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Quality of jobs and services in the Personal care and Household Services sector in Sweden

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INTRODUCTORY NOTE

This report has been prepared, reviewed and finalised through the research of its authors, the contributions and suggestions of the project partners, the suggestions and remarks made by the participants-members of partners' organisations at the regional seminars (Rome / Brighton / Vienna 2015) and by the Advisory Board members (AGE Platform, Eurofound). The authors wish to thank warmly all these persons for their time and contribution. The report presents the personal care and household services sector in the country at stake and in the framework of the For quality! project objectives, following the methodological grid validated by the consortium, without being exhaustive. Authors have tried to incorporate corrections and comments that were reported to them during this process. However, the content does not necessarily reflect the vision of the project partners who are not responsible for the information contained in this report.

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The information contained in this publication does not necessarily reflect the position or opinion of the European Commission.

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1. NATIONAL OR LOCAL REGULATION AND POLICIES

1.1. Policy and legal backgrounds

Sweden is currently among the Member States with the largest share of population of 80+ (around 5%). More than 19% of the population is aged 65 or more. Projections show that in the next 30 years, the highest growth in population in Sweden will occur among people aged 65 and over. The country has also among the highest healthy life years – the years that a person can live in a healthy condition.

In international comparisons the Swedish long-term care system stands out as being very generous and as providing a high level of formal care which is financed primarily by public rather than private money. There is an increasing role of informal care, with considerable support for informal carers. The country is also on the edge of innovation. Intelligent and user-friendly technical supports have been developed. The Swedish view is that Long-term care is a very promising area for efficiency-enhancing technologies.

1.2. Care policies

In the field of **care policies**, public service provisions still account for the overwhelming majority of all formal provisions, despite some downsizing of public service provisions.¹ The main characteristics of this model (sometimes referred to as illustrating the Nordic care regime) are a universal delivery of services for all persons in need, with affordability for users and financial sustainability, a comparatively skilled workforce and assistive technology.

Since the Social Services Act was passed in 1982, the elderly in Sweden have had the right to receive public service and assistance at all stages of life. Responsibility for the welfare of the elderly is divided among three governmental levels – the central government, regional authorities, and the municipalities – **that are legally obliged to deliver social services and that currently provide about 75-80% of all formal care** (i.e. excluding friends and family). Although special housing and home care can be run by a municipality or by a private health and social care provider (such as companies, trusts or cooperatives), the local authorities remain the ultimate responsibility to supply and maintaining the level of care even when private organizations supplement some of their responsibilities. The governance of the model is hence much decentralised.

¹ We draw here on DG Justice, *Long-Term care for the elderly, Provision and providers* in 33 European countries, 2012; N. Fukushima, J. Adami and M. Palme, *The Swedish Long-term care System*, ENEPRI research report n° 89, June 2010

The available types of formal care in Sweden are: institutional care, home care, and home nursing care. Home carers, in particular, provide assistance with shopping, cleaning, cooking, washing and personal care to elderly persons living in ordinary housing who cannot cope on their own and may be offered assistance around the clock, if needed. Day activities, meals services, personal safety alarms, home adaptation, and transportation services are additional services supplied by the municipalities and are also regulated by law. The focus is put on keeping dependent people at their home, even though the number of LTC beds remains the highest in the OECD.² The number of beds has been diminishing over the last decade.

Taxes and general allowances finance the bulk of expenditure on long-term care, while fees finance only around 4 percent. Most LTC services are financed through local municipal taxes collected by 290 municipalities.

Since the 2009 law on System choice in the public sector (LOV reform), private providers can enter the market and marketisation is growing up. The assumption is made that municipalities and recipients will choose providers based on their performance. Municipalities have autonomy to grant licences for operation, set prices and monitor compliance. If they participate to this choice system, they have to provide quality information on providers. All providers receive the same reimbursement (according to the amount of help decided by the needs assessor), and are thus competing by service quality, not by prize.

One aspect of the high degree of municipal autonomy is that the municipalities may decide whether or not to open up eldercare to private providers. Today, in around 35% of the Swedish municipalities still all home care services are publicly provided. In contrast, in 4 per cent of the municipalities more than half of the tax-funded home care services are provided by private companies (NBHW, 2011). The two biggest cities in Sweden have chosen different ways forward in this respect: 59 per cent of the home care hours in Stockholm are privately provided compared to zero in Gothenburg until very recently (ibid).³ In June 2015 the municipality of Gothenburg took the decision to implement the choice system.

The proportion of care services provided by private entrepreneurs increased from 1% in 1990 to 16% in 2010. In 2011, nearly 19% of elderly people receive home help from private providers.⁴

On 1 July 2002, a new system of fees was introduced for the long-term care of the elderly and the disabled. The purpose of the system was to protect individuals against excessively high costs for municipal care, and to ensure that all citizens retain a minimum sum for living expenses after all fees have been paid. This minimum is known as ‘**reserve sum**’ (*förbehållsbelopp*). In 2010, the reserve sum amounted to 4787 Swedish crowns (SEK, around €475) per month for single people and 4045 SEK

² OECD *Reviews of Health Care Quality: Sweden 2013- Long-term care in Sweden* p. 128.

³ M. Szebehely and G.-B. Trydegård, “Home Care in Sweden”, Living independently at home. Reforms in home care in 9 European countries, LIVINDHOME Report, 2011, <http://www.sfi.dk/Files/Filer/SFI/LIVINDHOME/LIVINDHOME.pdf>

⁴ OECD p. 129

(around € 400) per person for married or common-law spouses living together. The reserve sum should cover household expenses for food, clothes and shoes, leisure activities, hygiene, consumable goods, daily newspapers, telephone costs, television licenses, furniture and home appliances, home insurance, household electricity, travel, dental care, outpatient medical and health care, and medicines. It does not cover expenses for care services and support from the municipalities, or rent. Regular additional expenses incurred on account of functional disability may be added to the reserve sum, which, however, may be reduced if the fee for home help services includes food at a day care centre, or if the fee for accommodation also includes other costs that should be covered by the reserve sum. At any rate, the maximum fee that the municipal authorities may charge for home care services is SEK 1,696 (around 170 Euro) per month in 2010 (*ibid.*).

1.3. Tax-subsidised household services

Another form of services has become available through a reform in 2007: *Tax-subsidised household services*. In Sweden, a tax reduction for household services was introduced on 1 July 2007, strongly inspired by the Finnish tax credit experience.

Today, two parallel mechanisms co-exist, namely the RUT-reduction (for domestic services) and the ROT-reduction (for renovation services of one's own home, launched in 2008). Together, these two schemes are known as “husavdrag”, i.e. for the tax advantage allowed to anyone who buys “housework”.

Taxpayers are entitled to deduct 50 percent of the expenditure up to SEK 100,000 on household services, including care services. The deduction, then, is up to SEK 50,000 (close to € 5,500) per person and year if the service company has a business tax certificate. The services may be carried out in their own home or in a parent's home.

- The RUT-reduction applies to services conducted close to the house or apartment where the taxpayer lives. These services actually include cleaning services, cooking, laundry and clothes care, window cleaning, snow removal, garden services such as grasscutting, removal of leaves and childcare. The service must be provided by a registered company (or a single person who has his/her own registered company). The RUT reduction system benefited 600 000 households during 2014 and the rate of buyers is increasing constantly. The last five years the turn-over in the industry has increased by an average of 20% yearly. In 2014 the largest increase was recorded since 2010 - an increase of 1 billion Swedish kroner reaching 6 billion. The industry is indeed very young as the business really started in 2007 for almost one company out of two. In 2014, 17 000 companies provided domestic services to RUT-users. The majority of these companies are companies with a single person, 58%, 31% are private limited companies.⁵ The RUT deduction is

⁵ DGCIS, *Les services à la personne en Europe*, 2011 p. 97.

most common among families with children, between 35-60 and among elder people above the age of 67. The proportion was 8.5 percent for the group over age 75. 5.4% of women have recurred to the system compared to 3.5% of men. In a large majority of cases, these companies operate in the cleaning sector. There is no statistics for the breakdown of the sector regarding the various service activities, but homekeeping seems to represent around 80-90% of the activities. The industry employed 20 000 people by the end of 2014 where 3 out 4 came from a situation of non-employment over time. These 20 000 jobs are new jobs.

- The ROT-reduction stands for *Reparation, Ombyggnad, Tillbyggnad* and is actually a collection term for measures to renovate and upgrade existing buildings, mostly residential. The ROT deduction was first introduced in 1993, aimed to increase capacity utilization within the Swedish construction sector and thereby reduce unemployment.

One main objective of these tax incentives was to increase formal employment and to combat undeclared work. According to Företagarna (Swedish Federation of Business Owners), 18,000 new full-time jobs were created thanks to the two schemes in the two first years of implementation (2007-2009): 14,000 in the renovation sector and 4,000 in the housework sector⁶.

These services are not needs assessed, and they are not regulated by the state or local authority, but according to M. Szebehely and G.-B. Trydegård, they may serve as a functional equivalent to the tax-funded home-care services in some cases.⁷

In 2009, 3.5 per cent of persons 65 years and older used the tax deduction; the majority bought services for less than € 600 during the year (Sköld & Heggemann, 2011). The deduction is used significantly more often by high income older persons than by those with lower incomes. However a considerable amount of younger persons buy RUT-services for their elder parents, some of these parents having lower incomes. The true use of the RUT deduction among the elderly cannot be discerned through statistics. In the Swedish context still privately purchased services play a lesser role compared to both family care and publicly funded services.

2. WORK AND EMPLOYMENT QUALITY

2.1. Overall outlook

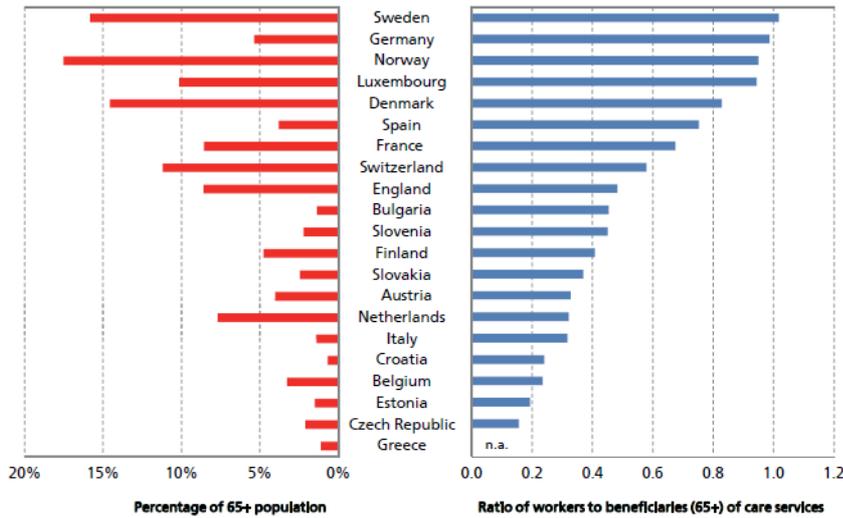
Sweden is the European country with the highest share of people working in the care sector, compared

⁶ Företagarna, Två år med ROT och RUT (Two years with ROT and RUT), August 2010. <http://www.foretagarna.se/Aktuellt-och-opinion/Rapporter/-2010-/Tva-ar-med-ROT-och-RUT/>

⁷ LIVINDHOME, op cit.

with the number of older people or service users.

Figure 4: People formally employed in the care sector as a % of those aged 65 and older (left) and ratio of people formally employed in the care sector to service users (right)



According to OECD, Sweden has a high relative number of LTC workers, with 130 LTC workers per 1000 people aged 65+.

One particularity of the Swedish model is the **high share of public employment** and the importance of municipal employees.

Globally speaking, the care sector shows **relatively good working conditions**, because in this mainly tax-financed system with predominantly public providers the employment relationships are regulated, subject to scale salaries. They are not as much characterised by atypical employment relationships and low wages as in other EU Member States.

Care work for older or disabled persons is **mainly a female occupation**; over 90 percent of the employees in the care sector are women (SALAR, 2009, p. 75).⁸ The work force is relatively mature; one third of the care workers are older than 55 (ibid, p. 79).

In 2007, 20 per cent of the public employees in care of older or disabled persons were employed by the hour. Of those who were employed on a monthly basis, **only 39 per cent worked full time**. The average activity level among part time workers was 73 per cent of full-time; among hourly employees about 37 per cent (SALAR, 2009). A significant proportion of part-timers would prefer to work longer hours (Nyberg, 2003).

An increasing proportion of the care workers in care of older or disabled people are **foreign-born**; in

⁸ The new paragraphs draw on LIVINDHOME, <http://www.sfi.dk/Files/Filer/SFI/LIVINDHOME/LIVINDHOME.pdf>

2008, 18 per cent were born outside Sweden (3 per cent were born in other Nordic countries, 6 per cent in Europe or North America and 9 per cent in Africa, Asia or Latin America). In the metropolitan areas like Stockholm, more than 40 per cent of the care workers are foreign born (Statistics Sweden, 2010). There is no active recruitment of care workers from other countries; the vast majority of workers born in other countries have migrated for other reasons, many as refugees. Currently the local authorities manage the recruitment of the staff they need for care work. Sick leave among care workers is higher than in many other occupations, but has been decreasing since 2002 (SALAR, 2009). Also the turnover rate is slightly declining and was 14 per cent in 2009 (NBHW, 2010a).

2.2. Professions

The vast majority of the employees are care workers (assistant nurses, nurse's aides or personal assistants). The share of nurses among LTC staff is very low (5.5% in 2011, compared to an average of 23.7% in the OECD)⁹. According to data survey, in addition to these 5-6% of Registered Nurses, more than a half of Swedish care workforce were Assistant Nurses, one third were Care Aids (remaining workers being managers, therapists or support workers).¹⁰ Regular statistics do not differentiate between home based and residential based care or between care for older and disabled people.

The two largest occupational groups in home care are assistant nurses (undersköterskor) and nurse's aides (vårdbiträden). They are supervised by home care supervisors (often social workers with university training) and registered nurses, supplemented by occupational therapists and physiotherapists on a more consultative basis. Assistant nurses typically have 2 or 3 years of upper-secondary nursing training which they may have acquired before starting to work as care workers or they may have received the training as part of their job, paid by the employer (the municipality). Nurse's aides have a shorter education, often provided by the municipality.

The two groups of care workers have similar workdays; both are providing household tasks such as cleaning, laundry, cooking meals, etc., as well as 'body work', including help with dressing, bathing, toileting and handing out medicine. They also regularly contact health care providers, and both occupational groups are engaged in relational aspects of work and other social and recreational activities. Half of the assistant nurses and one quarter of the nurse's aides also give insulin injections on delegation from a registered nurse. In comparison to the other Nordic countries, the Swedish home-care workers have much less contact with a supervisor – only one third of the Swedish workers have a meeting with their supervisor at least weekly, compared to two thirds in the other Nordic countries taken together.

⁹ OECD, *op cit.*, p. 145

¹⁰ Marta Szebehely & Tamara Daly (2009), "Unheard voices, unmapped terrain: comparative welfare research and paid care for older people in Sweden and Canada" http://www.cccg.umontreal.ca/rc19/pdf/szebehely-m_rc192009.pdf

2.3. Training and qualification: no minimal qualification

For home-care workers in Sweden, publicly or privately employed, **there are no mandatory qualifications**, other than what is stated in the Social Services Act: that staff have ‘suitable training and experience’. Of all eldercare workers (those employed by the hour excluded), 73 per cent had some kind of vocational training in 2007; slightly more in residential care and less in home care (NBHW, 2009b). The relatively low training level is an issue for policy makers. In recent years, several state subsidies have been offered to the municipalities in order to encourage them to provide training for already employed care workers and thus raise their vocational skills. However, for the moment there are no plans to introduce minimum standards for formal training.

Just over three-quarters (76%) of Swedish care workers have at least one year of formal training. This is a partial reflection of the fact that the majority (70%) of the Swedish care workers are assistant nurses (AN)¹¹.

However other figures mentioned in the ENEPRI report indicate that 70 – 75 % of the total labour force has specific occupational training in LTC today. This is an increase with 10% compared to 10 years ago. The proportion of staff with post-secondary school education has not changed in the last 10 years and is about 13 – 15 % of the labour force.

All in all, the lack of targeted qualifications for LTC staff can pose challenges to the quality of services according to OECD.

There are no requirements or qualifications for LTC workers, nor are there national standards for workforce qualifications. It is often up to the municipality to establish a training programme. Many workers therefore may face constraints at work when lacking a minimal training.

There are some initiatives to develop and upgrade employees’ skills. In 2012, the National Board of Health and Welfare (NBHW) provided recommendations on staff qualifications for basic elderly care (to be equivalent to a 3-year secondary school health care programme) and for specialised tasks such as dementia care, mental illness etc. Participation by municipalities remains on a voluntary basis. In 2011 the Swedish government began the *Omvårdnadslyftet*, a 4-year education initiative to improve LTC staff competencies. The focus was put on workers with no formal education. The municipalities were given monetary incentives to participate (reward given to those that have raised competence levels to a certain degree). 10,000 employees have been trained under this initiative since its launching.

Another project was built to overcome low language skills among LTC workers (*Språksam* Project) but it

¹¹ Ibid.

is delivered only in a few workplaces.

There also exist initiatives directed at directors working in elderly care.

2.4. Employment status

According to some authors, care work in Sweden has been “casualized”, as a large proportion of the care workers work **part-time** (55% according to SALAR). Part-time work is much more common among care workers than it is amongst the female workforce overall. In public residential care, the share of part-timers is around 63%, compared to nearly 69 in private residential care.¹²

Moreover as stated above, a significant proportion of part-timers **want to work more hours** (one third according to Kommunal survey). Holding more than one job is also an indication of the involuntary nature of part-time work. Some surveys report a figure around 7% of the workforce holding more than one job¹³.

We do not have managed to collect data about **temporary employment in home-care work**. A recent report written by Kommunal reports that 28% of municipal employees in residential care work under temporary contracts, compared to 32% in private organisation.

2.5. Income and wages

There is **no legal minimal wage in Sweden**. A **collective agreement** fixes a minimum for each sector depending on qualification. To illustrate:

- Municipal care employee
 - Basic qualification: 1820€/month on average¹⁴
 - Nurse qualification: 2455€/month on average
- The collective agreement for personal service sector fixed a minimum 1778€/month in April

¹² Kommunal, Så mycket bättre? En jämförelse av anställningsvillkor och löner i privat och kommunalt driven äldreomsorg, 2014.

¹³ http://www.cccg.umontreal.ca/rc19/pdf/szebehely-m_rc192009.pdf

¹⁴ 2009 figures. Source: report DG justice (op cit), annex Table 5A.

2011¹⁵.

According to the recent Kommunal survey, wages are higher for municipal employees in elderly care compared to employees in private residential care.

2.6. Health and well-being

Here as well we lack enough information. We can mention the result of a survey conducted by researchers among unionised residential carers (n= 292) in 2005. The following table gives some quantitative results.

Table 2. Workload and negative experiences of work. Residential care workers in Canada and Sweden

	Care workers		Canada		Sweden	
	Canada	Sweden	Assistant nurses	Care aides	Assistant nurses	Care aides
Number of residents helped per workday weekday (average)	19.9	8.8	32.7	15.2	8.8	8.8
Carry, lift or pull heavy loads or persons (%) ⁱ	77.4	66.3	59.2	83.3	69.5	59.1
Too much to do (%) ⁱⁱ	57.8	40.9	50.4	60.3	42.9	36.4
Work short staffed due to sickness, vacation or vacancy (%) ⁱ	48.3	12.2	55.2	46.0	12.0	12.8
Experience physical violence from a resident or resident's family (%) ⁱ	38.2	5.8	24.6	43.0	5.9	5.7
Can affect the planning of each day's work (%) ⁱⁱⁱ	24.1	48.1	24.8	23.8	48.3	47.7
Feel physically tired after a working day (%) ⁱⁱⁱ	60.4	27.8	53.2	62.9	28.6	26.1
Feel mentally exhausted after a working day (%) ⁱⁱⁱ	43.0	14.5	41.4	43.5	15.8	11.4

Figures marked in bold indicate a statistically significant difference (p<0.05).

ⁱ More or less every day. Other response alternatives: Every week, Every month, Less often, Never.

ⁱⁱ All or most of the time. Other response alternatives: Sometimes, Rarely, Never.

ⁱⁱⁱ Almost always. Other response alternatives: Often, Sometimes, Rarely, Never.

Source: Marta Szebehely & Tamara Daly (2009), "Unheard voices, unmapped terrain: comparative welfare research and paid care for older people in Sweden and Canada" http://www.cccg.umontreal.ca/rc19/pdf/szebehely-m_rc192009.pdf

¹⁵ Source: DGCIS op cit.

3. SERVICE QUALITY

3.1. Overall approach

The official objectives of LTC care in Sweden is to provide the elderly with support to carry on living a high qualitative and independent life for as long as possible¹⁶; to participate and engage in civic and personal life, and to be treated with respect and to have access to good elderly care (Ministry of Health and Social Affairs, 2009). **The government guideline is to ensure that care receivers along with relatives should be able to trust the care offered in Sweden is both dignified and high in quality.**

From 2010 to 2014, quality of services has been reinforced through a top-down incentivized system that will reward well performing municipalities for its achievements. This system, called the “Better Life Initiative”, relies on a framework agreement between SKL (Swedish Association of Local Authorities and Regions) and the Swedish government (SALAR, 2015). The initiative covered five areas: preventative approach, good care for dementia, good care in the final stages of life, good drug treatment, and coordinated health and social care, with objectives connected to each. Regions, municipalities and counties that achieved the set objectives were awarded performance bonuses

This approach was aimed at all those involved in health and social care for sick elderly people and it resulted in a real cultural change, i.e. shifting perspective from the organization to the person. The approach very much relied on the use of metrics and quantitative benchmarks. The evaluation report writes: “At the start of 2010, most municipal employees were relatively unaware of the quality registries – why they existed and how it was possible to use quality registries in the local improvement initiatives. The dissemination of quality registries in municipal health and social care has taken place at record speed. The desire for change and the determination to move from words to action played a vital role in this, along with the stimulus of the performance bonuses.” As a result, this report shows **real improvement in terms of the quality of the service.** It includes several quantitative data witnessing for instance an improved care in the final stages of life or a decrease in appropriate medication.

Other officially stated policy objectives are to provide training to supervisors and managers in the elderly care, which in trials proven to improve the quality and efficiency along with some educational requirement for all staff in elderly care.

Since the 2009 reform on System choice in the public sector, opening the access to private providers, the assessment of quality is an important element of the functioning of the system. People need to base their choices on measures of quality and municipalities base their purchasing decisions on indicators of providers’ performance. A system with free choice of providers indeed requires better information on quality and efficiency.

¹⁶ We draw here on ENEPRI report, op cit.

In the last 20 years, there has been an emphasis on quality assurance and quality measurements in Swedish eldercare services. **The Social Services Act includes a general declaration that services and care under the act should be of good quality and that the care quality should be systematically and continuously developed and secured.** Local authorities are obliged to establish systems for the quality work, and professionals and authorities on national and local levels are working intensely to develop reliable and valid measurements or indicators of care quality.

The users of home-care services are generally fairly satisfied with the services they receive. In 2008, the Swedish government commissioned the Swedish National Board of Health and Welfare to conduct biannual national user satisfaction surveys. In 2010, the survey was sent to more than two thirds of all eldercare recipients of tax funded eldercare services in Sweden. The response rate was 70 per cent for those receiving home care. On a scale of 1–100 the average level of satisfaction with home care was 75. The study found no class difference in evaluations of service quality. Older people with a university education were just as satisfied with the services as were older people with compulsory education only (NBHW, 2010d).

The LIVINDHOME report quotes a large survey conducted in 2008 (covering more than 11,000 home care users in Stockholm) that found no difference in perceived quality between privately and publicly provided services. It has to be noted that this survey took place before the implementation of the LOV reform (consumer choice models) in 2009. Five waves of the same survey since 1995 show a gradual decrease from 45 to 36 per cent of the care users reporting being ‘very satisfied’ with the ‘general quality of the received home care’. If those who reported to be ‘fairly satisfied’ are included, the level of satisfaction is more stable – a decrease from 83 to 81 per cent (USK, 2009, p. 18). In any case, competition through consumer choice models seemingly did not improve the quality of care.

3.2. Use of performance incentive and IT

The National Board of Health and Welfare cooperates with municipalities and county councils to develop **open comparison** and public performance reports on health care and social services.¹⁷ Surveys of service providers and users together with official statistics are used to build a wide range of indicators of quality which can be used to illustrate how municipalities and county councils are performing in different aspects. This provides useful information for prospective service users as well as for politicians seeking to improve the quality of local services and it can raise the awareness of staff about quality of care. Additionally, two **quality registers** for elderly care have been developed building on modern IT solutions and enabling participating providers to compare their own results over time and with those of others.

¹⁷ We draw here on “Closing the Gap — in Search for Ways to Deal with Expanding Care Needs And Limited Resources”, Peer review in social protection and social exclusion, Stockholm , 20 - 21 October 2011

But for the time being, registers concentrate more on health care indicators than on social care. The introduction of a performance-based grant system has increased the input to registers dramatically and improved the coverage and quality of data. The next step is to promote the use of the registers for local improvements in quality by strengthening analytical capacity at the local level.

In cooperation with stakeholders, the Swedish government has drawn up an **eHealth strategy** to ensure efficient and effective use of information and communication technology (ICT) in order to promote safer, more accessible and efficient health and elderly care services. Development of a common approach and nationally established guidelines and solutions are necessary and call for collaboration of all actors in the health and care sector.

3.3. Needs assessment

Sweden uses a comprehensive and subjective system to assess care needs.

People requesting services approach the “care manager” – a municipal employee who determines eligibility and types of services. There is today no general guidance for assessment of need in Sweden. Instead, the assessment is much down the evaluator and is performed on a discretionary basis. Although there is no general guidance, the most commonly used tests when assessing the need of the elderly in Sweden is drawn from the National Board of Health and Welfare. The absence of standardisation may permit to more easily tailor the help to individual needs. The Swedish model is built on trust in the care managers’ professional discretion.

The national report for Sweden in LIVINDHOME project note that **as a consequence of the tighter resources for eldercare, many municipalities have elaborated restricting local guidelines for their care services.** These have turned out to have a strong impact on the care managers’ assessment and decisions, and increasingly, care managers are urged to consider the municipal budget and make the necessary priorities. Further, studies have shown that the needs assessment often takes its starting point in the “municipal tool-box”, i.e. people’s needs are transformed into what services the municipality can offer, and a suitable client is thus constructed.

As of 1 January 2010, the local authorities are required to draw up an individual plan for each care receiver that clearly states each step of the required treatments and services. The plan must also disclose the name of the person that is officially in charge of the case and clearly specify which authority to be responsible for each component of service and care offered.

Still according to LIVINDHOME report, **the careworkers’ latitude for discretion has diminished in later years as restrictive local guidelines have come to dominate over professional judgments.** Moreover, the demands to create pre-regulated packages for the purchasing of services have standardised the care managers’ work. The newly suggested national instruments for needs assessments will further undermine the professional judgement.

3.4. Propositions for improvement

According to the OECD, not all conditions are met for the moment regarding the Swedish LTC system:

- Most stakeholders believe that competition across providers has not been driven by quality but instead by location or diversification of the services provided (e.g., specific treatments)
- Some people find it difficult to choose among different providers (In particular due to cognitive limitations) and report that they need more support from the local municipality.
- Municipalities face several limitations in their attempts to collect quality data. There is no requirement regarding how quality should be assured and Social Care Act stipulations are not easily operationalised into quality indicators.
- It is not sure, eventually, that free choice has an impact on increasing efficiency. If consumers prove more satisfied, there is no evidence that this is linked to an increased efficiency.

There are several tools on offer to facilitate people's choice, such as the "Elderly Guide" or the "Quality and Efficiency" reports published by the National Board.

The OECD observes that the quality indicators still remains focussed on process and structures (or means) and not yet outcomes. The measurement of user experience and quality of life represent service satisfaction rather than real outcomes. However it is very difficult to develop metrics or indicators of quality of life (other countries use the Adult Social Care Outcomes Toolkit – ASCOT). Another difficulty is that many small municipalities have not enough resources to collect data. The information provided to final users is not always accessible as it is only available online (this is the case for the Elderly Guideline).

Reinforcing quality assurance to complement transparency and competition is another recommendation formulated by the OECD. According to the OECD, Sweden has only weak quality assurance mechanisms for LTC. This quality assurance system relies mostly on self-regulation, inspection and a right to appeal. The model is grounded in the principles of the 1982 Social Services Act, i.e. that everybody has the right to claim public services and help to support their day to day existence. If a person is dissatisfied with the quality of the services, he/she has the right to appeal in an administrative court. Alongside this "self-regulation" model, ad hoc inspections can also be realised. The system is reactive and largely based on complaints made by recipients.

According to the OECD, as the LTC model is very decentralised, this reliance on self-regulation and ad hoc inspections entails a risk of variability in quality across localities. There is no uniform and systematic regulatory system, and no specific assessment criteria to base the inspector's evaluations.

The absence of a standardised needs assessment procedure also contrasts with many other countries in the

EU or the OECD.

More generally, a lot of confidence is put in performance-based incentives to encourage quality in elderly care (e.g., monetary grants given to counties that demonstrated a statistically significant improvement in reducing unnecessary hospitalisations). However, this “pay for performance” arrangements do not necessarily improve quality outcomes and may cause perverse effects (selectivity for instance).

According to the OECD, a greater use of guidelines and protocols for care, and establishing minimum qualification for LTC workers, would be necessary. It also recommends considering the possibility of introducing a system of accreditation of LTC system linked to required minimum quality standards.

The OECD concludes that Sweden has a very well developed model regarding the coverage of care needs, but not yet for quality assurance. The country is a best practice for elderly care. It has a comprehensive and highly accessible model. There is a high share of public spending and little financing required by individuals. The OECD recommends to develop a “more holistic and shared vision of quality assurance in LTC services” and “more decisive steps towards a quality assurance model for LTC”, this including a clear need for minimum competency standards for care workers.

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