Case study

Sweden

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Abstract

Health and social care for the elderly are important parts of Swedish welfare policy. Sweden is internationally regarded as a model for care for the frail and dependent elderly (eldercare). It has a tax-based universal comprehensive coverage for eldercare, and most eldercare is funded by municipal taxes and government grants. The system has very generous coverage, little cost-sharing at the point of service and a strong emphasis on improving elderly well-being by encouraging them to remain at home for as long as possible.

Four main features characterize Sweden's eldercare governance model:

- *Decentralized governance*. While the legal framework is set at the national level, both the Health and Medical Services Act (1982) and the Ädelreformen (Elderly Reform Bill, 1992) specify that care for the elderly is organized within a decentralized political structure. The municipalities have the legal obligation and autonomy to provide social services and services to fulfil the nursing and housing needs of the elderly.
- *Focus on keeping dependent people at their homes*. One of the main aims of the Ädelreformen was to provide incentives for municipalities to organize home-based elderly care – often termed as "ageing in place". While the number of eldercare beds still remains well above the OECD average, Sweden has seen one of the largest reductions in eldercare beds in the OECD area between 2007 and 2017, with a reduction of 15 beds per 1000 people aged 65 years old and over, compared to a reduction of 3.4 beds across the OECD during the same period. Sweden has also seen one of the most marked increases in the share of home care eldercare recipients in the OECD, and the hours allocated to home-based services amounted to 5.28 million in 2018, compared to 4.82 million in 2007.
- *Emphasis on choice and the market*. Provider competition is regarded as an important tool for driving performance improvement. The 2009 Law on System Choice in the Public Sector opened the provider market to competition across (public and private) providers of home care and residential care services, under the assumption that municipalities and recipients would choose providers based on their performance. Municipalities participating in a choice system have to disclose on a national website provider details, acceptance criteria and quality information. Municipalities have significant autonomy to grant licenses for operation, set prices and monitor compliance.

- *A powerful use of incentives.* Sweden has made significant use of financial incentives to steer change. Starting in 2010, there have been occasions when the annual transfers from the central government to municipalities have included performance targets based on outcomes results for elderly care. The Ädelreformen reform, the Law on System Choice in the Public Sector, and the use of performance targets in connection with transfers from the state to the municipalities have created an environment where eldercare providers' performance is encouraged through incentives for providers to compete, for users to choose across providers, and for municipalities to deliver value and quality.

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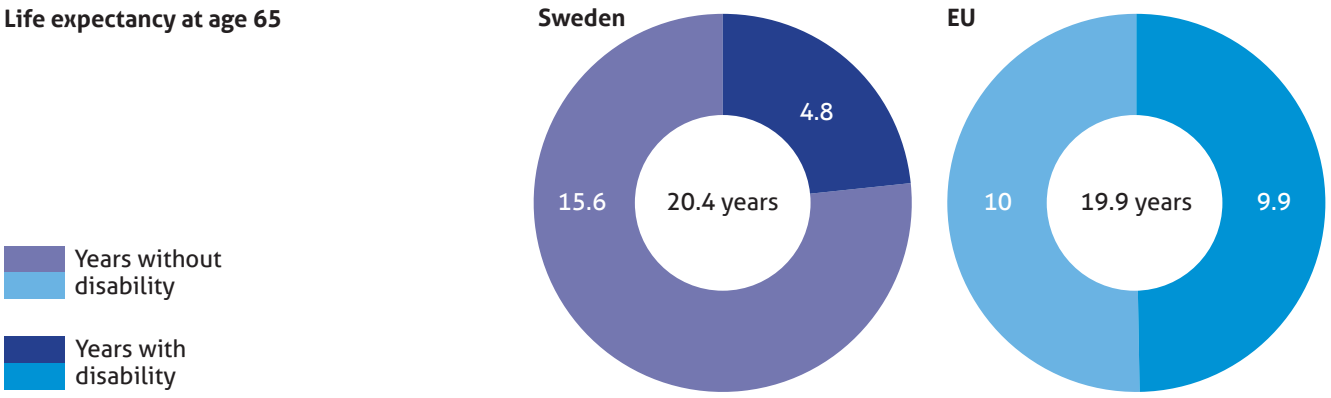
1
The context

Sweden had a population of 10 million inhabitants in 2018, which is expected to reach 13.9 million in 2070. In 2017, the life expectancy at birth of the Swedish population was 82.5 years, more than 1.5 years above the European Union (EU) average (80.9 years). Progress, however, has been slightly slower in Sweden than elsewhere in the EU. Between 2000 and 2017, Swedes gained 2.7 years of life, compared with 3.6 years for all EU citizens. The gender gap in Sweden has narrowed, as men have gained more years in life expectancy than women.

The share of people aged 65 and over is steadily growing in Sweden because of rising life expectancy. In 2017, one in five people in Sweden were aged 65 and over, up from 16% in 1980; this is projected to reach one in four people by 2050. In 2017, Swedes aged 65 could expect to live slightly more than 20 years – an increase of about two years since 2000 – and most of these years are spent without disability (Figure 1). The fact that Swedes are living longer brings about new challenges in terms of the sustainability of welfare systems and their financing (Government Offices of Sweden 2013). The challenges concern the declining share of people regarded as being of working-age, as fewer and fewer people will have to support an increasing percentage of the population. An ageing population also means that costs for elderly care can be expected to rise, especially since new health technologies tend to be cost inflating (Marino and Lorenzoni 2019).

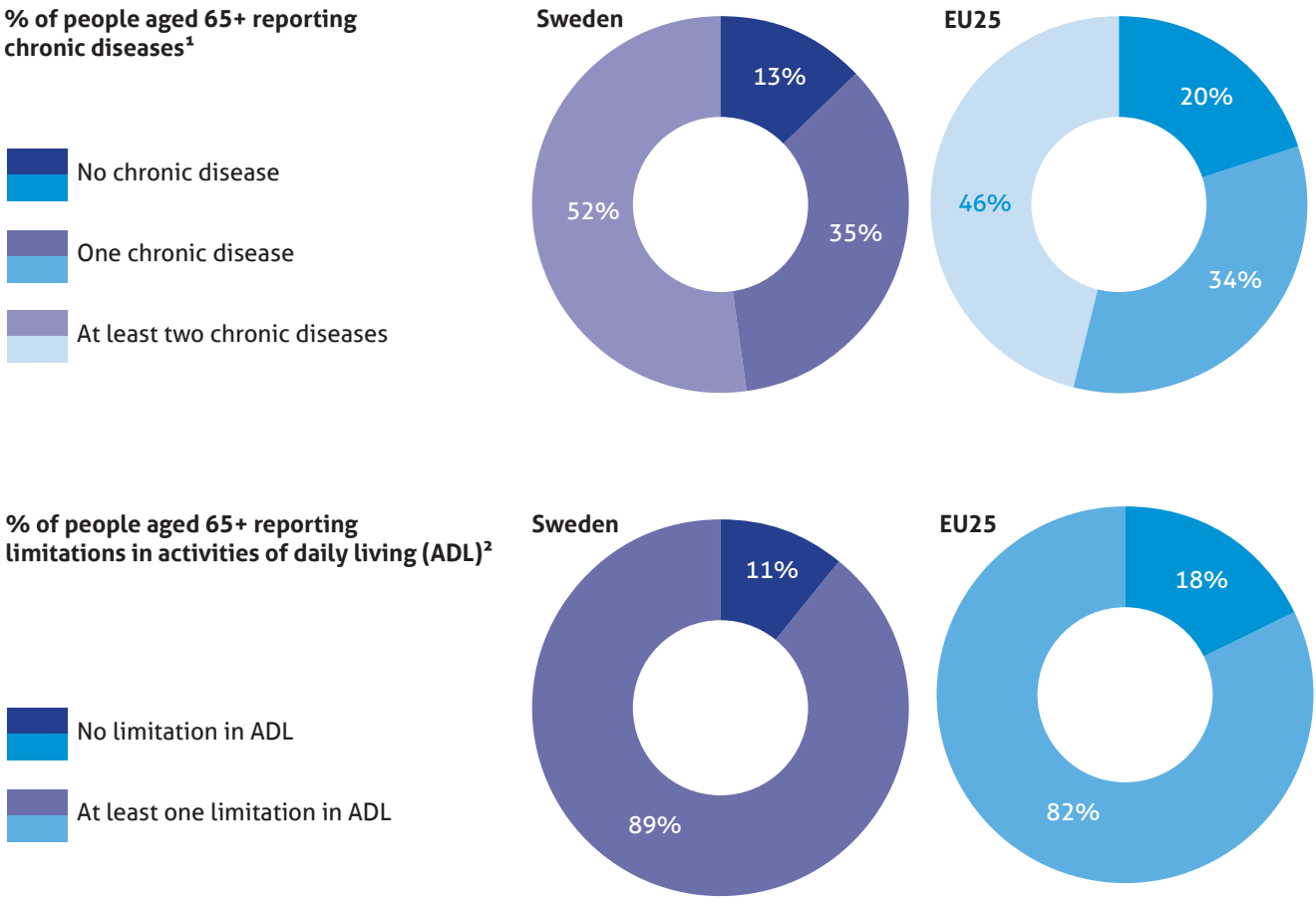
While nearly half of Swedes aged 65 reported them having at least one chronic condition, this does not necessarily hinder them from living a normal life and carrying on their usual activities. Most people are able to continue to live independently in old age; just over one in five people aged 65 and over reported some limitations in basic activities of daily living (ADL), such as dressing and eating, that may require assistance with fewer than one in twelve people reporting severe limitations (Figure 2). This proportion is much lower than the EU average and mainly concentrated among people aged over 80. In Sweden, adults aged 65 years and older in the lowest income quintile are more than twice as likely to report living in poor health compared to adults in the highest income quintile (OECD 2019a).

Figure 1
Comparison between Sweden and the European Union (EU) of life expectancy at age 65 and years with disability.



Source: OECD (2019c).

Figure 2
Comparison between Sweden and the European Union (EU) of people aged 65+ reporting chronic diseases and limitations in ADL.



Notes: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson's disease, Alzheimer's disease, rheumatoid arthritis and osteoarthritis. 2. Basic ADL include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.

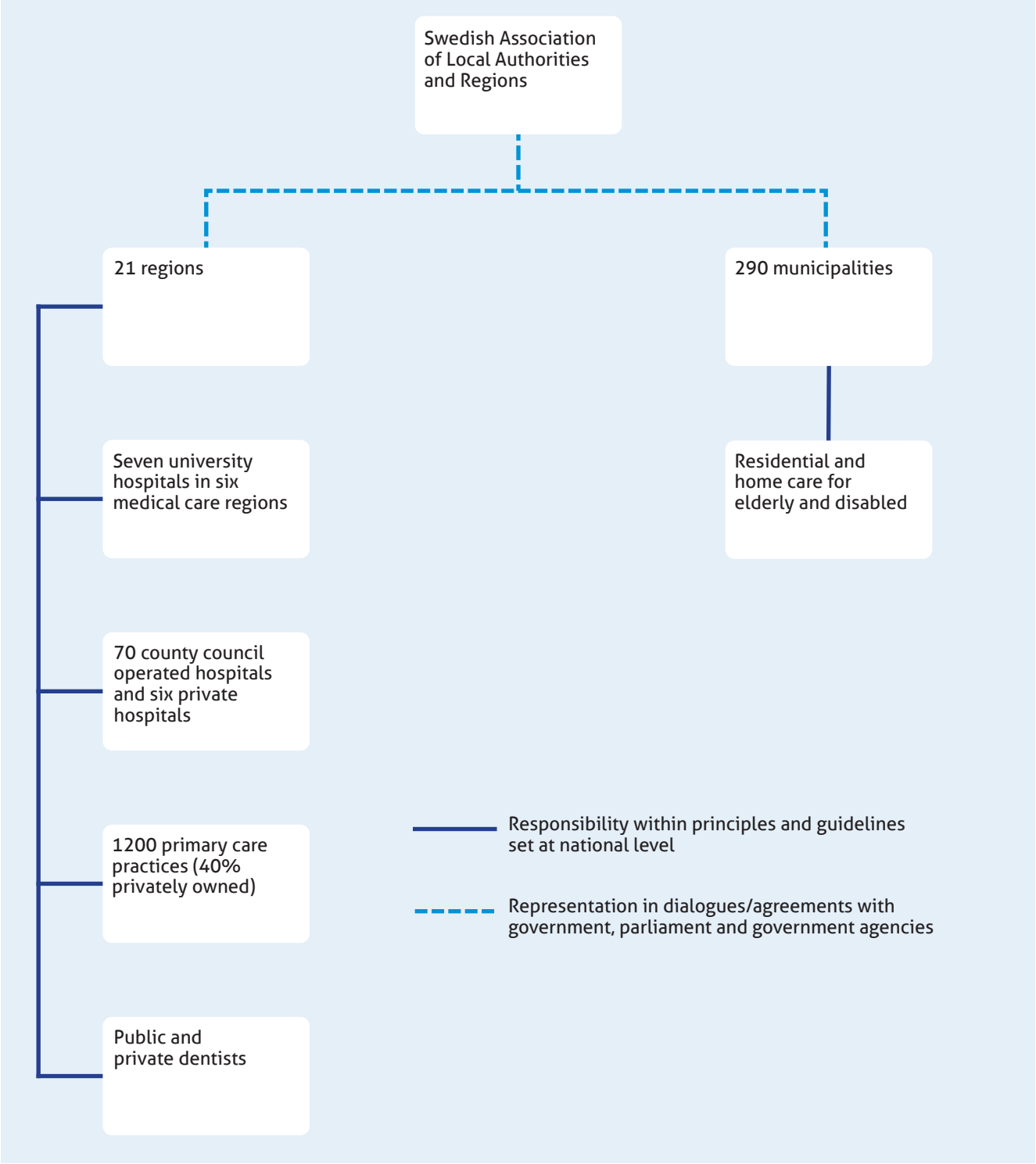
Source: OECD (2019c).

The Swedish health care system is decentralized. At the central government level, the Ministry of Health and Social Affairs is responsible for developing legislation on health care, social insurance and social issues. These laws and regulations are the basis also for the planning, funding and provision of eldercare services through the cooperation of regions and municipalities. To this aim, the central government is in constant dialogue with the Swedish Association of Local Authorities and Regions, a cooperative national organization that represents all regions and municipalities.

Sweden is divided into 290 municipalities and 21 regions (including Gotland, an island in the Baltic Sea, which is both a municipality and a region). The size of the population in the municipalities varies widely, from slightly less than 2500 in Bjurholm to almost 1 million in the largest city, Stockholm. The average population in each region is about 487 000 inhabitants. The Stockholm region is the largest, with about 2.4 million inhabitants, whereas the smallest is Gotland, with about 60 000 inhabitants (Statistics Sweden 2020).

At the regional level, there are 17 regions and 4 regional bodies (Västra Götaland, Skåne, Halland and Gotland). There is an appointed governor with an administrative board, which is the regional representative of the national government. Policy-making assemblies are directly elected by the residents of the region. Health care is the largest and most important part of the regional responsibilities. At the local level, there are 290 municipalities (including Gotland). Each municipality has an elected assembly – the municipal council – that makes decisions on municipal matters. The municipal council appoints the municipal executive board, which leads and coordinates municipality work. The municipalities are responsible for matters relating to their inhabitants and their immediate environment, such as primary and secondary education and care of older and disabled people (Figure 3). Moreover, they are responsible for the water supply, sewerage and streets, spatial planning, rescue services and waste disposal. Regions and municipalities are highly autonomous with respect to central government. Both have the right to levy and collect taxes.

Figure 3
Overview of the regional and local level organization of the Swedish health care system



Source: Adapted from Anell, Glenngård and Merkur (2012) and reproduced with permission.

2
Description of eldercare services

In the Swedish language, the notion "long-term care" is not used. Instead, policies in this field are qualified as "eldercare". All forms of eldercare are covered by the Social Security Act (2001), which ensures that older people have "the right to claim public service and help to support their day-to-day life if their need cannot be met in any other way." Similarly, the Health and Medical Services Act (1983) calls the health system to maintain a good standard of health among the entire population and provide care on equal terms.

Eldercare includes both varying forms of assistance in a home environment, institutional (or special-housing) care (old people's homes, residential care, homes for the demented/dementia units, nursing homes and similar). It includes personal care – such as help with bathing, getting dressed and in and out of bed – as well as help with shopping, cooking, cleaning and laundry. It also provides elderly in need with assistive devices, transportation, housing adaptations, handicap aids and support for informal caregivers.

Different kinds of residences for the elderly are available, including assisted living and nursing homes (Table 1). Assisted living means that the person lives in her/his own apartment with a security alarm and has access to certain shared services and rooms. The person also has access to a nurse, occupational therapist and physiotherapist. To move into an assisted living home, the person must have received a decision approving for social assistance. This decision is based on an overall assessment of the person's care needs, sense of insecurity and age. If the person needs support and assistance once she/he has moved into an assisted living home, she/he can apply for home help services. In an assisted living home, unlike normal housing or accommodations for seniors, the person is able to choose her/his home help services provider.

A nursing home is a residence with service and care around the clock. Residence in a nursing home includes all the assistance the person needs, including a nurse and access to a doctor, occupational therapist and physiotherapist. There are also shared community areas for socialising. The person can live in a nursing home for the rest of her/his life, even if need for care changes. The person needs an assistance decision to be granted a place. When a person has been granted a nursing home, she/he can choose the home she/he prefers[1]. There are nursing homes with specialist skills to handle a particular diagnosis or disability, e.g. Parkinson's disease or a physical disease. A person can choose her/his own nursing home with

1 The Social Services Act states that as far as possible, married couples and partners are to be given the opportunity to continue to live together even if they have different care needs. In those cases where this is possible, a husband or wife can choose to move to a nursing and care facility even if he or she does not have an equally great need for assistance.

specialist skills but will only be granted a place at a facility designed for her/his specific needs.

Table 1
Overview of the types of residences for the elderly (from age 65).

	Assisted living	Nursing home
Key features	Own apartment with personal security alarm For care needs that are difficult to provide at home Nurse available Community room for activities and meals	Own apartment or room with personal security alarm Extensive assistance if needed Full service and care round the clock
How to apply	An assistance decision is required Granted according to need	An assistance decision is required Granted according to need Possibility to choose residence and provider

Source: adapted from Elderly care for people living in the city of Stockholm (https://aldreomsorg.stockholm/olika-former-av-aldreomsorg/).

A person can also stay in a nursing home for a short time. Short-time care may recur regularly; hence, the person lives alternately in her/his own home and in a nursing home. Short-term care can be granted to relieve people caring for a close relative at home. Short-term care may also be provided while the city district administration assesses the person's future need for care and housing or if the person has been in hospital and needs time to recover before returning to her/his own home. Short-term care is not covered by the freedom of choice rules, which means that the person cannot choose a provider.

Home care comprises help with daily activities such as shopping, cooking, cleaning and laundry as well as help with personal care, such as help with bathing, going to the toilet, getting dressed and getting in and out of bed.

The following eldercare services are also available in Sweden: meal services, home adaptation and personal security alarms. There are also transportation services for care recipients who are unable to use public transport. In addition, local authorities also provide non-means tested grants to assist the disabled to use their homes in an efficient manner.

Regions 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 eldercare is mainly funded by local taxation underlines the independence of the local authorities from national government. With the Local Government Act, which came into force in 1992, municipalities were handed responsibility over local nursing homes and other forms of institutional eldercare. In contrast, the responsibility for health care belongs to the regions.

Over the years, all regions and municipalities, except the municipalities within the Stockholm region, have formed agreements on transferring the responsibility for home health care also in all ordinary homes from the regions to the municipalities. This has led to a more coherent organization. However, regions are still responsible for patients until they are discharged from a hospital. The responsibility of medical care and rehabilitation for elderly in ordinary homes is shared between municipalities and regions. This places high demands on the coordination of care between municipalities and regions. A lack of coordination may lead to an inefficient use of resources, cooperation issues, and lack of continuity as well as attempts by regions and municipalities to transfer both responsibilities and costs to one another. From 1 January 2010, local authorities have to draw up an individualized 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.

Sweden engaged in a deinstitutionalization of their eldercare supply through the promotion of home-based solutions and a reallocation of public eldercare spending towards home-based care. In Sweden, the number of eldercare beds has declined over the decade 2007-2017 from 86.5 to 71.5 per 1000 people 65 years and above (OECD 2019a). In the meantime, Sweden is one of the OECD countries where the number of elders receiving care at home increased the most (+9%) in 2016 (OECD 2017).

3
Eligibility criteria and utilization

In the Swedish universal care regime, comprehensive, publicly financed and high-quality services are available to all citizens according to need rather than ability to pay. There is therefore no means-testing criterion applied to the provision of eldercare. The Swedish eldercare system is decentralized, and municipalities are responsible for institutional care such as nursing homes, residential care facilities and group homes for persons with dementia, and home-help care and services. There are no national regulations on eligibility, and local authorities decide on the service levels, eligibility criteria and the range of services provided for home help and institutional care.

Need for care is assessed either by a general practitioner or through a request for assessment to the relevant local authority. For direct requests to the authority, the potential recipient as well any eventual relatives are interviewed by a municipal assessor representing the Social Board in the municipality. The municipal Social Board then decides on the provision of services based on the GP or municipal assessor's proposal. The legislation gives no details on the assessment procedure itself, the criteria to be used in the needs assessment or in determining the extent of support required, and whether the care can be provided in the 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 other cases, however, home care is not advisable (for instance, due to the inadequacy of the home), and institutional care will be considered as a last resort policy. A new provision has been introduced in the Social Services Act, which makes it possible for the 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.

In October 2018, 11.8% of the Swedish population aged 65 years or above received an average of 22.8 hours of home care services, a decrease from 12.6% and 24.3 hours respectively in 2007 (Table 2).

Table 2
Number of persons receiving home care services and average number of hours of services per month by type of management, 2007-2018.

		% of persons		Average number of hours		
Year	Number of persons 65 + receiving home care	Municipal management	Private management	Municipal management	Private management	Total
2007	198 877	89.3	10.7	24.0	26.4	24.3
2008	201 922	87.5	12.5	21.9	28.4	22.7
2009	205 797	86.2	13.8	21.8	26.9	22.5
2010	210 966	84.5	15.5	22.0	27.9	22.9
2011	220 607	84.3	15.7	21.5	29.5	22.7
2012	219 564	83.2	16.8	21.7	32.1	23.4
2013	219 695	81.9	18.1	22.1	31.3	23.8
2014	221 634	81.5	18.5	22.2	32.1	24.1
2015	223 250	81.7	18.3	23.1	32.5	24.8
2016	228 476	82.2	17.8	22.2	30.5	23.7
2017	231 324	82.3	17.7	21.6	30.8	23.2
2018	236 360	83.0	17.0	21.0	31.5	22.8

Source: adapted from the National Board of Health and Welfare Statistics (2019a).

Note: in municipal management, health and social care provided primarily by staff employed by the municipality; in private management, health and social care is ultimately the responsibility of the municipality, but is provided by someone other than the municipality, such as a company, foundation or cooperative on behalf of, and paid by the municipality, or where the municipality purchases places in residential care homes from private entities.

From 2007 to 2018, a large part of elderly received home services primarily by staff employed by the municipality, even if the share of persons to whom services were provided by private management increased by more than 6 percentage points to 17 % (Table 2). The average number of hours of home services provided per month decreased by 1.5 hours between 2007 and 2018, whereas the number of hours provided by private management increased by 5 hours during the same period.

There is a large variation in the proportion of services provided by the private management and the average hours of service by region. In Norrbotten, a region in the north of Sweden, almost all services are provided by staff employed by the municipalities, whereas in Stockholm, the capital region, more than half of the persons aged 65 years or above received privately managed services (Table 3). In 2018, the average number of hours of home services in Gotlands was two times the number of hours provided in Blekinge, a region in the southeast of Sweden.

Table 3
Number of persons receiving home care services and average number of hours of services per month by region by type of management, 2018.

		% of persons		Average number of hours		
Region	**Number of persons 65+ receiving home care**	**Municipal management**	**Private management**	**Municipal management**	**Private management**	**Total**
Stockholm	42 387	49.1	50.9	23.6	33.4	28.6
Västra Götalands	39 781	94.4	5.6	19.1	27.8	19.6
Skåne	33 555	88.9	11.1	21.0	14.9	20.3
Östergötlands	11 149	89.2	10.8	17.6	30.6	19.0
Jönköpings	8937	92.0	8.0	20.6	31.7	21.5
Värmlands	8172	94.2	5.8	20.5	21.7	20.6
Gävleborgs	8129	87.1	12.9	17.6	36.2	20.0
Dalarnas	7793	94.8	5.2	22.6	41.7	23.6
Örebro	7501	92.9	7.1	20.9	47.1	22.8
Södermanlands	7377	84.3	15.7	19.8	29.9	21.4
Hallands	6924	87.6	12.4	26.6	35.8	27.7
Västmanlands	6798	75.9	24.1	18.5	34.3	22.3
Västernorrlands	6790	93.6	6.4	21.3	29.9	21.9
Kalmar	6782	97.3	2.7	25.7	33.1	25.9
Västerbottens	6637	85.6	14.4	23.9	36.8	25.8
Norrbottens	5942	97.8	2.2	25.5	32.6	25.6
Uppsala	5924	74.9	25.1	24.7	35.1	27.3
Blekinge	5071	92.4	7.6	15.9	24.0	16.5
Kronobergs	5069	94.3	5.7	19.0	39.1	20.1
Jämtlands	4133	89.3	10.7	18.5	15.8	18.2
Gotlands	1509	80.4	19.6	26.4	53.5	31.7
Total	236 360	83.0	17.0	21.0	31.5	22.8

Source: adapted from the National Board of Health and Welfare Statistics (2019a).

In October 2018, a little over 88 000 persons aged 65 years or older were living permanently in residential care homes (National Board of Health and Welfare 2019b), down from 97 500 in 2007 (- 9.7%). The proportion of elderly persons living in privately managed residential care homes increased every year from 2007 until 2014. Since then, the increase has levelled out, and around one in five persons are served by privately managed facilities (Table 4).

Table 4.
Number of permanent residents by type of facility management, 2007-2018.

		% of residents	
Year	Number of permanent residents aged 65 or older	Municipal management	Private management
2007	97 494	86.2	13.8
2008	96 736	84.7	15.3
2009	95 377	83.5	16.5
2010	93 980	81.4	18.6
2011	92 212	79.9	20.1
2012	90 521	79.5	20.5
2013	88 986	79.1	20.9
2014	88 712	79.1	20.9
2015	87 903	80.5	19.5
2016	88 886	79.5	20.5
2017	88 208	80.4	19.6
2018	88 044	80.5	19.5

Source: adapted from the National Board of Health and Welfare statistics (2019a).

The proportion of residents in privately managed residential care homes varies by region. At the one end, all services are provided by municipal managed facilities in Blekinge, whereas one in two residents are served by privately managed facilities in Stockholm (Table 5).

Table 5
Number of permanent residents by region by type of facility management, 2018.

		% of residents	
Region	**Number of permanent residents aged 65 or older**	**Municipal management**	**Private management**
Stockholm	15 608	50.9	49.1
Västra Götalands	14 104	90.3	9.7
Skåne	10 331	75.6	24.4
Östergötlands	4573	72.5	27.5
Jönköpings	3439	98.8	1.2
Gävleborgs	3202	89.6	10.4
Norrbottens	3183	98.9	1.1
Västmanlands	3067	86.4	13.6
Västernorrlands	3015	97.0	3.0
Västerbottens	2932	99.5	0.5
Uppsala	2909	63.8	36.2
Dalarnas	2885	92.1	7.9
Värmlands	2757	87.6	12.4
Hallands	2725	75.7	24.3
Södermanlands	2723	90.1	9.9
Örebro	2713	95.7	4.3
Kalmar	2261	94.6	5.4
Kronobergs	1873	84.8	15.2
Blekinge	1677	100.0	0.0
Jämtlands	1482	91.2	8.8
Gotlands	585	67.2	32.8
Total	**88 044**	**80.5**	**19.5**

Source: adapted from the National Board of Health and Welfare statistics (2019a).

4
Funding and co-payments

Health expenditure is mostly paid through local taxes, along with contributions from the national government via general grants, subsidies to the regions for outpatient medicines and specific national programmes. In 2018, the government invested 1 billion Swedish kronor (kr; €100 million) to improve access to care, with the two main objectives of providing greater treatment guarantees in primary care and developing 'patient contracts'. The latter are described as a coherent map of planned care that would contribute to 1) increasing care coordination, treatment and prevention efforts for patients with multiple health care contacts; 2) ensuring that all patients receive the care they need within a reasonable time; 3) ensuring that patients get an overview of planned care so that they can follow the care initiatives step by step and ask questions; and 4) increasing collaboration between health care providers and between regions and municipalities in care coordination and transitions.

Sweden allocated 10.9% of its GDP to health spending in 2019, the third highest share among EU countries and well above the EU 27 average of 8.3%. Sweden also has the third highest spending on health per person among EU countries, at €3919 [2] in 2019. Public expenditure accounts for 85 %, which is considerably above the EU average (73%). Households pay most of the remaining health spending (14%) directly out of pocket, while voluntary health insurance only accounts for about 1% of health spending. However, the number of people with private voluntary health insurance coverage is increasing rapidly, as this facilitates quicker access to consultation and care than using the public services.

Expenditure on care for the elderly by municipalities has slightly increased at an annual average of 0.2% (in constant 2017 prices) between 2013 and 2017 (Table 6). During this period, expenditures on nursing homes decreased by 0.4% annually, whereas expenditure for home care services increased by 1.9%. In 2017, expenditures on nursing homes and home care accounted for 56.9% and for 33.6% of total municipality expenditures for the elderly respectively. Between 2013 and 2017, the share of expenditures on nursing home in total municipality expenditures for the elderly decreased by one and half percentage points, while the share of home care increased by more than two percentage points during the same period.

2 Adjusted for differences in purchasing power.

Table 6
Expenditures on eldercare by municipalities, in constant prices, 2013-2017

	Year					
Expenditure (in billion SEK)	**2013**	**2014**	**2015**	**2016**	**2017**	**% share 2017**
Total	120.5	123	120.7	122.2	121.7	100
% change		2.1	-1.9	1.2	-0.4	
Nursing homes	70.5	70.7	68.5	69.6	69.3	56.9
% change		0.3	-3.1	1.6	-0.4	
Home care	37.9	40.1	40.5	41	40.9	33.7
% change		5.8	1.0	1.2	-0.2	
Other services	12.1	12.2	12.7	11.6	11.5	9.4
% change		0.8	4.1	-8.7	-0.9	

Source: adapted from the National Board of Health and Welfare (2019c).

The average expenditure per user varied significantly among municipalities. For home care services, the most expensive municipality spent more than five times the amount of the least expensive municipality, whereas for nursing homes, this difference was slightly lower (4.5 times). In 2018, spending per user of nursing homes was 3.4 times higher than the spending per user of home care (Table 7). Furthermore, spending decreased with increasing municipality size, whereas for home care services, expenditure was lower in municipalities with a population greater than 70 000.

Table 7
Average annual expenditure per user by municipality, 2018.

	Mean expenditure per user (in SEK)		Mean expenditure per user (in EUR)	
Municipality population	**Home care**	**Nursing home**	**Home care**	**Nursing home**
< 15000	286 709.8	1 005 976.4	27 568.2	96 728.5
15000 – 30000	294 616.8	928 013.4	28 328.5	89 232.1
30000 – 70000	264 520.4	883 140.6	25 434.6	84 917.4
70000 – 200000	238 946.3	837 407.3	22 975.6	80 519.9
> 200000	238 383.5	830 651.8	22 921.5	79 870.4
Total	**279 279.5**	**944 919.4**	**26 853.8**	**90 857.6**

Source: adapted from the National Board of Health and Welfare (2020).

Approximately 85% of eldercare funding comes from municipal/county taxes, and another 10% comes from national taxes. Users pay only a small share of the costs out-of-pocket[3]. Cost sharing for eldercare 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 (the "reserve amount") as annually defined by the government. The reserve amount is the minimum amount to cover daily costs, rent and long-term additional costs due to individual needs. For a single person the reserve amount in 2015 was 5023 kr/month after housing costs. This means that if the person income after housing costs were paid was below 5023 kr/month, there was no elderly care fee. Within these rules, each municipality will determine its own schedule of cost-sharing fees for recipients.

As an example, Table 8 reports user's fees set by the City of Stockholm. The fee a beneficiary pays is based on her/his income, housing costs and what kind of assistance the person is granted. A person will never have to pay more than the maximum fee for the assistance she/he is granted. However, the person may pay a lower fee depending on her/his income, housing costs and certain other costs.

Table 8
Fee by assistance granted. City of Stockholm

Fee group	Scope of assistance granted	Max fee per month in SEK (EUR)
1	Only a personal security alarm or basic facilities in assisted living	142 (13.9)
2	1-4.5 hours of home care services and/or respite care 17-20.5 hours per month	492 (48.2)
3	5-10.5 hours of home care services and/or respite care 21-26.5 hours per month and/or day care activities 1-2 day per week	896 (87.8)
4	11-25.5 hours of home care services and/or respite care 27-41.5 hours per month and/or day care activities 3-4 day per week	1194 (117)
5	26-40.5 hours of home care services and/or respite care 42-56.5 hours per month and/or day care activities 5 day per week	1650 (161.7)
6	41-55.5 hours of home care services and/or respite care 57 hours or more per month and/or day care activities 6-7 day per week	1872 (183.4)
7	More than 56 hours of home care services per month. Short-term care and nursing home with round-the-clock care	2139 (209.6)

Source: Stockholms Stadt (2021).

3 In Sweden, fees are applied to almost all types of services and goods, with exceptions for maternal and child health services provided in primary care settings and some services for people aged over 85. The regions set the fees independently, and the fee structure provides an incentive to consult primary care over hospital visits. Only the fees for prescribed medicines and dental services are set at a national level.

Results of an OECD survey show that an hour of home care costs nearly €61 in Sweden, whereas institutional care costs from €1590 per week (Muir 2017). This survey also shows that in Sweden the costs for a person with severe needs represent three times and six times the median disposable income for individuals of retirement age for institutional care and home care, respectively (Muir 2017; OECD 2019a).

5
Contracting out eldercare services

There are two primary ways that Swedish municipalities contract out residential elderly care (Winblad, Blomqvist and Karlsson 2017; Bergman, Jordahl and Lundberg 2018): either through direct procurement according to the Public Procurement Act (2016), or through the freedom of choice system according to the Free Choice Act (2008). In the former case, private companies submit offers, either exclusively on price or on price and quality combined, and a municipality decides who gets the contract. In the latter case, the municipality sets the price and specifies some minimum quality requirements, and the individual choses a provider, according to her/his preferences, from an authorized list of providers that have met the municipality's criteria.

The evidence is that prices have played a determining role when contracts are awarded, even if most municipalities have some form of quality "base line" which all tenders must pass in order to be considered. According to Swedish competition law, contracts between the municipality and private providers cannot be entered into without a transparent and non-discriminatory selection process, which means that non-profit organizations are obliged to compete for municipal contracts on the same basis as for-profit firms. Notably, what is contracted out is the operation of nursing homes, which implies that the facilities are in most cases still owned by the municipalities. Swedish law also stipulates that the staff employed at the nursing home in question must retain their employment for at least one year after a new provider takes over the operation. Contracts are relatively short, typically 3–4 years, with the possibility of a single extension. It is important to note that contracting out nursing homes is voluntary and was used in about one third of municipalities in 2016. There is also large regional variation in this regard, as some municipalities chose to contract out all local nursing homes, i.e. 100%, whereas others chose to contract out only a limited number.

Compared with nursing homes, home care is characterized by low entry and low switching (Bergman, Jordahl and Lundberg 2018). From 2007 to 2014, the privately produced share of home care had increased from 10.7% to 18.5% of users and from 11.6% to 24.6% of the delivered hours of service. Between 2015 and 2018, these shares have decreased to 17% and 23.5% respectively (National Board of Health and Welfare

2019b). Within each municipality, the per hour payment is equal for all providers, including services provided by the municipality. Add-on payments may apply for night-time services and services in remote areas (Bergman, Jordahl and Lundberg 2018).

A system with free choice of providers requires robust, timely and reliable pieces of information on quality. For consumer choice to encourage better quality, it is essential that information regarding services and their quality be valid, clear and accessible and that consumers have the effective ability to exercise choice across a plurality of providers. To this aim, an 'Open Comparisons' national quality monitoring system for long-term care was established by the Swedish Government, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions in 2007. The Open Comparisons tool shows providers' quality of care delivered to the elderly based on 28 indicators along with grading of provides' performance. A relative comparison between municipalities is based on a traffic light system. Quality of elderly care indicators are also avaialble online (https://kolada.se/verktyg/jamforaren/?_p=jamforelse&focus=16551).

6
The role of the private sector

The Local Government Act of 1991 made it possible for municipalities to outsource the provision of eldercare to non-governmental actors, both for-profit and non-for-profit. To stimulate a greater variety of eldercare providers and enhance the quality of services provided, the government introduced a new law in 2008, the Act of System of Choice in the Public Sector. This Act applies when a contracting authority decides to apply a system of choice regarding services within health and social services. 'System of choice' means a procedure where the individual is entitled to choose the supplier to perform the service and with which a contracting authority has approved and concluded a contract. The contracting authority shall treat suppliers in an equal and non-discriminatory manner. The contracting authority must also observe the principles of transparency, mutual recognition and proportionality when applying a system of choice. The aim of this act 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.

Municipalities and regions can decide on how to organize the provision of eldercare, including collaboration with different providers. Either a municipality or a private provider (which can include private companies but also trusts and cooperatives) may provide institutional and home care. However, even when care is actually provided by the private sector, municipalities

and country councils still have the exclusive responsibility for financing care and ensuring an adequate level of quality.

Sweden has a higher proportion of private for-profit companies providing welfare services than any other country in Europe. Competition and choice can be effective and positive. Nevertheless, in a broader perspective, private interests often deviate from the interests of society (OECD 2019b). In effect the possibility of generating profits in the publicly financed welfare sector could result in for-profit organizations not acting as society would like them to do. The welfare sector must therefore be regulated so that organizations operating within it work to further society's interests.

In Sweden, large international corporations increasingly dominate the eldercare services market (Harrington et al. 2017). Of all nursing home care in Sweden, 12 934 permanent and temporary beds (13.5% of all beds) were provided by the five largest chains in 2015. This corresponded to 71.8% of private beds, and the 10 largest chains provided 86.8% of private beds. The two largest corporations, Attendo (92 homes, 5024 beds) and Ambea (77 homes, 3358 beds), ran half of the beds in for-profit homes. In the context of the Scandinavian tradition of universal, tax-financed care services centred on public provision, the recent wave of marketization and the increasing role of for-profit companies in residential care for older people were unexpected. In Sweden, for-profit chains operated 17% nursing home beds. This growth was considerable given that there were no for-profit actors in Scandinavia before the beginning of the 1990s.

The government has recently introduced increased license requirements and special rules for procurement in the welfare sector, including home help services for the elderly. The legislation aims at ensuring that private organisations have sufficient prerequisites for conducting business with good quality, and at strengthening the confidence in the sector.

Sweden was one of the pioneering countries to privatize its eldercare system ("marketization" started in the 1990s). Recent empirical research shows that the marketization of eldercare appears to be associated with an increase in some aspects of care quality like, for instance, choice offered by meals-on-wheels companies (Stolt, Blomqvist and Winbald 2011) or mortality rates (Bergman et al. 2016), but the results are mixed and inconclusive (Winblad, Blomqvist and Karlsson 2017). The increase in user satisfaction following the free-choice reform seems to be related to choice opportunity instead of private provision (Bergman, Jordahl and Lundberg 2018). The marketization of eldercare services is a controversial matter, because it raises potential quality-related and working condition issues as private eldercare providers could be involved in cherry-picking clients, and the influence of increased competition from private providers on public providers is uncertain. The marketization of the eldercare sector can lead to the emergence of competition issues when it takes place by take-overs (OECD 2019b).

An increase in the for-profit provision of publicly funded care services through policies promoting marketization, an increase of family care as well as services paid out-of-pocket appears to challenge universalism towards what Ranci and Pavolini (2015) call "restricted universalism" (Szebehely and Meagher 2018; Ulmanen and Szebehely 2018).

7
Informal caregiving, cash benefits to family members and housing adaptation

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 the carers 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. 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 responsibilities 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.

There are two types of cash benefits available for family carers in Sweden: the attendance allowance and the carers allowance. These allowances are, however, not provided everywhere as each municipality may decide whether to provide this programme or not and also decide what the eligibility criteria and level of payment should be. The "attendance allowance" is given on top of services provided to the care recipient. It is a net cash payment given to the care recipient to be used to pay for help from a family member. The level of reimbursement is at most about 4000 kr/month (€450). The other benefit is the "carers allowance": the municipality employs a family member to do the care work. Carers allowance is taxed and gives the same salary and similar social security as for home-help workers in the municipality's own services.

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. 150 million Swedish kronor was allocated for this purpose in 2016, 300 million Swedish kronor in 2017 and from 2018, 400 million Swedish kronor is allocated on a yearly basis. 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.

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