.2	5.4	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	82.9	83.1	83.1	83.3	83.5	83.6	83.8	83.6	83.8	84.2	84.1	82.6	83.1	83.3	83.3
Life expectancy at birth for males	78.5	78.8	79.0	79.2	79.4	79.6	79.9	79.9	80.2	80.4	80.4	76.6	77.3	77.7	77.9
Healthy life years at birth for females	63.2	67.5	66.8	69.0	69.6	66.4	65.5	:	66.0	73.6	73.8	62.0	62.1	61.5	63.3
Healthy life years at birth for males	64.5	67.3	67.7	69.4	70.7	67.0	67.0	:	66.9	73.6	74.0	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	35.2	34.8	33.9	32.8	31.5	32.9	34.7	36.0	36.1	35.9	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	8.2	7.8	9.0	8.0	8.4	8.1	:	7.7	3.8	3.7	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	97	140	184	227	230	232	87	88	88	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	222	223	224	225	227	229	206	208	210	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	3.5	4.0	4.4	4.8	4.8	4.9	3.1	3.1	3.1	2.0	2.2	2.2	2.2
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	:	200	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	224	224	222	217	221	222	224	226	232	238	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.27.2: **Statistical Annex - continued – Sweden**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	9.9	10.3	11.3	12.0	12.7	13.3	13.9	40%	2%
Dependency									
Number of dependents in millions	0.51	0.54	0.63	0.69	0.74	0.79	0.84	63%	25%
Share of dependents, in %	5.2	5.2	5.6	5.7	5.8	5.9	6.0	17%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	3.2	3.3	3.8	4.1	4.3	4.7	4.9	53%	73%
AWG risk scenario	3.2	3.3	3.9	4.3	4.6	5.2	5.7	77%	170%
Coverage									
Number of people receiving care in an institution	103,250	108,902	138,178	162,395	180,020	202,835	221,755	115%	72%
Number of people receiving care at home	198,257	210,468	262,970	298,636	328,861	363,352	395,261	99%	86%
Number of people receiving cash benefits	237,142	251,338	312,939	357,550	391,771	436,048	472,961	99%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	5.4	5.5	6.3	6.8	7.1	7.5	7.9	45%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	:	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	99.9	99.9	99.9	99.9	99.9	99.9	99.9	0%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	8%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	66.1	66.0	66.2	66.9	67.0	67.4	67.5	2%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	33.9	34.0	33.8	33.1	33.0	32.6	32.5	-4%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	204.3	204.5	205.2	204.3	204.9	207.9	208.4	2%	10%
Unit costs of home care per recipient, as % of GDP per capita	54.7	54.6	55.1	54.9	55.2	56.1	56.2	3%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	0.2	0.2	0.2	0.2	0.2	0.2	0.2	16%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).